FORM V. S. No. 3-20 M. 1-19

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 32387
Registered No. 121

1. PLACE OF DEATH
County of Ada
City of Boise.
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No.
(No. St. Alphonsus Hospital.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Pat. Allen. Rhodes.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White.	Married.

6. DATE OF BIRTH Jan. 21. 1894
(Month) (Day) (Year)

7. AGE 26 Yrs. 11 Mos. 10 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Lumberman.
(b) General nature of industry, business or establishment in which employed (or employer) Logging.

9. BIRTHPLACE (State or Country) Delta. Colo.

10. NAME OF FATHER Geo. Rhodes.

11. BIRTHPLACE OF FATHER (State or Country) Mo

12. MAIDEN NAME OF MOTHER Dora. Marshall.

13. BIRTHPLACE OF MOTHER (State or Country) Colo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wm M. Bratney
(Address) Boise Idaho

15. Filed Jan 12. 1921 R. H. Pratt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan. 11 — 1921
(Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 4th 1920 to Jan 11 1921 that I last saw h— alive on Jan 10 1921, and that death occurred on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) Yrs. mos. 5 ds.

Contributory (Secondary) Tuberculosis Intestinal

(Duration) yrs mos. 14 ds.

(Signed) R. E. Glantz M. D.

1/11/21 (Address) Boise Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Morris Hill Cemetery	1/13 1921
20. UNDERTAKER W M Bratney	ADDRESS Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 2004
File No. 32531
Registered No.

1. PLACE OF DEATH
County of Canyon
City of
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James N Walker
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Nov (Month) 16 (Day) 1858 (Year)

7. AGE: 62 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Penn

10. NAME OF FATHER: Andrew Walker

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Isabell Cambell

13. BIRTHPLACE OF MOTHER (State or Country): Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs J Walker
(Address) Nampa Ida

15. Filed Jan 10 1921 Pearle Dodds
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: January (Month) 1st (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1st 1920, to Jan 1st 1921
that I last saw h[illegible] alive on Dec 31 1920
and that death occurred on the date stated above, at 9 A M.
The CAUSE OF DEATH* was as follows:

mitral regurgitation

(Duration) 2 Yrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) J M Sellars M. D.
1/1 1921 (Address) Nampa Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Catholic Penn
DATE OF BURIAL: 1/3 1920

20. UNDERTAKER: J K Robinson
ADDRESS: Nampa

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 2004
File No. 32532
Registered No.

1. PLACE OF DEATH
County of Canyon
City of Nampa
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lois N. Shenk

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): ~~M~~ S

6. DATE OF BIRTH: Dec (Month) 6 (Day) 1870 (Year)

7. AGE: Yrs. 1 Mos. ~~11~~ ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: L
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: J. B. Shenk.

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Lana King

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. B. Shenk.
(Address)

15. Filed Jan 16 1921 Pearle Dodds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 5 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 2 1921, to Jan 5 1921, that I last saw her alive on Jan 5 1921, and that death occurred on the date stated above, at 4 0 M.
The CAUSE OF DEATH* was as follows:
Capillary Bronchitis
(Duration) ..... Yrs. ..... mos. 3 ds.
Contributory (Secondary) Pneumonia
(Duration) ..... yrs. ..... mos. 2 ds.
(Signed) Geo. R Proctor M. D.
Jan 8 1921 (Address) Nampa Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mennonite Cem
DATE OF BURIAL: 1-6 1921

20. UNDERTAKER: F K Robinson
ADDRESS: Nampa

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 2004
File No. 32533
Registered No.

1. PLACE OF DEATH
County of Canyon
City of Nampa
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Frank H Scott
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	white	married

6. DATE OF BIRTH: Oct (Month) 10 (Day) 1851 (Year)

7. AGE: 69 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer): (Retired)

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: H M. Scott

11. BIRTHPLACE OF FATHER (State or Country): Ill.

12. MAIDEN NAME OF MOTHER: V

13. BIRTHPLACE OF MOTHER (State or Country): V

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ora Scott
(Address) Nampa Ida

15. Filed Jan 11 1921 Pearle Dodds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 1 (Month) 4 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12/25 1920, to 1-4 1921
that I last saw h.cim alive on 1/4 1921
and that death occurred on the date stated above, at 4 P. M.
The CAUSE OF DEATH* was as follows:

Septicemia

(Duration) — Yrs. — mos. 11 ds.
Contributory (Secondary) Septic Endocarditis
(Duration) — yrs. — mos. 4 ds.

(Signed) Leo N. Chilton M. D.
19 (Address) Nampa Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Nampa Ida
DATE OF BURIAL: 1-7 1921

20. UNDERTAKER: C K Robinson
ADDRESS: Nampa

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

C

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Canyon

City of Nampa

(No. Mercy Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 7

Primary Registration District No. 1054

File No. 32537

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Hilda Helen Day

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.):

6. DATE OF BIRTH: Apr (Month) 14 (Day) 1920 (Year)

7. AGE: Yrs. 8 Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Frank Day

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: Emily Thomas

13. BIRTHPLACE OF MOTHER (State or Country): Neb

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Hydegger

(Address) Nampa Ida

15.

Filed Jan 10 1921 Pearle Dodds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 1 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 29 1920, to Jan 1 1921 that I last saw her alive on Jan 1 1921 and that death occurred on the date stated above, at 3 A. M.

The CAUSE OF DEATH* was as follows:

Acute obstruction of Bowel

(Duration) Yrs. mos. 10 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) J H Murray M. D.

1/3 1921 (Address) Nampa Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Nampa Ida — DATE OF BURIAL: 1/6 1921

20. UNDERTAKER: F K Robinson — ADDRESS: Nampa Ida

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. .....
Primary Registration District No. 866
File No. 32515
Registered No. .....

1. PLACE OF DEATH

County of Canyon
City of Nampa
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Margaret Newton

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Female	White	Married (Write the word.)

6. DATE OF BIRTH August (Month) 29 (Day) 1863 (Year)

7. AGE 57 Yrs. 4 Mos. 4 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Housekeeper

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Canada

10. NAME OF FATHER ✓

11. BIRTHPLACE OF FATHER (State or Country) ✓

12. MAIDEN NAME OF MOTHER ✓

13. BIRTHPLACE OF MOTHER (State or Country) ✓

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) D. L. McBane

(Address) Nampa

15. Filed Jan 10 1921 Pearle Dodds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 1. (Month) 2. (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12-29 1920, to 1-2 1921 that I last saw her alive on 1-1 1921 and that death occurred on the date stated above, at .....M.

The CAUSE OF DEATH* was as follows:

Bronchitis - Pneumonia

.....(Duration) .....Yrs. .....mos. 5 ds.

Contributory (Secondary) Hypostatic Heart

.....(Duration) 14 yrs. .....mos. .....ds.

(Signed) H C Robinson M. D.

1-3 1921 (Address) Nampa

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Emerald Rest — **DATE OF BURIAL** ..... 19.....

20. UNDERTAKER H. Robinson — **ADDRESS** Nampa Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

EVANS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 21
Primary Registration District No.
File No. 32606
Registered No.

1. PLACE OF DEATH
County of Gooding
City of Hagerman
If death occurs away from usual residence, give facts called for under special information.
(No. , St.)

2. FULL NAME Katie Shore

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widow
6. DATE OF BIRTH: March (Month) 29 (Day) 1845 (Year)
7. AGE: 77 Yrs. 9 Mos. 3 ds.
IF LESS than 1 day how many hrs. or min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: aged-
(b) General nature of industry, business or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Mo
10. NAME OF FATHER: Jas Penney
11. BIRTHPLACE OF FATHER (State or Country): England
12. MAIDEN NAME OF MOTHER: ann macey
13. BIRTHPLACE OF MOTHER (State or Country): England
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. A. Shore
(Address) Dalle
15.
Filed Jan 2 1920 R. H. Greene Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 1 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 30 1920 to Jan 1 1921, that I last saw h-- alive on Jan 1 1921, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Pneumonia

2 or 3 days

(Duration) Yrs. mos. ds.

Contributory (Secondary) Old Age

(Duration) Yrs. mos. ds.

(Signed) R. H. Greene M. D.

Jan 2 1921 (Address) Hagerman

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Gooding
DATE OF BURIAL: Jan 3 1920

20. UNDERTAKER: Thompson
ADDRESS, Gooding

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 65

Primary Registration District No. 2145

(No. ....., ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32648

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Latah

City of Potlatch

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Raymond Arthur Yates.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. June (Month) 8 (Day) 1894 (Year)

7. AGE: 26 Yrs. 7 Mos. 4 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Lumberman

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Iowa.

10. NAME OF FATHER: John W Yates

11. BIRTHPLACE OF FATHER (State or Country): Ill.

12. MAIDEN NAME OF MOTHER: Poxson

13. BIRTHPLACE OF MOTHER (State or Country): Indiana.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) D W Yates

(Address) Potlatch

15. Filed Jan 4th 1921 D.W. Thompson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 2 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 2nd 1921, to Jan 2nd 1921, that I last saw him alive on Jan 2nd 1921, and that death occured on the date stated above, at 3.30 P.M.

The CAUSE OF DEATH* was as follows:

Septicemia - following extraction of tooth

(Duration) ..... Yrs. ..... mos. 3 ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J.W. Thompson M. D.

1/4/1921 (Address) Potlatch Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Potlatch Ida — DATE OF BURIAL: 1/6 1920

20. UNDERTAKER: L. M. Irwin — ADDRESS: Palouse Wash.

BYMS - YORK CO., PTRS. & BORS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 65.
Primary Registration District No. 2145.
(No. ....., ... St.)

File No. 32650
Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Latah
City of Princeton
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Alice Gilmore.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single.

6. DATE OF BIRTH. Jan. (Month) 16 (Day) 1920 (Year)

7. AGE: ..... Yrs. 11 Mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None.
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Eddie M. Gilmore.

11. BIRTHPLACE OF FATHER (State or Country): Washington

12. MAIDEN NAME OF MOTHER: Gladys Hemmerman.

13. BIRTHPLACE OF MOTHER (State or Country): Montana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Lincoln Gilmore.
(Address) Potlatch Idaho.

15. Filed Jan. 5th 1921 J. H. Thompson Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. (Month) 6 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 31st 1920, to Jan. 4th 1921, that I last saw her alive on Jan 4th 1921, and that death occured on the date stated above, at 9 A. M.

The CAUSE OF DEATH* was as follows:
Broncho-pneumonia.

(Duration) ..... Yrs. ..... mos. 7 ds.
Contributory (Secondary) Measles.
(Duration ..... yrs. 6 mos. ..... ds.

(Signed) J. H. Thompson M. D.
1/5 1921 (Address) Potlatch.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Meadenhall Cemetery — DATE OF BURIAL: Jan. 7 1921

20. UNDERTAKER: Parents. — ADDRESS: Princeton

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 16
Primary Registration District No. 1016
(No. ....., ... St.)

File No. 32659
Registered No. 32

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Lincoln
City of Shoshone
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary E Patrick

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. Jan 3 1863
(Month) (Day) (Year)

7. AGE: 58 Yrs. ..... Mos. 3 ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Virginia

10. NAME OF FATHER: John Fuller

11. BIRTHPLACE OF FATHER (State or Country): Virginia

12. MAIDEN NAME OF MOTHER: unknown

13. BIRTHPLACE OF MOTHER (State or Country): Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Roscoe Patrick
(Address) Shoshone

15. Filed Jan 6' 1921
J. L. Fuller
Local Registrar

SYMS - YORK CO., PTRS. & STRS. 24858

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 6 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 3 1921, to Jan 3 1921, that I last saw h alive on Jan 3 1921, and that death occured on the date stated above, at 6 a M.

The CAUSE OF DEATH* was as follows:
Gastric Cancer

(Duration) 4 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
1/6 1921 (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Shoshone — DATE OF BURIAL: 1-6 1921

20. UNDERTAKER: O F Brennan — ADDRESS: Shoshone

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 122
Primary Registration District No. 1200
File No. 32628
Registered No. 62

1. PLACE OF DEATH.
County of Shoshone
City of Mullan
If death occurs away from usual residence, give facts called for under special information.
(No. ....., ... St.)
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Alfred Gribble

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	White	Married

6. DATE OF BIRTH: Oct (Month) 31 (Day) 1873 (Year)

7. AGE: 47 yrs. 2 mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Mining
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: William Gribble

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Annie Rogan

13. BIRTHPLACE OF MOTHER (State or Country): Logan England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Foster Gribble
(Address) Mullan Ida

15. Filed ..... 191 .....
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan (Month) 8 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1 1920, to Jan 8 1921, that I last saw him alive on Jan 8 1921 and that death occurred on the date stated above, at 7.40 a M.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis

(Duration) 2 yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F W Ralfs M. D.
Jan 8 1921 (Address) Mullan Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence Mullan Idaho

19. PLACE OF BURIAL OR REMOVAL: Wallace Ida — DATE OF BURIAL: Jan 8 1921

20. UNDERTAKER: Ward's Und Tak Co — ADDRESS: Wallace Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 32703
Registered No. .....

1. PLACE OF DEATH
County of Shoshone
City of Wallace Idaho
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 123
Primary Registration District No. 7401
(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Elva Mae Buttler

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: April 22 (Month) (Day) 1899 (Year)

7. AGE: 21 Yrs. 8 Mos. 13 ds.
IF LESS than 1 day how many .... hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Kellogg Ida

10. NAME OF FATHER: P. J. Lynch

11. BIRTHPLACE OF FATHER (State or Country): New Hampshire

12. MAIDEN NAME OF MOTHER: Ellen Stack

13. BIRTHPLACE OF MOTHER (State or Country): Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) P. J. Lynch
(Address) Kellogg, Idaho

15. Filed 1/10 1921 Geo. D. Lesher Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan 5 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 5 1921 to Jan 5 1921
that I last saw h.. alive on Jan 5 1921
and that death occurred on the date stated above, at 9 P M.

The CAUSE OF DEATH* was as follows:
Puerperal Eclampsia
(Duration) ..... Yrs. ..... mos. 1 ds.
Contributory (Secondary) .....
(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) Dr Mowery M. D.
1/6 1920 (Address) Wallace Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Kellogg Idaho — DATE OF BURIAL: Jan 8. 1921

20. UNDERTAKER: M. C. Thornhill — ADDRESS: Kellogg, Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-12 M. 6-15-17.

Lindsay

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 32704
Registered No. .....

1. PLACE OF DEATH
County of Shoshone
City of Kellogg
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 173
Primary Registration District No. 1701
(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Sarah C. Swanson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1871 (Year)

7. AGE: 49 Yrs. ..... Mos. — ds. IF LESS than 1 day how many .... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Boarding house
(b) General nature of industry, business, or establishment in which employed (or employer): Helper

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER: S. Gustafson

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Mary Johnson

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A. Swanson
(Address) Kellogg, Idaho

15. Filed 1/7 1921 Geo. D. Lesher Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH ..... Jan (Month) 6 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 31 1920 to Jan 6 1921, that I last saw h..... alive on Jan 6 1921, and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Uraemic poisoning

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Chronic nephritis

..... (Duration) 4 Yrs. ..... mos. 7 ..... ds.

(Signed) W. C. Lindsay M. D.

1/7 1921. (Address) Kellogg Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs.....mos....days. In the ,State....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Spokane. Wash. DATE OF BURIAL: Jan 8, 1921.

20. UNDERTAKER: M. S. Thomlie ADDRESS: Kellogg, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

32706

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 1
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

Registration District No. 173
Primary Registration District No. 7701
(No. ....., ... St.)

1. PLACE OF DEATH
County of Shoshone
City of Kellogg
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Chas. N. Rowland

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Oct (Month) 5 (Day) 1859 (Year)

7. AGE: 61 Yrs. 7 Mos. 29 ds.
IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Brickmason
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): British Columbia

10. NAME OF FATHER: Henry Rowland

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Sarah Hughes

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. E. La Gamaratte
(Address) Fort Hall Idaho

15. Filed 1/6 1921 Geo. D. Lesher
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 4 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1st 1920 to Jan 4 1921
that I last saw him alive on Jan 4 1921
and that death occurred on the date stated above, at 10:30 P.M.

The CAUSE OF DEATH* was as follows:

Valvular heart disease

(Duration) .... Yrs. .... mos. .... ds.

Contributory (Secondary): Pulmonary tuberculosis

(Duration) .... Yrs. 2 mos. 1 ds.

(Signed) W. L. Lindsay M. D.

1/5 1921 (Address) Kellogg Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs....mos....days. In the State....yrs....mos....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Blackfoot Idaho — DATE OF BURIAL: Jan 6 1921

20. UNDERTAKER: M. C. Thornbrue — ADDRESS: Kellogg Ida

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 8
Primary Registration District No. 2024
File No. 3179
Registered No. 1

1. PLACE OF DEATH
County of Ada
City of
If death occurs away from usual residence, give facts called for under special information.
(No. County Cemetery St.)
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Juan Gonzalez

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White,
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: 1871 (Month) 1 (Day) (Year)

7. AGE: 50 Yrs. — Mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Unknown

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Clyde E. Summers
(Address) Boise Idaho

15. Filed Jan 8 1921 R. H. Pratt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 5 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 10 1920, to Jan 5 1921, that I last saw him alive on Jan 4 1921, and that death occurred on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:
Valvular Heart Disease
(Aortic Stenosis)

(Duration) 3 Yrs. mos. ds.
Contributory (Secondary) Pulmonary Oedema
(Duration) yrs. mos. 2 ds.

(Signed) T. N. Brattan M. D.
Jan 8 1921 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: County Cemetery — DATE OF BURIAL: Jan 6 1921
20. UNDERTAKER: Summers & Krebs — ADDRESS: Boise Ida

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Ada

City of

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 8

Primary Registration District No. 2004

(No. County Hospital, St.)

File No. 32150

Registered No. 2

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Seth J Crawford

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: ~~Single~~ (write word.)

6. DATE OF BIRTH: Dec. 30 (Month) (Day) 1855 (Year)

7. AGE: 66 Yrs. 0 Mos. 17 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Penna

10. NAME OF FATHER: Henry E. Crawford

11. BIRTHPLACE OF FATHER (State or Country): Penna

12. MAIDEN NAME OF MOTHER: Sarah Coon

13. BIRTHPLACE OF MOTHER (State or Country): Penna

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Joseph W Crawford

(Address) Lucile Ida.

15. Filed Jan 20 1924 R. H. Coate Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. 17th 1924 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 1st 1924, to Jan 17th 1924, that I last saw h[illegible] alive on Jan 15th 1924, and that death occurred on the date stated above, at 6 A.M.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

caused by Emphysema

Asthma

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) 0

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Guy Beach M. D.

1-18 1924 (Address) Boise Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain View Cemetery | DATE OF BURIAL: Jan 21 1924

20. UNDERTAKER: Summers & Turbo | ADDRESS: Boise Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

EVANS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32751

Registered No. 3

1. PLACE OF DEATH

County of Ada,

City of

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 8

Primary Registration District No. 2004

(No. 3 Miles West St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Margaret Ellen Shaw

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: June 10 (Month) (Day) 1847 (Year)

7. AGE: 73 Yrs. 5 Mos. 18 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio.

10. NAME OF FATHER: Johnson Leslie

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Mary Howe.

13. BIRTHPLACE OF MOTHER (State or Country): Unknown.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ray Allen Shaw.

(Address) RR no 2. Boise Idaho.

15. Filed Jan 28 1921

R. H. Pratt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 28 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1920 to Jan 28 19..., that I last saw h... alive on Jan 28 19..., and that death occurred on the date stated above, at ... M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

..... (Duration) 3 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. H. Tallman M. D.

1/28 1921 (Address) Boise, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery | DATE OF BURIAL: Jan 29 1921

20. UNDERTAKER: Summers & Kreps | ADDRESS: Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32192

Registered No. 4

Registration District No. 8

Primary Registration District No. 2004

1. PLACE OF DEATH

County of Ada

City of

If death occurs away from usual residence, give facts called for under special information.

(No. 4 Miles S.W. of Boise (St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Charles F. Frazer

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word.): Married

6. DATE OF BIRTH: (Month) (Day) 1856 (Year)

7. AGE: 65 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A. A. Graves.

(Address) Boise, Ida.

15. Filed Jan 31 1921

P. H. Bate
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. (Month) 29 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I ~~attended~~ deceased ~~from~~ Jan. 30 1921 to 19, that I last saw h alive on 19, and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Valvular Heart trouble

(Duration) Yrs. mos. ds.

Contributory (Secondary): Had suffered from Heart trouble for some time

(Duration) yrs. mos. ds.

(Signed) Clyde E. Summers Coroner ada county

1/31 1921 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery

DATE OF BURIAL: Jan 31 1921

20. UNDERTAKER: Summers & Kirtz

ADDRESS: Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 2004
File No. 32753
Registered No. 1

1. PLACE OF DEATH
County of Ada
or town Boise
(No. Bowers crossing St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Arnold Mickels

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married
6. DATE OF BIRTH: June (Month) 4 (Day) 1863 (Year)
7. AGE: 57 Yrs. 7 Mos. 29 ds.
IF LESS than 1 day how many ... hrs. or ... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Wis
10. NAME OF FATHER: Peter Mickels
11. BIRTHPLACE OF FATHER (State or Country): Germany
12. MAIDEN NAME OF MOTHER: ?
13. BIRTHPLACE OF MOTHER (State or Country): Holland
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Frank Mickels
(Address) Boise Idaho R 1.
15. Filed Feb 3 1921 P. E. Smith Local Registrar

SYMS-YORK CO. PRINTERS & BINDERS, BOISE

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 2 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 20 1920 to Feb 2 1921 that I last saw him alive on Feb 1, 1921, and that death occurred on the date stated above, at 8.45 M.
The CAUSE OF DEATH* was as follows:

Angina Pectoris.

(Duration) 3 Yrs. — mos. — ds.
Contributory (Secondary) Arteriosclerosis

(Duration) ... yrs. ... mos. ... ds.

(Signed) C. L. Sutton M. D.
2/3 1921 (Address) Garland Bldg.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
St Johns Cemetery	2/4 1921
20. UNDERTAKER: Summers & Sidenfaden	ADDRESS: Boise

Fuller

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 32754
Registered No.

1. PLACE OF DEATH

County of Ada

City of Eagle

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 9

Primary Registration District No.

(No. 1½ Mile N. of Eagle (St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mabel Records

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: June (Month) 26 (Day) 1920 (Year)

7. AGE: — Yrs. 6 Mos. 16 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: At home

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ada Co. Idaho.

10. NAME OF FATHER: Alfred Records

11. BIRTHPLACE OF FATHER (State or Country): Ills.

12. MAIDEN NAME OF MOTHER: Edith M. Brown

13. BIRTHPLACE OF MOTHER (State or Country): Jefferson Co. Nebr

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Alfred Records

(Address) Eagle, Ida

15.

Filed Jan. 13 1921 Ferdinand K. Laun
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: January (Month) 12 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 12 1921, to Jan 12 1921 ~~that I last saw h___ alive on ___ 19__~~, and that death occurred on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:

Endocarditis

(Duration) Yrs. 6 mos. — ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Geo. M. Hall M. D.

Jan 13 1921 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Dry Creek Cemetery — DATE OF BURIAL: 1/14 1921

20. UNDERTAKER: Schreiber & Sidenfaden — ADDRESS: (Boise)

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32755

Registered No.

1. PLACE OF DEATH

County of Ada

City of Eagle

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 9

Primary Registration District No. 1

(No. ..... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Robert Lee Warrling

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH

January (Month) 19 (Day) 1921 (Year)

7. AGE

— Yrs. — Mos. 6 ds.

IF LESS than 1 day how many — hrs. or — min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Childhood

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Ada Co. Idaho

10. NAME OF FATHER Benjamin P. Warrling

11. BIRTHPLACE OF FATHER (State or Country) Missouri

12. MAIDEN NAME OF MOTHER Nora V. Muelir

13. BIRTHPLACE OF MOTHER (State or Country) Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Benjamin P Warrling

(Address) Eagle Idaho

15. Filed Jan 25 1921 Fredrick K Lewis Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

January (Month) 24 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 19 1921, to Jan 24 1921, that I last saw h.im alive on Jan 24 1921, and that death occurred on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:

Endocarditis

(Duration) — Yrs. — mos. 6 ds.

Contributory (Secondary) Premature birth

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo. McK. Hall M. D.

Jan 21 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Meridian	Jan 26 1921
20. UNDERTAKER W. S. Mahrt	ADDRESS Meridian

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 32758
Registered No. 2

1. PLACE OF DEATH.
County of Ada
City of Meridian
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No. 11
(No. RR 2 St.)

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Joy Irene LaRue

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: 12 (Month) 18 (Day) 1920 (Year)

7. AGE: ..... yrs. ..... mos. 1 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Meridian

10. NAME OF FATHER: Roy D. LaRue

11. BIRTHPLACE OF FATHER (State or Country): Nebraska

12. MAIDEN NAME OF MOTHER: Daisy M. Roberts

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Roy D. LaRue
(Address) Meridian, Ida. RR 2

15.
Filed 2-8 1921 H. F. Neal
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 12 (Month) 18 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 17 1921, to Dec. 18 1921, that I last saw her alive on Dec 18 1921 and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Valvular Lesion

(Duration) ..... yrs. ..... mos. 1 ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. F. Neal M. D.
Feb. 7 1921 (Address) Meridian Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place ..... In the
of death ..... yrs ..... mos ..... ds. State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Meridian Cemetery
DATE OF BURIAL: Dec 20 1921

20. UNDERTAKER: None
ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32760

Registered No. 4

1. **PLACE OF DEATH**

County of Ada

City of Meridian RR 1 · (No. 16½ mi west of Boise St.)

Registration District No.

Primary Registration District No.

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. **FULL NAME** John F. Sample

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word.)
M.	White.	Single

6. **DATE OF BIRTH** Nov 18 1 (Month) (Day) (Year)

7. **AGE** 17 Yrs. 1 Mos. 14 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. **OCCUPATION**

(a) Trade, profession or particular kind of work Student

(b) General nature of industry, business or establishment in which employed (or employer) ——

9. **BIRTHPLACE** (State or Country) Idaho.

10. **NAME OF FATHER** Samuel Sample

11. **BIRTHPLACE OF FATHER** (State or Country) Illinois.

12. **MAIDEN NAME OF MOTHER** Melissa Davis.

13. **BIRTHPLACE OF MOTHER** (State or Country) Oregon

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**

(Informant) Samuel Sample

(Address) Meridian Idaho

15. Filed Feb 8 1921 W F Neal Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH** Dec 1 (Month) 7 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 20 1920 to Dec 30 1920, that I last saw h.im alive on Dec 30 1920, and that death occurred on the date stated above, at 12 P.M.

The CAUSE OF DEATH* was as follows:

Cuts infection

(Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary) Tonsilar Abscess

(Duration) ..... yrs. ..... mos. 8 ds.

(Signed) W. F. Neal M. D.

2-7 1921 (Address) Meridian Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Morris Hill Cem.	19
20. UNDERTAKER	**ADDRESS**
Summers & Kebs.	Boise Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32761

Registered No. 5

1. PLACE OF DEATH

County of Ada

City of Meridian

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No. 11

(No. R.R.3 St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Jessie W. Rhodes

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Mal.	White	Married

6. DATE OF BIRTH: Aug. (Month) ... (Day) 1873 (Year)

7. AGE: 47 Yrs. 5 Mos. ... ds.

IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Harrison Co. Ind.

10. NAME OF FATHER J. W. Rhodes.

11. BIRTHPLACE OF FATHER (State or Country) Pittsburg Penn.

12. MAIDEN NAME OF MOTHER Kathrin Travel.

13. BIRTHPLACE OF MOTHER (State or Country) Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Agnes W. Rhodes

(Address) Meridian Idaho

15. Filed Feb. 8 1921 T. F. Neal
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 2 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 27 1921 to Feb. 1 1921 that I last saw h.... alive on Feb 1 1921 and that death occurred on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Duration) ... Yrs. ... mos. 5 ds.

Contributory (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) T. F. Neal M. D.

Feb 8 1921 (Address) Meridian Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Meridian Cemetery	19...

20. UNDERTAKER	ADDRESS
W. D. Mattes	Meridian Id

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2

Primary Registration District No. 1004

(No. 410 State St.)

File No. 32762

Registered No. 4

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Jose Arriabe

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: About (Month) (Day) 1899 (Year)

7. AGE: about 21 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Sheepherder

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Spain

10. NAME OF FATHER: Antonio Arriabe

11. BIRTHPLACE OF FATHER (State or Country): Spain

12. MAIDEN NAME OF MOTHER: Petra Ascuna

13. BIRTHPLACE OF MOTHER (State or Country): Spain

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Eustasio Ormaechea

(Address) 613 Idaho

15.

Filed 19

R. H. Pond
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. (Month) 3 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 24 1920, to Jan 3 1921, that I last saw him alive on Jan 3 1921, and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Typhoid fever

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Geo Callista M. D.

19 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: St Johns Cemetery — DATE OF BURIAL: 1/5 1921

20. UNDERTAKER: Schreiber & Sederstrom — ADDRESS: Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 1004
File No. 32763
Registered No. 2

1. PLACE OF DEATH

County of Ada
City of Boise
(No. 410 State St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Pearl May Trader

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: June (Month) 14 (Day) 1884 (Year)

7. AGE: 36 Yrs. 6 Mos. 18 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housekeeper
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Merrick Co. Neb.

10. NAME OF FATHER: John Combs

11. BIRTHPLACE OF FATHER (State or Country): N.Y.

12. MAIDEN NAME OF MOTHER: Mintie Bowerman

13. BIRTHPLACE OF MOTHER (State or Country): Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Gertie Gill
(Address) Hill City, Idaho

15. Filed Jan 3 1921 R. H. Pratt
Local Registrar
D. Tatum

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 1st (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 28 1920, to Jan 1 1921 that I last saw h.. alive on Dec 31 1920 and that death occurred on the date stated above, at 4 A. M.

The CAUSE OF DEATH* was as follows:
Peritonitis

(Duration) Undetermined Yrs. ..... mos. ..... ds.
Contributory (Secondary) Tuberculosis Pulmonalis
(Duration) ..... yrs. Several mos. ..... ds.

(Signed) W. S. Tatum M. D.
1-3 1921 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. 2 days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence Hill City, Idaho.

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 1/3 1921

20. UNDERTAKER: Schreiber & Siebenfaden — ADDRESS: Boise, Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 32764
Registered No. 3

1. PLACE OF DEATH

County of Ada.

City of Boise.

(No. 1705 N. 10th St.)

Registration District No. 7

Primary Registration District No. 1004

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Margaret Ann Palmer

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widowed (Write the word.)

6. DATE OF BIRTH: December (Month) 14th (Day) 1836 (Year)

7. AGE: 84 Yrs. 0 Mos. 19 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: John Nesbit

11. BIRTHPLACE OF FATHER (State or Country): Pennsylvania

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Pennsylvania

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. W. Palmer

(Address) Boise, Idaho.

15. Filed Jan 4 1921

R. H. Pratt
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 2. (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to Jan 2 1921 that I last saw her alive on Jan 2 1921 and that death occurred on the date stated above, at 3:30 P.M.

The CAUSE OF DEATH* was as follows:

Senile Degeneration

(Duration) 1 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) P. P. French M. D.

1/4 1921 (Address) Boise, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. ~~LENGTH~~ OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 1/6 1921

20. UNDERTAKER: W. McBratney — ADDRESS: Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

Spring.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 1204
File No. 52166
Registered No. 8

1. PLACE OF DEATH
County of Ada
City of Boise
(No. 110 E. Bannock St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Gladys E Dickson
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F	White	Married

6. DATE OF BIRTH: May (Month) 14 (Day) 1891 (Year)

7. AGE: 29 Yrs. 7 Mos. 21 ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Minn

10. NAME OF FATHER: W H Cressy

11. BIRTHPLACE OF FATHER (State or Country): Minn

12. MAIDEN NAME OF MOTHER: Anna Nelson

13. BIRTHPLACE OF MOTHER (State or Country): Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Fred J Myers
(Address) Pocatello Ida.

15. Filed Jan 8 1921 R H Pratt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. (Month) 5 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 28 1920 to Jan 5th 1921 that I last saw h... alive on Jan 5th 1921 and that death occurred on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:
acute Miliary Tuberculosis
(Duration) ... Yrs. ... mos. ... ds.
Contributory (Secondary) Tuberculosis of Kidneys
(Duration) ... yrs. ... mos. ... ds.

(Signed) J A Sprenger M. D.
Jan 6 1921 (Address) Boise Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery | DATE OF BURIAL: Jan 7 1921

20. UNDERTAKER: Summers & Yerbe | ADDRESS: Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

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WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

Hill.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 1904
File No. 32767
Registered No. 7

1. PLACE OF DEATH
County of Ada
City of Boise.
(No. St Alphonsus Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Trumans A. Prestegard

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Mar 13 (Month) (Day) 1907 (Year)

7. AGE: 8 Yrs. 9 Mos. 29 ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: O. M. Prestegard.

11. BIRTHPLACE OF FATHER (State or Country): Norway.

12. MAIDEN NAME OF MOTHER: Gail E. Edson

13. BIRTHPLACE OF MOTHER (State or Country): Wisconsin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): O. Prestegard
(Address): ...

15. Filed Jan 8 1921 — P. H. Powell, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan 6 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1/5/21 19..., to 1/6/21 19..., that I last saw h... alive on 1/6/21 19... and that death occurred on the date stated above, at 1215 P M.

The CAUSE OF DEATH* was as follows:

Streptococci meningitis

(Duration) ... Yrs. ... mos. 3 ds.

Contributory (Secondary) ...
(Duration) ... yrs. ... mos. ... ds.

(Signed) J. Earl Hiles M. D.
1/6/21 19... (Address) Boise. Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death? ...

Former or usual residence ...

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cem — DATE OF BURIAL: Jan 7 1921

20. UNDERTAKER: Summers & Kebo. — ADDRESS: Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

McCalla,

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32768

Registered No. 10

1. PLACE OF DEATH

County of Ada

City of Boise (No. 111, C, St.)

Registration District No. 7

Primary Registration District No. 1004

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Electa D. Getts

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Oct. (Month) 28 (Day) 1844 (Year)

7. AGE: 76 Yrs. 2 Mos. 9 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Penn

10. NAME OF FATHER: John McIntire

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Chas D. Getts

(Address) 418 Arthur St Caldwell Ida

15. Filed 1/10 1921

R H Pratt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. (Month) 7 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 14 1920, to DEC. 25 1920 that I last saw h[illegible] alive on Dec 21 1920 and that death occurred on the date stated above, at 6 9 M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis -
Myocarditis

(Duration) 1 Yrs. mos. ds.

Contributory (Secondary) Senility,

(Duration) yrs. mos. ds.

(Signed) J. Earl Hill M. D.

1/8 1921 (Address) Boise Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Jan. 9 1921

20. UNDERTAKER: Summers & Tribe — ADDRESS: Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

Oregon.

CERTIFICATE OF DEATH

Registration District No. 7

Primary Registration District No. 1004

(No. St Lukes Hospital St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32769

Registered No. 11

1. PLACE OF DEATH

County of Ada.

City of Boise.

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William D. White

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M.	White	Single

6. DATE OF BIRTH

Dec 8 1920
(Month) (Day) (Year)

7. AGE

— Yrs. 1 Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business or establishment in which employed (or employer) —

9. BIRTHPLACE (State or Country) Idaho.

10. NAME OF FATHER William D. White.

11. BIRTHPLACE OF FATHER (State or Country) Oregon.

12. MAIDEN NAME OF MOTHER Mary E. Sargent

13. BIRTHPLACE OF MOTHER (State or Country) Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm E White

(Address) .....

15.

Filed 1/10/ 1921 R. Z. Todd
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 8 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 2 1921, to Jan 8 1921, that I last saw him alive on ..... 19..., and that death occurred on the date stated above, at 7.30 P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) R. S. Gregory M. D.

..... 19..... (Address) 104 N. 8th St.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Morris Hill Cem.	Jan. 19.....
20. UNDERTAKER	**ADDRESS**
Summers & Webb.	Boise Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Parker

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32770

Registered No. 13

1. PLACE OF DEATH

County of Ada

City of Boise

Registration District No. 7

Primary Registration District No. 1009

(No. 1717 No 16. St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Smith.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
M.	White	Widower

6. DATE OF BIRTH: Mar (Month) 18 (Day) 1828 (Year)

7. AGE: 92 Yrs. 9 Mos. 24 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): England.

10. NAME OF FATHER: Henry Smith.

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Anna Kinsey.

13. BIRTHPLACE OF MOTHER (State or Country): Wales

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs E. A. Barker

(Address) Boise, Idaho,

15. Filed Jan 12 1920 R. H. Pratt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 11 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1, 1919, to Jan 11 1921, that I last saw h~~im~~ alive on Jan 11 1921, and that death occurred on the date stated above, at 1.50 P. M.

The CAUSE OF DEATH* was as follows:

Catarrhal Pneumonia

(Duration) ..... Yrs. 1 mos. ..... ds.

Contributory (Secondary) Senility

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) O H Parker M. D.

Jan 11 1921 (Address) 303 Idaho Bldg Boise, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Nampa Idaho. DATE OF BURIAL: Jan. 13 1921

20. UNDERTAKER: Summers & Kibbe ADDRESS: Boise Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 32771
Registered No. 14

1. PLACE OF DEATH
County of Ada
City of Boise
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 1
Primary Registration District No. 1004
(No. ..... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME James G. Allen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widower
6. DATE OF BIRTH: (Month) ..... (Day) ..... (Year) 1836
7. AGE: 85 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): North Carolina
10. NAME OF FATHER: Unknown
11. BIRTHPLACE OF FATHER (State or Country): Unknown
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (State or Country): Unknown
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Clyde E. Summers
(Address) Boise Idaho
15. Filed Jan 14 V 1921 R. H. Pratt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. (Month) 11 (Day) 1921 (Year)
17. I HEREBY CERTIFY, That I ~~attended deceased from~~ saw Jan 11 1921, to ~~..... 19..~~ ~~that I last saw him alive on ..... 19..~~ ~~and that death occurred on the date stated above, at ..... M.~~
The CAUSE OF DEATH* was as follows:
Valvular Heart disease
found dead in bed this morning
Duration about yrs. 10 mos. 2 ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Clyde E. Summers Coroner
1/12 1921 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Jan 14 1921
20. UNDERTAKER: Summers & Kuta — ADDRESS: Boise Idy

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

Numbers.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32772

Registered No. 15

1. PLACE OF DEATH

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 7

Primary Registration District No. 1004

(No. 1715 W Bannock St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Cathryn Hart

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Oct. (Month) 18, (Day) 1909 (Year)

7. AGE: 11 Yrs. 2 Mos. 26 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Student

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Boise Idaho.

10. NAME OF FATHER: M. L. Hart

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Ida W. Thomas

13. BIRTHPLACE OF MOTHER (State or Country): Nebraska

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant): M. L. Hart

(Address): 1715 Bannock St.

15. Filed Jan 15 1921

R H Pratt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. (Month) 14 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 6th 1921, to Jan 14th 1921, that I last saw h.r alive on Jan 14 1921, and that death occurred on the date stated above, at 6:30 A.M.

The CAUSE OF DEATH* was as follows:

Pleuro-pneumonia & Empyema

(Duration) ..... Yrs. ..... mos. 7 ds.

Contributory (Secondary): Empyema

(Duration) ..... yrs. ..... mos. 14 ds.

(Signed) Wm R Meadows M. D.

1/15 1921 (Address) Boise Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery

DATE OF BURIAL: Jan 16 1921

20. UNDERTAKER: Summers & Kelly

ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SMITH-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32773

Registered No. 16

1. PLACE OF DEATH

County of Ada

City of Boise

(No. 413 N. 16th St.)

Registration District No. 2

Primary Registration District No. 1004

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Wm. C. Carlton

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widower

6. DATE OF BIRTH: June 22 1834 (Month) (Day) (Year)

7. AGE: 86 Yrs. 6 Mos. 25 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: retired Farmer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Maine

10. NAME OF FATHER: Amos Carlton

11. BIRTHPLACE OF FATHER (State or Country): Me.

12. MAIDEN NAME OF MOTHER: Mary Carlton

13. BIRTHPLACE OF MOTHER (State or Country): Me.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Robt. J. Carlton

(Address)

15. Filed Jan 18 1921 R. H. Oates Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan 17th 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 16 1920 to Jan 17 1920 that I last saw h.. alive on Jan 17 1920 and that death occurred on the date stated above, at 12 noon M.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(Duration) ..... Yrs. ..... mos. 1 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W S Sutton M. D.

1-17 1920 (Address) Boise

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence Boise, Idaho

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Masonic Cemetery	1/19 1921
20. UNDERTAKER	ADDRESS
Schreiber & Siebenfaden	Boise, Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32774

Registered No. 17

1. PLACE OF DEATH

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 7

Primary Registration District No. 1014

(No. 410 [illegible] St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Louis Crighton Gallagher

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word.): Single

6. DATE OF BIRTH: August 30 1913 (Month) (Day) (Year)

7. AGE: 6 Yrs. 4 Mos. 19 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Student

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Helena Montana

10. NAME OF FATHER: Louis C. Gallagher

11. BIRTHPLACE OF FATHER (State or Country): Nebraska

12. MAIDEN NAME OF MOTHER: Gladys Quigley

13. BIRTHPLACE OF MOTHER (State or Country): Wisconsin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. C. Gillen

(Address) Boise Idaho

15. Filed Jan 19 1921 R. H. Hall Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: January 18 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 18 1921, to ——— 19..., that I last saw h[illegible] alive on Jan 18 1921, and that death occurred on the date stated above, at 9:30 P.M.

The CAUSE OF DEATH* was as follows:

Paralysis of heart and respiratory Center, probably due to Ether Anesthesia

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) L. P. McCall M. D.

1/18 1921 (Address) Boise, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: St Johns Cemetery — DATE OF BURIAL: 1/20 1921

20. UNDERTAKER: Schreiber & Hidenfeldt — ADDRESS: Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 1
Primary Registration District No. 1904
File No. 32775
Registered No. 18

1. PLACE OF DEATH
County of Ada
City of Boise
(No. St Alphonsus Hospital, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charles E. Dawson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write word.)

6. DATE OF BIRTH: Dec 30 (Month) (Day) 1872 (Year)

7. AGE: 48 Yrs. — Mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Accountant.
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Indiana.

10. NAME OF FATHER: Albert C. Dawson

11. BIRTHPLACE OF FATHER (State or Country): Indiana.

12. MAIDEN NAME OF MOTHER: Martha J. Rush.

13. BIRTHPLACE OF MOTHER (State or Country): Indiana.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Martha J. Dawson
(Address) .....

15. Filed 1/20 1921 — R H Pratt, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan 19 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 10 1921 to Jan 19 1921 that I last saw h— alive on Jan 18 1921 and that death occurred on the date stated above, at 1 A M.

The CAUSE OF DEATH* was as follows:

Abdominal Hematoma

(Duration) ..... Yrs. ..... mos. 30 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) R E Eshleman M. D.

Jan 20 1921 (Address) R E Eshleman

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cem. — DATE OF BURIAL: Jan 20 1921

20. UNDERTAKER: Summers & Webb. — ADDRESS: Boise Ida.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 Rev. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 4
Primary Registration District No. 1004
File No. 32776
Registered No. 20

1. PLACE OF DEATH
County of Ada
City of Boise
(No. 1514, Franklin St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lu Rene Young.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female.
4. COLOR OR RACE: White.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single.
6. DATE OF BIRTH: Jan - 7 - 1921 (Month) (Day) (Year)
7. AGE: — Yrs. 15 Mos. ds. (IF LESS than 1 day, how many hrs. or min.?)
8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Boise, Idaho.
10. NAME OF FATHER: J. O. Young.
11. BIRTHPLACE OF FATHER (State or Country): Idaho
12. MAIDEN NAME OF MOTHER: La Verda Read
13. BIRTHPLACE OF MOTHER (State or Country): Idaho
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. O. Young Jr.
(Address) Boise, Idaho.
15. Filed Jan 22 1921 R H Coate Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan, 22 - 1921 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from Jan 19 1921, to Jan 22 1921, that I last saw h[illegible] alive on Jan 22 1921, and that death occurred on the date stated above, at 6 A.M.
The CAUSE OF DEATH* was as follows:
Pneumonia
(Duration) Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. 3 ds.
(Signed) Geo. N. Handy M. D.
1/22 1921 (Address) Boise, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 1/27 1921
20. UNDERTAKER: C. W. McBratney — ADDRESS: Boise Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SIMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 3004
File No. 3277
Registered No. 21

1. PLACE OF DEATH
County of Ada
City of Boise (No. 100, East Bannock St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Thomas Joan Burns
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: May 28 1891 (Month) (Day) (Year)

7. AGE: 29 Yrs. 7 Mos. 24 ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Brakeman
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: James Burns

11. BIRTHPLACE OF FATHER (State or Country): Am.

12. MAIDEN NAME OF MOTHER: Mathilda Anderson

13. BIRTHPLACE OF MOTHER (State or Country): Am.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): A Schneider
(Address): Boise

15. Filed Jan 24 1921 — R. H. Asall, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. (Month) 21 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 7 1921, to Jan 21 1921, that I last saw h[illegible] alive on Jan 21 1921, and that death occurred on the date stated above, at 6 P. M.
The CAUSE OF DEATH* was as follows:
Typhoid Fever
(Duration) Yrs. 2 mos. 3 ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) J Earl Hill M. D.
1/22 1921 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. 15 days. State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence: Boise Idaho

19. PLACE OF BURIAL OR REMOVAL: Mount Pleasant Utah — DATE OF BURIAL: 1/25 1921

20. UNDERTAKER: Schneider & Liedenfaden — ADDRESS: Boise Ida.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 9
Primary Registration District No. 1004
File No. 32778
Registered No. 22

1. PLACE OF DEATH

County of Ada.
City of Boise.
(No. 910 No. 17th St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Marjorie Adiel Martin

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Apr. 27 1913
(Month) (Day) (Year)

7. AGE: 7 Yrs. 8 Mos. 25 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: In School
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: C. M. Martin

11. BIRTHPLACE OF FATHER (State or Country): Oregon

12. MAIDEN NAME OF MOTHER: Florence Dielschneider

13. BIRTHPLACE OF MOTHER (State or Country): Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wm McBratney
(Address) Boise Ida.

15. Filed Jan 24 1921 R. H. Pratt Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan 22 19 21
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 22 1921, to Jan 22 1921, that I last saw her alive on Jan 22 1921, and that death occurred on the date stated above, at 4 25 P.M.

The CAUSE OF DEATH* was as follows:' Pharyngeal Diphtheria

(Duration) ..... Yrs. ..... mos. 3 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Edward H Bruce M. D.

1/24 1921 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 1/24 1921

20. UNDERTAKER: Wm McBratney — ADDRESS: Boise Idaho

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

Burton

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 1
Primary Registration District No. 1004
File No. 32779
Registered No. 23

1. PLACE OF DEATH

County of Ada

City of Boise

(No. 110 E. Bannock St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Helen Beal Bryant

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F	White	Married

6. DATE OF BIRTH

August 15 1896
(Month) (Day) (Year)

7. AGE

24 Yrs. 9 Mos. 9 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Boise Idaho

10. NAME OF FATHER A. M. Beal

11. BIRTHPLACE OF FATHER (State or Country) Del

12. MAIDEN NAME OF MOTHER Grace M. Clark

13. BIRTHPLACE OF MOTHER (State or Country) Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Burton E Bryant

(Address) 1354 Grand ave

15. Filed Jan 25 1921 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 24 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 8 1921, to Jan 24 1921, that I last saw her alive on Jan 24 1921, and that death occurred on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

Hyperemesis Gravidarum

(Duration) Yrs. 4 mos. ds.

Contributory (Secondary) Malnutrition

(Duration) yrs. 1 mos. 15 ds.

(Signed) T. N. Brayton M. D.

Jan 25 1921 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Morris Hill Cemetery | DATE OF BURIAL Jan 26 1921

20. UNDERTAKER Summers & Kirk | ADDRESS Boise Idy

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 32780
Registered No. 24

1. PLACE OF DEATH

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2

Primary Registration District No. 1004

(No. 410 State St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary Grover Caulfield

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Jan 29 (Month) (Day) 1859 (Year)

7. AGE: 61 Yrs. 11 Mos. 27 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: School teacher
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Thomas Caulfield

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Catherine Millerkin

13. BIRTHPLACE OF MOTHER (State or Country): Ohio.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. J. Caulfield
(Address) Akron, O

15. Filed Jan 27 1921 R. H. Pratt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan 26 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 19 1921, to Jan 26 1921 that I last saw h[illegible] alive on Jan 26 1921, and that death occurred on the date stated above, at 8 P. M.
The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... Yrs. ..... mos. 6 ds.

Contributory (Secondary) Influenza

(Duration) ..... yrs. 1 mos. ..... ds.

(Signed) Wm. R. Rumens M. D.

1/27 1921 (Address) Boise, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Jackson, Ohio. DATE OF BURIAL: June 31 1921

20. UNDERTAKER: Summers & Trots ADDRESS: Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

Registration District No. 7

Primary Registration District No. 1004

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32781

Registered No. 25

1. PLACE OF DEATH

County of Ada

City of Boise (No. 711 Fort St. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charles E. Elmer.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
M.	White.	Married (or Wid.)

6. DATE OF BIRTH: Dec 22 (Month) (Day) 1860. (Year)

7. AGE: 60. Yrs. 1 Mos. 6 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Accountant —
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Canada.

10. NAME OF FATHER: Andrew B Elmer.

11. BIRTHPLACE OF FATHER (State or Country): Canada.

12. MAIDEN NAME OF MOTHER: Delphine A. Perrault.

13. BIRTHPLACE OF MOTHER (State or Country): Canada.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) .....
(Address) .....

15. Filed Jan 31 1921 — R H. Pratt, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan 28 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 13 1921 to Jan 28 1921 that I last saw h. alive on Jan 22 1921, and that death occurred on the date stated above, at 8:30 A.M.

The CAUSE OF DEATH* was as follows:
Acute heart failure.
Coronary sclerosis.
(Duration) 2 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) M. H. Gallman M. D.
1/29 1921 (Address) Boise. Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? ✓

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Masonic Cemetery.	Jan 30 1921
20. UNDERTAKER	ADDRESS
Summers & Cobb.	Boise Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32782

Registered No. 28

Registration District No. 2

Primary Registration District No.

1. PLACE OF DEATH

County of Ada

City of Boise. (No. 1216 No 22. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Amelia M. Mosby.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
F.	White	Married (or Widowed)

6. DATE OF BIRTH: Nov 24 (Month) (Day) 1865 (Year)

7. AGE: 55 Yrs. 2 Mos. 8 ds.

IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Denmark.

10. NAME OF FATHER: Nels Nelson

11. BIRTHPLACE OF FATHER (State or Country): Denmark.

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Denmark.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J C Mosby
(Address)

15. Filed Feb 2 1921 — A. H. Peate, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 1 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jany 29 1921 to Feby 1 1921 that I last saw h[illegible] alive on Feby 1 1921, and that death occurred on the date stated above, at 9.30 P. M.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) Chas Howes M. D.

2/2 1921 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Morris Hill Cemetery	Feb 3 1921
20. UNDERTAKER	ADDRESS
Summers & Kebo.	Boise Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-A—25 M. 1-19.

32783

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 28
Primary Registration District No. 2 2161
File No. 37
Registered No. 3488

1. PLACE OF DEATH
County of Bannock
City of Pocatello
(No. 1035 West Fremont St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Frank Matlock

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write word.): Widower

6. DATE OF BIRTH: Aug (Month) 8th (Day) 1839 (Year)

7. AGE: 81 Yrs. 5 Mos. 2 ds.
IF LESS than 1 day: how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Jackson Kentucky

10. NAME OF FATHER: ✓

11. BIRTHPLACE OF FATHER (State or Country): ✓

12. MAIDEN NAME OF MOTHER: ✓

13. BIRTHPLACE OF MOTHER (State or Country): ✓

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. F. Matlock
(Address) Pocatello

15. Filed 1/10 1921

Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jany (Month) 10 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 6— 1921, to Jany 10 1921
that I last saw her alive on Jany 6— 1921
and that death occurred on the date stated above, at 8 a. M.
The CAUSE OF DEATH* was as follows:
old age — Cause ?

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Stroke
(Duration) 4 yrs. ..... mos. ..... ds.

(Signed) J. F. Hyman M. D.
Jany 10 1921 (Address) Pocatello Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: New Cemetery — DATE OF BURIAL: 1/11 1921

20. UNDERTAKER: W. J. Tucker — ADDRESS: Pocatello Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

32784

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 28
Primary Registration District No. 2161
File No. 37
Registered No. 8489

1. PLACE OF DEATH
County of Bannock
City of Pocatello
(No. 306 N. 2nd ave. St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lucinda Shoulcroft
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widow

6. DATE OF BIRTH: Jan 1 1832 (Month) (Day) (Year)

7. AGE: 89 Yrs. — Mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: was housewife
(b) General nature of industry, business or establishment in which employed (or employer): years ago.

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: John Loux

11. BIRTHPLACE OF FATHER (State or Country): Pennsylvania

12. MAIDEN NAME OF MOTHER: Not Known

13. BIRTHPLACE OF MOTHER (State or Country): Pennsylvania

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ephriam Shoulcroft
(Address) 306 N. 2nd ave

15. Filed Jan 12 1921
J. R. Young
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan 11 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from January 3rd 1920, to 1-11 1921, that I last saw h[er] alive on January 10 1921 at 3:20 a.m. and that death occurred on the date stated above, at 3:20 a.m.

The CAUSE OF DEATH* was as follows:
Hypostatic Pneumonia
Result of Cardiac Dilatation
(Duration) ..... Yrs. ..... mos. 4 ds.
Contributory (Secondary): Chronic Bright's Disease
Senility (Duration) 5 yrs. ..... mos. ..... ds.

(Signed) James F. Manning M. D.
1-12 1921 (Address) Church Wyatt Bldg Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 7 yrs. ..... mos. ..... days. In the State 7 yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence Oklahoma.

19. PLACE OF BURIAL OR REMOVAL: Mt View Cem. DATE OF BURIAL: Jan 12 1921

20. UNDERTAKER: L. L. McClanahan ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

32785

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 28
Primary Registration District No. 2161
File No. 87
Registered No. 3490

1. PLACE OF DEATH

County of Bannock,
City of Pocatello,
(No. General Hosp. St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME. Ira M. Smith.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
male	white	married.

6. DATE OF BIRTH

(Month) (Day) (Year)

7. AGE

53 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Traveling Salesman.

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) not known.

10. NAME OF FATHER " "

11. BIRTHPLACE OF FATHER (State or Country) " "

12. MAIDEN NAME OF MOTHER " "

13. BIRTHPLACE OF MOTHER (State or Country) " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm. Cash.

(Address) Yellowstone Hotel.

15. Filed 1/12 1921

J. R. Young. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan 11 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 10, 1921, to Jan 11 1921, that I last saw him alive on Jan 11 1921, and that death occurred on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

Gastric Hemorrhage

(Duration) Yrs. mos. 2 ds.

Contributory (Secondary) Probably gastric ulcer

(Duration) yrs. mos. ds.

(Signed) John J. Rook M. D.

1/12 1921 (Address) Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Richmond Mich.	1/16 1921
20. UNDERTAKER	ADDRESS
H. L. McStan	Pocatello Ida.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

22786

Registration District No. 24
Primary Registration District No. 7141
File No. 37
Registered No. 3491

1. PLACE OF DEATH
County of Bannock
City of Pocatello
(No. General Hospital St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lucile Lewis

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Married

6. DATE OF BIRTH: February (Month) 24 (Day) 1 (Year)

7. AGE: 48 Yrs. 10 Mos. 19 ds.
IF LESS than 1 day how many ____ hrs. or ____ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Brigham City Utah

10. NAME OF FATHER: Joseph Southworth

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Aldora Norton

13. BIRTHPLACE OF MOTHER (State or Country): ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. J. Lewis
(Address) McCammon.

15. Filed 1/13 1921 J. P. Gannon Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: January (Month) 13 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 6 1921 to Jan 13 1921
that I last saw her alive on Jan 13 1921
and that death occurred on the date stated above, at 1 P.M.
The CAUSE OF DEATH* was as follows:
Secondary Hemorrhage
following Operation for
Obstruction of Common duct
(Duration) ____ Yrs. ____ mos. 6 ds.
Contributory (Secondary) Chronic Lithiasis
(Duration) 12 yrs. ____ mos. ____ ds.
(Signed) W. W. Brothers M. D.
Jan 13 1921. (Address) Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: McCammon Ida — DATE OF BURIAL: 1-16 1921

20. UNDERTAKER: Schumacher & Hall — ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

32787

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bannock
City of Ft Hall

Registration District No. 28
Primary Registration District No. 2461
(No. Ft Hall St.)

File No. 37
Registered No. 3492

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Robert Nielsen

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Jan 8 (Month) 1921 (Year)

7. AGE: — yrs. — mos. 5 ds.
IF LESS than 1 day how many 10 hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ft Hall Reservation Idaho

10. NAME OF FATHER: Niel Peter Nielsen

11. BIRTHPLACE OF FATHER (State or Country): Haarby Denmark

12. MAIDEN NAME OF MOTHER: Lillie Theresa Peterson

13. BIRTHPLACE OF MOTHER (State or Country): Ogden Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Carl Nielsen
(Address) Fort Hall Id.

15.
Filed 1/14 1921 J R Young. Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan 13 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 8 1921, to Jan 13 1921 that I last saw him alive on Jan 13 1921 and that death occurred on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:
Premature birth

(Duration) — yrs. — mos. 5½ ds.

Contributory (Secondary) — (Duration) — yrs. — mos. — ds.

(Signed) Henry R Wheeler M. D.
Jan 13, 1921 (Address) Fort Hall, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Ogden Utah — DATE OF BURIAL: 1/14 1921

20. UNDERTAKER: W. Waller — ADDRESS: Pocatello Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

FORM V. S. No. 5-25 M. 1-19.

32788

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 37

Registered No. 3493

1. **PLACE OF DEATH**

County of Bannock

City of Pocatello (No.) (St.) Registration District No. Primary Registration District No. McCullough Hospital

If death occurs away from usual residence, give facts called for under special information.

2. **FULL NAME** Robert W. Beacham

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. **DATE OF BIRTH** Jan 14 1921
(Month) (Day) (Year)

7. **AGE** ... Yrs. ... Mos. 4 ds.

IF LESS than 1 day how many ... hrs. or ... min.?

8. **OCCUPATION**

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. **BIRTHPLACE** (State or Country) Idaho

10. **NAME OF FATHER** Bryan Beacham

11. **BIRTHPLACE OF FATHER** (State or Country) Kansas

12. **MAIDEN NAME OF MOTHER** Julia May Thomas

13. **BIRTHPLACE OF MOTHER** (State or Country) Idaho

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**

(Informant) Bryan Beacham

(Address) 817 S. Harrison

15. Filed 1/19 1921

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH** Jan 18 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 17 1921, to Jan 18 1921, that I last saw h... alive on Jan 18 1921, and that death occurred on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia
from Ear Following
Influenza

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) H. S. Wasson M. D.

(Address) Pratten Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. **PLACE OF BURIAL OR REMOVAL** Pocatello Mem. | **DATE OF BURIAL** June 20 1921

20. **UNDERTAKER** Schumacher Bros. | **ADDRESS** City

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-A—25 M. 1-19.

32789

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 28
Primary Registration District No. 2161
File No. 37
Registered No. 3494

1. PLACE OF DEATH
County of Bannock
City of Pocatello
(No. 155 N. Grant St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John James Stevenson Jr.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: March 21 (Month) (Day) 1914 (Year)

7. AGE: 6 Yrs. 10 Mos. 2 ds.
IF LESS than 1 day: how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Rupert Ida

10. NAME OF FATHER: John J. Stevenson

11. BIRTHPLACE OF FATHER (State or Country): Belleville Kans

12. MAIDEN NAME OF MOTHER: Florence E. Breding

13. BIRTHPLACE OF MOTHER (State or Country): Pawnee Okl

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): John J. Stevenson
(Address): 155 N. Grant

15. Filed 1/20 1921
J. P. Young
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: January 19 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 31 1920 to Jany 19 1921
that I last saw him alive on Jany 14 1921
and that death occurred on the date stated above, at 8 P. M.
The CAUSE OF DEATH* was as follows:
acute peritonitis following injury, Hayd sleigh colliding with automobile
(Duration) ..... Yrs. ..... mos. 6 ds.
Contributory (Secondary) Injury to liver. Measles
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) J. C. Ray M. D.
1921 (Address) Pocatello

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mt View cemetery
DATE OF BURIAL: Jan 21 1921

20. UNDERTAKER: P. V. Tucker
ADDRESS: Pocatello Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-25 M. 1-19.

32790

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 28
Primary Registration District No. 2141
File No. 37
Registered No. 349

1. PLACE OF DEATH
County of Bannock
City of Pocatello
(No. 904 Wayne ave. St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elizabeth Killips
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6. DATE OF BIRTH: April 7 (Month) (Day) 1857 (Year)

7. AGE: 63 Yrs. 9 Mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: house wife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: Wm. Wilson

11. BIRTHPLACE OF FATHER (State or Country): Scotland

12. MAIDEN NAME OF MOTHER: Elenor Jackson

13. BIRTHPLACE OF MOTHER (State or Country): Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. W. Small
(Address) 904 Wayne ave.

15. Filed Jan 22 1921
J. P. Young
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan 20 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 17 1921, to Jan 21 1921, that I last saw her alive on Jan 20 1921, and that death occurred on the date stated above, at 7.35 A. M.

The CAUSE OF DEATH* was as follows:
Pernicious anaemia

(Duration) 3 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. P. Magee M. D.
1.22. 1921 (Address) Pocatello

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. 1 mos. ..... days. In the State ..... yrs. 1 mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence Denver Colo.

19. PLACE OF BURIAL OR REMOVAL: Mt Vernon Cemet Pocatello — DATE OF BURIAL: Jan 24 1921

20. UNDERTAKER: H. L. McClain — ADDRESS: Pocatello

32791

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 28
Primary Registration District No. 2161
File No. 37
Registered No. 3496

1. PLACE OF DEATH
County of Bannock
City of Pocatello
(No. General Hospital)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Enfis Tominago

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Japanese
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: (Write the word) Single

6. DATE OF BIRTH: Not Known (Month) (Day) (Year)

7. AGE: Years 44 Mos. ds. — IF LESS than 1 day how many hrs. or min.? — If less than one year give age in months, days or hours.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Cook
(b) General nature of industry, business or establishment in which employed (or employer): For Section men Lima Mont.

9. BIRTHPLACE (State or Country): Japan

10. NAME OF FATHER: Not Known

11. BIRTHPLACE OF FATHER (State or Country): Japan

12. MAIDEN NAME OF MOTHER: Not Known

13. BIRTHPLACE OF MOTHER (State or Country): Japan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Kikushi Ito
(Address) Pocatello Idaho

15. Filed Jan 24 1921 — J. J. Young, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 22 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1-18 1921, to 1-22 1921, that I last saw h[illegible] alive on 1-22 1921, and that death occurred on the date stated above, at 9:30 P.M.

The CAUSE OF DEATH* was as follows:

Hemorrhage from
moderate fever

(Duration) — Yrs. mos. 12 ds.

Contributory (Secondary): Chronic duodenal ulcer

(Duration) — yrs. mos. ds.

(Signed) [signature] M. D.

1/24 1921 (Address) Pocatello

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. 5 days. In the State yrs. mos. 3 days

Where was disease contracted if not at place of death?

Former or usual residence Lima Montana

19. PLACE OF BURIAL OR REMOVAL: Mt View Cem — DATE OF BURIAL: Jan 25 1921

20. UNDERTAKER: H. L. McHan — ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

32793

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 28
Primary Registration District No. 2161
File No. 87
Registered No. 3498

1. PLACE OF DEATH
County of Bannock
City of Pocatello
(No. General Hospital St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Christina Anderson
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widow (Write the word.)

6. DATE OF BIRTH: April (Month) 13 (Day) 1847 (Year)

7. AGE: 73 Yrs. 9 Mos. 10 ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER: Mons Matson

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs E.D. Harrison
(Address) 429 - 1st Garfield

15. Filed 1/25 1921
J.R. Young
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: January (Month) 23 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 23 1921 to Jan 23 1921
that I last saw ~~her~~ alive on Jan 22 1921,
and that death occurred on the date stated above, at 1 A.M.
The CAUSE OF DEATH* was as follows: Acute
Myocarditis
Burns Entire Body
(Duration) ... Yrs. ... mos. ... ds.
Contributory (Secondary)
(Duration) ... yrs. ... mos. ... ds.
(Signed) ... M. D.
Jan 24 1921 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain View Cem — DATE OF BURIAL: Jan 25 1921

20. UNDERTAKER: Schumacher & Hall — ADDRESS: Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

32794

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 28
Primary Registration District No. 3141
File No. 37
Registered No. 3499

1. PLACE OF DEATH
County of Bannock
City of Pocatello
(No. General Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Stanley Stewart Stites

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: September 15 1882 (Month) (Day) (Year)

7. AGE: 38 Yrs. 4 Mos. 9 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Traveling Salesman
(b) General nature of industry, business or establishment in which employed (or employer): Idaho Candy Co.

9. BIRTHPLACE (State or Country): South Dakota

10. NAME OF FATHER: Wm. D. Stites

11. BIRTHPLACE OF FATHER (State or Country): Not Known

12. MAIDEN NAME OF MOTHER: Helen E. Kent

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE, TO THE BEST OF MY KNOWLEDGE
(Informant) Maude L. Stites
(Address) 210 Forge Apartments Pocatello, Ida

15.
Filed Jan 25 1921
H. L. Young
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan 24 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 3 1920, to Jan 24 1921, that I last saw him alive on Jan 24 1921, and that death occurred on the date stated above, at 6:30 P.M.

The CAUSE OF DEATH* was as follows:
Frontal sinus (right) Chronic - 9 years
Caries - mpelitis right frontal bone
Right Pneumonia - Empyema - Dec - 1920
(Duration) Yrs. mos. ds.
Contributory (Secondary) Abscess of Brain
1st Known (Duration) yrs. mos. ds.
(Signed) Hamner C. Davis M. D.
1/25 1921 (Address) Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. 1 mos. 2 days. In the State 1 yrs. 9 mos. days
Where was disease contracted if not at place of death?
Former or usual residence Boise Idaho

19. PLACE OF BURIAL OR REMOVAL: Mt View Cem. DATE OF BURIAL: Jan 26 1921

20. UNDERTAKER: McHan Undertaking Co. ADDRESS: Pocatello, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

32795

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 28
Primary Registration District No. 2141
File No. 67
Registered No. 3501

1. PLACE OF DEATH
County of Bannock
City of Pocatello
(No. Brick Plant North of Lutz St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Albert Thomas Clark

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: July (Month) 13 (Day) 1898 (Year)

7. AGE: 22 Yrs. 6 Mos. 14 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Blackfoot Ida.

10. NAME OF FATHER: Thomas Clark

11. BIRTHPLACE OF FATHER (State or Country): Scotland

12. MAIDEN NAME OF MOTHER: Sarah Adams

13. BIRTHPLACE OF MOTHER (State or Country): Richmond Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Thomas Clark
(Address) Maryland Ida

15. Filed 1/28 1921

J. H. Jones
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: January (Month) 27 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows: Broken neck, by accidental fall

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D. D. Swanson Coroner M. D.
1-28-1921 (Address) Pocatello Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Maryland Ida — DATE OF BURIAL: 1/30 1921

20. UNDERTAKER: Schumacher & Hall — ADDRESS: Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

32796

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 28
Primary Registration District No. 2161
File No. 3
Registered No. 3500

1. PLACE OF DEATH
County of Bannock
City of Pocatello
(No. Residence St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Britton

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Widow

6. DATE OF BIRTH: October (Month) 13 (Day) 1831 (Year)

7. AGE: 89 Yrs. 3 Mos. 14 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Illinois

10. NAME OF FATHER William Sutton

11. BIRTHPLACE OF FATHER (State or Country) Pennsylvania

12. MAIDEN NAME OF MOTHER Catherine Lake

13. BIRTHPLACE OF MOTHER (State or Country) New Jersey

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Clara Elkins
(Address) Auditorium Bldg

15. Filed 1/28 1921
J. H. Young
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: January (Month) 27 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1919, to Jan 26 1921
that I last saw h.er alive on Jan 26 1921,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Acute nephritis

(Duration) ..... Yrs. 1 mos. ..... ds.
Contributory (Secondary) Myocarditis
(Duration) 2 yrs. ..... mos. ..... ds.
(Signed) R.M. Newton M. D.
Jan 5 1921 (Address) Pocatello Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Mountain View Cem	Jan 29 1921
20. UNDERTAKER	ADDRESS
Schumacher & Hall	Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

32799

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 24
Primary Registration District No. 2161
File No. 37
Registered No. 3483

1. PLACE OF DEATH
County of Bannock
City of Pocatello
(No. General Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Hogg Smith

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
male	White	Widower

6. DATE OF BIRTH: March (Month) 5 (Day) 1852 (Year)

7. AGE: 68 Yrs. 9 Mos. 27 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business or establishment in which employed (or employer): Rancher

9. BIRTHPLACE (State or Country): Scotland

10. NAME OF FATHER: Richard Smith

11. BIRTHPLACE OF FATHER (State or Country): Scotland

12. MAIDEN NAME OF MOTHER: Ellen Hogg

13. BIRTHPLACE OF MOTHER (State or Country): Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs E. J. Park
(Address) City

15. Filed 1/2 1921 — J. P. Clancy, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: January (Month) 2 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 28 1920, to Jan 2 1921 that I last saw him alive on Jan 1 1921, and that death occurred on the date stated above, at 5 A.M.

The CAUSE OF DEATH* was as follows:

I Arteriosclerosis

(Duration) ..... Yrs. ..... mos. 6 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John J. Park M. D.

1/2 1921 (Address) Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Logan Utah — DATE OF BURIAL: 1-6 1921

20. UNDERTAKER: Schumacher & Hall — ADDRESS: Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

CERTIFICATE OF DEATH

Registration District No. 21

Primary Registration District No. 2161

(No. St. Anthony Hospital St.)

32801

No. 27

Registered No. 3485

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

City of Pocatello

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Everett E. Butler

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: June 22 (Month) (Day) 1900 (Year)

7. AGE: 20 Yrs. 6 Mos. 12 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farming

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: James F. Butler

11. BIRTHPLACE OF FATHER (State or Country): Ill—

12. MAIDEN NAME OF MOTHER: Cora Clemens

13. BIRTHPLACE OF MOTHER (State or Country): Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) James F. Butler

(Address) Teton Idaho

15.

Filed 1/4 192[illegible]

J. P. Young Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan 4 (Month) (Day) 192[illegible] (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 29 192[illegible] to Jan 4 192[illegible]

that I last saw h[illegible] alive on Jan 3 192[illegible],

and that death occurred on the date stated above, at 8 P.M.

The CAUSE OF DEATH* was as follows:

Meningitis

(Duration) Yrs. ..... mos. 7 ds.

Contributory (Secondary) Chronic Emphysema

(Duration) ..... yrs. ..... mos. 2 1 ds.

(Signed) J. Clarkson M. D.

May 192[illegible] (Address) Pocatello

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: St Anthony Hospital — DATE OF BURIAL: Jan 6 192[illegible]

20. UNDERTAKER: [illegible] Undertaking Parlors — ADDRESS: City

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

CERTIFICATE OF DEATH

City of Pocatello (No. 839 N 10 ave St.) Registered No. 3484

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Alice Delores Marvin.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: July (Month) 18 (Day) 1920 (Year)

7. AGE: 0 Yrs. 6 Mos. 17 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business or establishment in which employed (or employer): none.

9. BIRTHPLACE (State or Country): Pocatello.

10. NAME OF FATHER: Earl Holden Marvin.

11. BIRTHPLACE OF FATHER (State or Country): Hamilton O.

12. MAIDEN NAME OF MOTHER: Alice Josephine Allen

13. BIRTHPLACE OF MOTHER (State or Country): Laramie Wyo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Earl Holden Marvin

(Address) 839 N 10 ave.

15. Filed 1/6 1921 J R Young Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 5 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1/2 1921, to 1-5 1921 that I last saw h.r alive on 1-5 1921 and that death occurred on the date stated above, at 4 A.M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... Yrs. ..... mos. 3 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J R Young M. D.

1/6 1921 (Address) Pocatello.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death — yrs. 6 mos. 17 days. In the State — yrs. 6 mos. 17 days

Where was disease contracted if not at place of death? .....

Former or usual residence 839 N. 10 ave.

19. PLACE OF BURIAL OR REMOVAL: Mt View Cem. DATE OF BURIAL: Jan 7 1921

20. UNDERTAKER: H. L. McHan. ADDRESS: Pocatello Ida.

215 So Main

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

32803

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 28
Primary Registration District No. 216
File No. 37
Registered No. 3487

1. PLACE OF DEATH

County of Bannock
City of Pocatello
(If outside city limits)
Common City Colo.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Jane Bramon

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female

4. COLOR OR RACE White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married

6. DATE OF BIRTH Aug (Month) 11 (Day) 1878 (Year)

7. AGE 44 Yrs. 4 Mos. 24 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: house wife

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Colo.

10. NAME OF FATHER Ed merit

11. BIRTHPLACE OF FATHER (State or Country) Unknown.

12. MAIDEN NAME OF MOTHER Martha Gamble

13. BIRTHPLACE OF MOTHER (State or Country) N. Carolina

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C. E. Bramon

(Address) Pocatello Ida

15. Filed Jan 8 1921 J. H. Young Local Registrar

SIMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 4 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 4 1920 to Jan 3 1921 that I last saw h.. alive on Jan 3 1921 and that death occurred on the date stated above, at 1145 P. M.

The CAUSE OF DEATH* was as follows:

Tuberculosis

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. E. Cole V.C. M. D.

1/5 1921 (Address) Canon City Colo.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. 1 mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence Pocatello Ida.

19. PLACE OF BURIAL OR REMOVAL Mt View Pocatello | **DATE OF BURIAL** Jan 8 1921

20. UNDERTAKER H. L. McHan | **ADDRESS** Pocatello

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 57

Primary Registration District No. 2022

File No. 32807

County of Blaine

City of Bellevue (No. ....., ... St.)

Registered No. 2

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James Franklin Bowers

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. ~~SINGLE~~, MARRIED, ~~WIDOWED OR DIVORCED~~ (Write the word)
Male	White	Married

6. DATE OF BIRTH: Jan. (Month) 20 (Day) 1853 (Year)

7. AGE: 67 yrs. 11 mos. 23 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Mechanic
(b) General nature of industry business, or dstablishment in which employed (or employer): Carpenter

9. BIRTHPLACE (State or Country): Massachusetts

10. NAME OF FATHER: Seth Bowers

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Ruth Dexter

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Sarah E Bowers
(Address) Bellevue Idaho

15. Filed 2-8 1921 R. H. Wright Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Wright.
Jan. (Month) 13 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec-16 1920 to Jan 13 1921
that I last saw him alive on Jan-12- 1921
and that death occurred on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:
Carcinoma of bowel

(Duration) 3 yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Robert H. Wright M. D.
1-14 1921 (Address) Hailey Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Bellene, Ida — DATE OF BURIAL: 3-15 1921

20. UNDERTAKER: R. D. Harris — ADDRESS: Ha...

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & SDRS. 19760

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 32808
Registered No.

1. PLACE OF DEATH

Registration District No. 79
Primary Registration District No. 215-5

County of Bonner
City of Sandpoint, Ida. (No. 439 So. Euclid Ave. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Eli Ashley.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Male	White	Single (Write the word.)

6. DATE OF BIRTH: Mar. (Month) 11, (Day) 1856 (Year)

7. AGE: 65 Yrs. Mos. ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer.
(b) General nature of industry, business or establishment in which employed (or employer): Active.

9. BIRTHPLACE (State or Country): Ohio.

10. NAME OF FATHER: Wm Ashley.

11. BIRTHPLACE OF FATHER (State or Country): Ohio.

12. MAIDEN NAME OF MOTHER: Mary Malnaux.

13. BIRTHPLACE OF MOTHER (State or Country): Ohio.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wm Ashley.
(Address) Sandpoint, Ida.

15. Filed Jan 24 1921 Floyd E. Hendricks Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. (Month) 18, (Day) 21, (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from Jan 16 1921, to Jan 18 1921, that I last saw him alive on Jan 18 1921, and that death occurred on the date stated above, at 12.45 P.M.

The CAUSE OF DEATH* was as follows:
Apoplexy - Cerebral
4 or 5
(Duration) Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) C. P. Stackhouse M. D.
Jan. 20 1921. (Address) Sandpoint, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Sandpoint, Ida. DATE OF BURIAL: Jan. 21 1921

20. UNDERTAKER: E.W. Pugh. ADDRESS: Sandpoint, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 32809

1. PLACE OF DEATH

Registration District No. 78
Primary Registration District No. 2153
(No. 214 Church St.)

County of Bonner
City of Sandpoint, Ida.
If death occurs away from usual residence, give facts called for under special information.

Registered No.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Diantha Mc Millan.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widowed. (Write the word.)

6. DATE OF BIRTH: May, 10, 1840. (Month) (Day) (Year)

7. AGE: 80 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired Housewife.
(b) General nature of industry, business or establishment in which employed (or employer): At Home.

9. BIRTHPLACE (State or Country): Ind.

10. NAME OF FATHER: Herman Richardson.

11. BIRTHPLACE OF FATHER (State or Country): N.Y.

12. MAIDEN NAME OF MOTHER: Nancie Nackles.

13. BIRTHPLACE OF MOTHER (State or Country): N.Y.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R.H.McMillan.
(Address) Sandpoint, Ida.

15. Filed Jan 27 1921
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan, 7, -21. (Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from Oct 21 1920, to Jan 7- 1921, that I last saw her alive on Jan 3- 1921, and that death occurred on the date stated above, at 1.30 P.M.

The CAUSE OF DEATH* was as follows:

Senility

(Duration) Yrs. mos. ds.

Contributory (Secondary) Sanitarium

(Duration) yrs. 20 mos. ds.

(Signed) C. S. Starchamme M. D.

Jan, 19 21. (Address) Sandpoint, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Sandpoint, Ida. | DATE OF BURIAL: Jan, 9 -21 19

20. UNDERTAKER: B.W.Pugh. | ADDRESS: Sandpoint, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 32810

1. PLACE OF DEATH

Registration District No. 78

Primary Registration District No. 2155

County of Bonner

City of Sandpoint

(No. City Hospital. St.)

If death occurs away from usual residence, give facts called for under special information.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Selma Reed.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married. (Write the word.)

6. DATE OF BIRTH: June, 24, 1886 (Month) (Day) 1 (Year)

7. AGE: 35 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife.

(b) General nature of industry, business or establishment in which employed (or employer): At Home.

9. BIRTHPLACE (State or Country): Sweden.

10. NAME OF FATHER: Jos Malakias.

11. BIRTHPLACE OF FATHER (State or Country): Sweden.

12. MAIDEN NAME OF MOTHER: Marie Market.

13. BIRTHPLACE OF MOTHER (State or Country): Sweden.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Agner Reed.

(Address) Clarks fork, Ida.

15. Filed Jan 24 1921

Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan, 8, 21. (Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12 — 26 — 1920 to 1 — 8 — 1921 that I last saw her alive on Jan. 8 1921, and that death occurred on the date stated above, at 11:30 P.M.

The CAUSE OF DEATH* was as follows:

Toxemia following puerperal Appendicitis, (Appendectomy)

(Duration) Yrs. mos. 14 ds.

Contributory (Secondary)

(Duration) yrs. mos. 6 ds.

(Signed) M. P. Wallentine M. D.

Jan., 19 21. (Address) Sandpoint, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. 14 days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Clarks - Fork, Ida. DATE OF BURIAL: Jan, 12, 1921

20. UNDERTAKER: B.W.Pugh, ADDRESS: Sandpoint, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 32811
Registered No.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH

Registration District No. 78
Primary Registration District No. 2155

County of Bonner
City of Sandpoint, Ida. (No. Cottage Rooming House. St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Frances Isabel Burdick.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Single

6. DATE OF BIRTH Nov. 14, -20. 1 (Month) (Day) (Year)

7. AGE Yrs. 1 Mos. 19 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Ida.

10. NAME OF FATHER Floyd Berdick.

11. BIRTHPLACE OF FATHER (State or Country) Ore.

12. MAIDEN NAME OF MOTHER Velzri Verl.

13. BIRTHPLACE OF MOTHER (State or Country) Wis.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Floyd Berdick.
(Address) Sandpoint, Ida.

15. Filed Jan 24 1921 Floyd E. Kendall Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan. 2, -21. 19 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 2 1921, to Jan 2. 1921 that I last saw h er alive on Jan 2 1921, and that death occurred on the date stated above, at 9:30 A.M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) Yrs. mos. 2 ds.

Contributory (Secondary) Malnutrition

(Duration) yrs. mos. ds.

(Signed) M P Wallentine M. D.

Jan. 19 21. (Address) Sandpoint, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Sandpoint, Ida. **DATE OF BURIAL** Jan. 4, -21. 19

20. UNDERTAKER B. W. Pugh. **ADDRESS** Sandpoint, Ida.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 32815
Registered No.

1. PLACE OF DEATH

Registration District No. 78
Primary Registration District No. 2/8-5

County of Bonner
City of Sandpoint (No. On Ranch, near Selly, Ida. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs. Ida. Smith.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female

4. COLOR OR RACE White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married. (Write the word.)

6. DATE OF BIRTH July, (Month) I, (Day) 1882. (Year) 1

7. AGE 38 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife.

(b) General nature of industry, business or establishment in which employed (or employer): At Home.

9. BIRTHPLACE (State or Country) Ind.

10. NAME OF FATHER Sam LEE.

11. BIRTHPLACE OF FATHER (State or Country) Ind.

12. MAIDEN NAME OF MOTHER Katherine, Keller.

13. BIRTHPLACE OF MOTHER (State or Country) Ind.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E. T. Lee,

(Address) Sandpoint, Ida.

15. Filed Jan 24 1921

Floyd E. Clark
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan. (Month) 4, (Day) -21. (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from ....19...., to ....19....,
that I last saw h.... alive on ....19....,
and that death occurred on the date stated above, at ....M.

The CAUSE OF DEATH* was as follows:

Residence burning on ranch near Selly, Ida. Body was found in debris of burnt residence, origin of fire unknown.

(Duration) ....yrs. ....mos. ....ds.

Contributory (Secondary) ....

(Duration) ....yrs. ....mos. ....ds.

(Signed) H. M. Knapp (Coroner) M. D.

Jan. 6, 19 21. (Address) Hope, Ida.

*State the *Disease Causing Death*; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs. ....mos. ....days. In the State ....yrs. ....mos. ....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Sandpoint, Ida. **DATE OF BURIAL** Jan. 8. -21. 19

20. UNDERTAKER B. ..Pugh. **ADDRESS** Sandpoint Ida.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 32816

Registration District No. 78
Primary Registration District No. 2575
Registered No.

1. PLACE OF DEATH

County of Bonner
City of Sandpoint
(No. On Ranch, near Selly, Ida. St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Sydney G. Smith.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married.

6. DATE OF BIRTH: Jan. (Month) Unknown. (Day) 1879. (Year)

7. AGE: 42 Yrs. Mos. ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ind.

10. NAME OF FATHER: ----- Smith.

11. BIRTHPLACE OF FATHER (State or Country): Ind.

12. MAIDEN NAME OF MOTHER: ----- Cartwright.

13. BIRTHPLACE OF MOTHER (State or Country): Ind.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. T. Lee.
(Address) Sandpoint, Ida.

15. Filed Jan 24 1921 Floyd K. Hamilton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. (Month) 4, (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Residence burning on ranch near Selly, Ida. Body was found in debris of burnt residence, origin of fire unknown. (Duration) yrs. mos. ds.

Contributory (Secondary) (Duration) yrs. mos. ds.

(Signed) W. M. Knapp (Coroner) M. D.
Jan. 6, 1921. (Address) Hope, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Sandpoint, Ida.	Jan. 8, 1921

20. UNDERTAKER	ADDRESS
B. W. Pugh	Sandpoint, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32817

Registered No. 27

1. PLACE OF DEATH

County of Bonner

City of Priest River

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 85

Primary Registration District No. 2185

(No. ..... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Duncan MacDougal

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH

Not known (Month) (Day) 1862. (Year)

7. AGE

59 Yrs. ___ Mos. ___ ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Lumberjack

(b) General nature of industry, business or establishment in which employed (or employer) Teamster

9. BIRTHPLACE (State or Country) Canada

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (State or Country) Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Elmer C Stone

(Address) Priest River Ida.

15.

Filed Jan 31 1921 19 .....

C. P. Getz

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan (Month) 7 (Day) 19 21 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 15 1920, to Jan 7 1921 19 ....., that I last saw him alive on Jan 5 1921 19 ....., and that death occurred on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Cancer of liver

(Duration) 2 Yrs. 11 mos. 22 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. P. Getz M. D.

Jan 7 1921 19 ..... (Address) Priest River Ida,

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 15 yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Priest River

DATE OF BURIAL Jan 7 19 21

20. UNDERTAKER Wm, Davis

ADDRESS Newport.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

32818

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 85
Primary Registration District No. 2185

File No. 1

Registered No. 25

1. PLACE OF DEATH

County of Bonner

City of PRIEST RIVER, IDAHO

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lucy May Nacaratto

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Single

6. DATE OF BIRTH

Sept 19 1920
(Month) (Day) (Year)

7. AGE

Yrs. 3 Mos. 25 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Idaho,

10. NAME OF FATHER

Gus, Nacaratto

11. BIRTHPLACE OF FATHER

(State or Country) Idaho

12. MAIDEN NAME OF MOTHER

Minnie Gauadonal

13. BIRTHPLACE OF MOTHER

(State or Country) Colo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Gus Nacaratto

(Address) PRIEST RIVER, IDAHO

15.

Filed Jan 31 1921 19 .....

C. P. Gehrke
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 14 1921
(Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 6 1921 19 ..., to Jan 14 1921 19 ..., that I last saw her alive on Jan 12 1921 19 ..., and that death occurred on the date stated above, at 5.30A M.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

(Duration) Yrs. 3 mos. -- ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. P. Gehrke M. D.

Jan 15 1921 (Address) PRIEST RIVER, IDAHO

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Priest River

DATE OF BURIAL: Jan 16 1921

20. UNDERTAKER: C. P. Nacaratto, Brother

ADDRESS: PRIEST RIVER, IDAHO

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 85
Primary Registration District No. 2185
File No. 32819
Registered No. 27

County of Bonner
City of Priest River, Ida.
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Walter P. Edris

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH: Aug (Month) 31 (Day) 1871 (Year)

7. AGE: 49 Yrs. 49 Mos. 4 ds. 24
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miller
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Oregon

10. NAME OF FATHER: William Edris

11. BIRTHPLACE OF FATHER (State or Country): Penn.

12. MAIDEN NAME OF MOTHER: Mary Carson

13. BIRTHPLACE OF MOTHER (State or Country): Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Lola A Offutt
(Address) Spokane Wash.

15. Filed Jan 31 1921 C. P. Getchell Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 24 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 2 1920 to Jan 24 1921, that I last saw h[im] 6m alive on Jan 23 1921, and that death occurred on the date stated above, at 4 a. M.

The CAUSE OF DEATH* was as follows:

Cardiac degeneration with anurysm of right auricle ..

(Duration) — Yrs. 5 mos. — ds.

Contributory (Secondary) Bronchial asthma

(Duration) — yrs. — mos. — ds.

(Signed) C. P. Getchell M. D.

Jan 24 21 (Address) Priest River, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Priest River Burial	Jan 26 1921
20. UNDERTAKER Wm Davis,	ADDRESS Newport

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 85

Primary Registration District No. 2185

File No. 1 32820

Registered No. 30

County of Bonner

City of Priest River (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Dorthy Alice Purcell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: Wjite

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: May (Month) 23 (Day) 1920 (Year)

7. AGE: ..... Yrs. 8 Mos. 3 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wash.

10. NAME OF FATHER: Chas Purcell

11. BIRTHPLACE OF FATHER (State or Country): Canada.

12. MAIDEN NAME OF MOTHER: Elisabeth McGrath

13. BIRTHPLACE OF MOTHER (State or Country): Not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Thos Purcell

(Address) Priest River, Ida

15. Filed Jan 31 1921 C. P Gaffney Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 26 (Day) 1921 (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from Jan 23 1921, to Jan 26 1921 19, that I last saw her alive on Jan 26 1921 19, and that death occurred on the date stated above, at 4.05 P.M.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) ..... Yrs. ..... mos. 3 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. P Gaffney M. D.

Jan 26 1921 (Address) Priest River Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Priest River Ida — DATE OF BURIAL: Jan 28 1921

20. UNDERTAKER: Neighbor Elmer Stone — ADDRESS: Priest River Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

[redacted] ATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Form V. S. No. 5

1. PLACE OF DEATH. [redacted] District No. 79

County of Boundary — Primary Registration District No. 3156 — File No. 32821

City of Addie — (No. ..... St.) — Registered No. .....

If death occurs away from usual residence, give facts called for under special information. If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Thomas Heady

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Nov (Month) 25 (Day) 1843 (Year)

7. AGE: 77 yrs. 1 mos. 10 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: Thomas Heady

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. F. J. Bond
(Address) Addie Ida

15. Filed 2/15/21 — E E Fry, Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan (Month) 10 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 28 1920, to Jan 9 1921, that I last saw h. i. m alive on Jan 9 1921, and that death occurred on the date stated above, at 1 P. M.

The CAUSE OF DEATH* was as follows:

Hemorrhage of Brain

(Duration) ..... yrs. 10 mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) L L Hammer M. D.

Jan 9 1921 (Address) Eastport, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Bonners Ferry Ida — DATE OF BURIAL: 1/12 1921

20. UNDERTAKER: C R Hooley — ADDRESS: Bonners Ferry Ida

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Boundary
City of Bonners Ferry
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 79.
Primary Registration District No. 2156.
(No. ....., ... St.)

File No. 32822
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Florence Edna Glover

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
F	W	Married

6. DATE OF BIRTH: Apr (Month) 14 (Day) 1880 (Year)

7. AGE: 40 yrs. 9 mos. 1 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Maine

10. NAME OF FATHER: William Booker

11. BIRTHPLACE OF FATHER (State or Country): Maine

12. MAIDEN NAME OF MOTHER: Emma Dewitt

13. BIRTHPLACE OF MOTHER (State or Country): Maine

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A. J. Glover
(Address) Kintla Mont.

15.
Filed Jan. 17th 1931 E E Fry Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan (Month) 15 (Day) 1931 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 2 1930, to Jan. 15 1931, that I last saw h alive on Jan. 14 1931, and that death occurred on the date stated above, at 8 A. M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ..... yrs. ..... mos. 6 ds.

Contributory (Secondary) Cholecystostomy

(Duration) ..... yrs. 1 mos. ..... ds.

(Signed) E E Fry M. D.

1/17 1931 (Address) Bonners Ferry, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Bonners Ferry Ida. DATE OF BURIAL: 1/18 1931

20. UNDERTAKER: C B Stookey ADDRESS: Bonners Ferry Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & SDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 32823
Registered No.

1. PLACE OF DEATH.
County of Boundary
City of Bonners Ferry
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 79
Primary Registration District No. 215-6
(No. , St.)

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Charles H. Gardner

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M.	white	married

6. DATE OF BIRTH
(Month) (Day) 1 (Year)

7. AGE
about 60 yrs. mos. ds.
IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Supt. of Logging
(b) General nature of industry business, or dstablishment in which employed (or employer)

9. BIRTHPLACE
(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER
(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H. P. McCoy
(Address) Bonners Ferry Idaho

15.
Filed Jan. 17th 1921 E. E. Fry
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Jan. (Month) 16 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 191, to 191, that I last saw h alive on 191, and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:
Heart failure
(Arteri-Sclerosis Coronary Artery)
(Duration) yrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) E. E. Saunders Coroner M. D.
1/17 1921 (Address) Bonners Ferry, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Stillwater Minn	1/18 1921
20. UNDERTAKER	ADDRESS
C. E. Storkey	

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 1005
File No. 32828
Registered No. 14

1. PLACE OF DEATH
County of Canyon
City of Caldwell
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Anita Mallory

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH: Dec (Month) 10 (Day) 1919 (Year)

7. AGE: ... Yrs. 1 Mos. 2 ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Lorenzo Mallory

11. BIRTHPLACE OF FATHER (State or Country) Idaho

12. MAIDEN NAME OF MOTHER Mamie Herrick

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Lorenzo Mallory
(Address) Caldwell Idaho

15. Filed Feb. 4 1921 John H. Meyers Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: February (Month) 4 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 25 1921, to Feb. 4 1921, that I last saw him alive on March 4 1921, and that death occurred on the date stated above, at 6 A.M.

The CAUSE OF DEATH* was as follows:

Septic Infection

(Duration) ... Yrs. 1 mos. ... ds.

Contributory (Secondary) —

(Duration) ... yrs. ... mos. ... ds.

(Signed) J. M. Henry M. D.
19... (Address) Caldwell Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill
DATE OF BURIAL: 2-5 19...

20. UNDERTAKER: CASE FURNITURE CO.
ADDRESS: Caldwell

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 2005
File No. 32829
Registered No. 13

1. PLACE OF DEATH
County of Canyon
City of Caldwell
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Asa McManus

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: July (Month) ..... (Day) 1853 (Year)

7. AGE: 67 Yrs. 6 Mos. 28 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER: McManus

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Jeff Carson (Barry)
(Address) Mr Cleveland Ida.

15. Filed Feb. 4 1921 John S. Meyers Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 3 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 1 1921, to Feb 3 1921, that I last saw h[illegible] alive on Feb 3 1921 and that death occurred on the date stated above, at 8 P. M.
The CAUSE OF DEATH* was as follows:
Uraemia.
(Duration) ..... Yrs. ..... mos. 4 ds.
Contributory (Secondary) Chronic Nephritis & Cystitis not known
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) [illegible] M. D.
2/4 1921 (Address) Caldwell, Ida

*State the *Disease Causing Death*; or in deaths from **Violent Causes**, state (1) **Means of Injury**; and (2) whether **Accidental, Suicidal or Homicidal.**

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill
DATE OF BURIAL: [illegible] 1921

20. UNDERTAKER: CASE FURNITURE CO.
ADDRESS: Caldwell

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 8-25 M. 1-20.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Canyon — Registration District No. 3

City of Middleton — Primary Registration District No. 2005

(No. ..... St.)

File No. 32831

Registered No. 11

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Grace R Cox

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: W Lite

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Aug (Month) 7 (Day) 1905 (Year)

7. AGE: 15 Yrs. 5 Mos. 24 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: ---
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Oregon

10. NAME OF FATHER: Ora Cox

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Savanah Cate

13. BIRTHPLACE OF MOTHER (State or Country): Oreg

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Clyde C Foster
(Address) Middleton Idaho

15. Filed Feb 1st 1921 — John L. Meyer, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 1 (Month) 31 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 28 1921, to Jan 31 1921, that I last saw her alive on Jan 31 1921, and that death occurred on the date stated above, at 7 P M.

The CAUSE OF DEATH* was as follows:

Diphtheria

(Duration) ..... Yrs. ..... mos. 4 ds.

Contributory (Secondary): none

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. W. Lamer M. D.

19..... (Address) Middleton Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 6 yrs. — mos. — days. In the State of Idaho 15 yrs. 4 mos. — days

Where was disease contracted if not at place of death? at home

Former or usual residence Former

19. PLACE OF BURIAL OR REMOVAL: Middleton — DATE OF BURIAL: Feb 1 1921

20. UNDERTAKER: CASE FURNITURE CO. — ADDRESS: Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE. 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Canyon

City of Caldwell

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 3

Primary Registration District No. 2003

(No. ....., ... St.)

File No. 32832

Registered No. 10

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Grace Wing

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Jan (Month) 10 (Day) 1921 (Year)

7. AGE: ..... Yrs. ..... Mos. 17 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Geo. Wing

11. BIRTHPLACE OF FATHER (State or Country) Colorado

12. MAIDEN NAME OF MOTHER Edna C. Pitzer

13. BIRTHPLACE OF MOTHER (State or Country) Colorado

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Geo E Wing

(Address) R. F. D. Caldwell

15. Filed Jan 28 1921 John V. Meyers Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51068

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 27 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 25 1921 to Jan 26 1921 that I last saw h.r. alive on Jan 26 1921, and that death occurred on the date stated above, at 3 A.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

..... (Duration) ..... Yrs. ..... mos. 3 ds.

Contributory (Secondary) Grippe

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Z B Dudley M. D.

19..... (Address) Caldwell - Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill

DATE OF BURIAL: 1-28 1921

20. UNDERTAKER: CASE FURNITURE CO.

ADDRESS: Caldwell

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 2005
File No. 32833
Registered No. 9

1. PLACE OF DEATH
County of Canyon
City of Caldwell
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Baby Alta Clark
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.):

6. DATE OF BIRTH: Jan (Month) 25 (Day) 1921 (Year)

7. AGE: ..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or 10 min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work:
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Caldwell Ida

10. NAME OF FATHER: Arthur B. Clark

11. BIRTHPLACE OF FATHER (State or Country): Michigan

12. MAIDEN NAME OF MOTHER: Alta Mark

13. BIRTHPLACE OF MOTHER (State or Country): Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Arthur B. Clark
(Address): Caldwell, Ida

15. Filed Jan. 26 1921 John S. Meyer
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 25 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 25 1921, to Jan 25 1921, that I last saw her alive on ..... 19....., and that death occurred on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:
Respiratory & Cardiac Failure

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary): Birth trauma
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) P. G. Young M. D.
1-26 1921 (Address) Caldwell

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Parma Cem — DATE OF BURIAL: 1-26-1921

20. UNDERTAKER: E. T. Jackson ADDRESS: Caldwell

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 2005
File No. 32834
Registered No. 8

1. PLACE OF DEATH
County of Canyon
City of Caldwell
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Olivier Green Rogers

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Sept (Month) 14 (Day) 1842 (Year)

7. AGE: 78 Yrs. 4 Mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New York.

10. NAME OF FATHER: O. G. Rogers.

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER: Sarah Van Nest Lowe

13. BIRTHPLACE OF MOTHER (State or Country): Connecticut.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) O. G. Rogers.
(Address) Caldwell, Idaho.

15. Filed Jan. 26 1921
John S. Meyers.
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 24 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 23 1920, to Jan. 24 1921
that I last saw h[illegible] alive on June 1920
and that death occurred on the date stated above, at 1-25 P.M.
The CAUSE OF DEATH* was as follows: (a) Pneumonia (Flu)

(Duration) 2 Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) O. M. Kaley M. D.
1-25 1921 (Address) Caldwell Ida

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Canyon Hill	1-26 1921
20. UNDERTAKER	ADDRESS
V. Peckham	Caldwell

Kelly

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Canyon — Registration District No. 9

City of Caldwell — Primary Registration District No. 1005

(No. ..... St.)

File No. 32835

Registered No. 7

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Betty Jo Ragsdale

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH: Aug (Month) 27 (Day) 1920 (Year)

7. AGE: — Yrs. 4 Mos. 23 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: At home

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: B. G. Ragsdale

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Inez Richle

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) B. G. Ragsdale

(Address) Caldwell Ida

15. Filed Jan. 21 1921 — John L. Meyers, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 20 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 8 1921, to Jan 20 1921 that I last saw her alive on Jan 19 1921 and that death occurred on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows: Pneumonia

(Duration) ..... Yrs. ..... mos. 6 ds.

Contributory (Secondary) Pertussis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) M. Raley M. D.

1-20 1921 (Address) Caldwell Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill — DATE OF BURIAL: 1-21 1921

20. UNDERTAKER: F. Peckham — ADDRESS: Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 1005
File No. 32837
Registered No. 5

1. PLACE OF DEATH
County of Canyon
City of Caldwell
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Andy Banks
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	white	Single

6. DATE OF BIRTH
..... (Month) ..... (Day) 1858 (Year)

7. AGE
62 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) England.

10. NAME OF FATHER —

11. BIRTHPLACE OF FATHER (State or Country) —

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER (State or Country) —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Martha Ann (Smith)
(Address) Caldwell Idaho

15. Filed Jan. 13 1921 John L. Meyer Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Jan (Month) 12 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 4 1921 to Jan 12 1921 that I last saw h.. alive on Jan 12 1921 and that death occurred on the date stated above, at 11 30 P.M.

The CAUSE OF DEATH* was as follows:
Cardiac embolus resulting from endocarditis
Sudden
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) endocarditis
(Duration) not known yrs. ..... mos. ..... ds.

(Signed) J. Nelson M. D.
1/13 1921 (Address) Caldwell, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Canyon Hill — DATE OF BURIAL 1-14 1921

20. UNDERTAKER CASE FURNITURE CO. — ADDRESS Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

Dudley

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 2003
File No. 32838
Registered No. 4

1. PLACE OF DEATH

County of Canyon
City of Wilder
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Elizabeth Watson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	white	married

6. DATE OF BIRTH: July (Month) 18 (Day) 1891 (Year)

7. AGE: 29 Yrs. 5 Mos. 22 ds.
IF LESS than 1 day: how many ..... hrs. or 5 min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Indianna

10. NAME OF FATHER: Samuel Vanderpool

11. BIRTHPLACE OF FATHER (State or Country): Indianna

12. MAIDEN NAME OF MOTHER: Anna Bell Tinkle

13. BIRTHPLACE OF MOTHER (State or Country): Indianna

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Tannich
(Address) Wilder R.D. #1

15. Filed Jan. 14 1921 — John L. Meyers, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: January (Month) 10 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 29 1920, to Jan 10 1921, that I last saw h.e. alive on Jan 9 1921, and that death occurred on the date stated above, at 4 P.M.
The CAUSE OF DEATH* was as follows:
Cardiac Thrombosis

(Duration) ..... Yrs. ..... mos. 3 ds.
Contributory (Secondary) Confinement
(Duration) ..... yrs. ..... mos. 11 ds. Appx

(Signed) S. B. Dudley M. D.
19..... (Address) Caldwell.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Roswell Cem	1-15 1921
20. UNDERTAKER C. V. Peckham	ADDRESS Caldwell, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

Registration District No. 3

Primary Registration District No. 2005

(No. ..... St.)

BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32839

Registered No. 3

1. PLACE OF DEATH

County of Canyon

City of Caldwell

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Sarah Anderson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
female	white	(write the word) widow

6. DATE OF BIRTH: Aug (Month) 28 (Day) 1841 (Year)

7. AGE: 79 Yrs. 4 Mos. 10 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Wm. Lucas

11. BIRTHPLACE OF FATHER (State or Country): ~~State of~~ Maryland

12. MAIDEN NAME OF MOTHER: Margaret Carson

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) M. E. Lauterbach

(Address) Caldwell, R.D. # 2

15. Filed Jan. 10 1921

John H. Meyer
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 8 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 24 1920 to Jan 24 1920 that I last saw h. alive on Dec 21 1920 and that death occurred on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:

Paralysis. General.

(Duration) Yrs. 2 mos. + ds.

Contributory (Secondary) Osteosclerosis

(Duration) 10 yrs. + mos. ..... ds.

(Signed) S. B. Dudley M. D.

1-10-1921 (Address) Caldwell Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill — DATE OF BURIAL: Jan 11 1921

20. UNDERTAKER: F. F. Peckham — ADDRESS: Caldwell

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

Registration District No. 3

Primary Registration District No. 2005

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32840

Registered No. 2

1. PLACE OF DEATH

County of Ogurhee

City of Homedale (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Augusta Smith

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: 6 (Month) 15 (Day) 1848 (Year)

7. AGE: 72 Yrs. 6 Mos. 22 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: House wife.

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Maine

10. NAME OF FATHER: J. W. Burrell

11. BIRTHPLACE OF FATHER (State or Country): Maine

12. MAIDEN NAME OF MOTHER: Rachael Bennett

13. BIRTHPLACE OF MOTHER (State or Country): Connecticut

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Lewis Smith

(Address) Homedale

15. Filed Jan. 8 1921 John L. Meyers Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 7 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 20 1920 to Jan 7 1921 that I last saw h-r alive on Jan 6 1921 and that death occurred on the date stated above, at 8 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) several Yrs. 1 mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. McCaw M. D.

1/8 1921 (Address) Caldwell Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Boise Idaho — DATE OF BURIAL: 1 6 1921

20. UNDERTAKER: CASE FURNITURE CO. — ADDRESS: Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 32841

1. PLACE OF DEATH
County of Canyon
City of Caldwell
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 3
Primary Registration District No. 2005
(No. ..... St.)
Registered No. 1

2. FULL NAME Simeon Brooks Woodcock
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH
1 (Month) 19 (Day) 1844 (Year)

7. AGE
76 Yrs. 11 Mos. 16 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Ohio

10. NAME OF FATHER W^m Woodcock

11. BIRTHPLACE OF FATHER (State or Country) Penn

12. MAIDEN NAME OF MOTHER Anna Brooks

13. BIRTHPLACE OF MOTHER (State or Country) New Jersey

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W C Woodcock
(Address) Caldwell

15. Filed Jan 5 1921 John L. Meyer Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Jan (Month) 3 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 21 1920, to ~~Dec~~ Jan 3 1921 that I last saw him alive on Dec 31 1920, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) ..... Yrs. ..... mos. 13 ds.

Contributory (Secondary) Asthma

(Duration) 2 yrs. ..... mos. ..... ds.

(Signed) J. M. Henry M. D.

19 ..... (Address) Caldwell Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Canyon Hill	Jan 5 1921

20. UNDERTAKER	ADDRESS
CASE FURNITURE CO.	Caldwell

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 82

Primary Registration District No. 2159

(No. ....., ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32843

Registered No. 1

1. PLACE OF DEATH.

County of Bonneau

City of Soda Springs

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Engel Hammerark

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Do not Know (Month) (Day) 1 (Year)

7. AGE 65 aunt ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer) Mfr

9. BIRTHPLACE (State or Country) Norway

10. NAME OF FATHER Jacob Jacobson

11. BIRTHPLACE OF FATHER (State or Country) Norway

12. MAIDEN NAME OF MOTHER Susie Nalen a

13. BIRTHPLACE OF MOTHER (State or Country) Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ellis Rawley

(Address) Soda Spgs Ida

15. Filed Jan 14 1921 Ellis Rawley Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 12 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 12 A 1921, to Jan 12 P 1921, that I last saw h[illegible] alive on Jan 12 1921, and that death occured on the date stated above, at 11.50 P M.

The CAUSE OF DEATH* was as follows

Lobar Pneumonia Left Lung

Mastoiditis

..... (Duration) ..... Yrs. 6 mos. ..... ds.

Contributory (Secondary) None

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) Ellis Rawley M. D.

Jan 12 1921 (Address) Soda Springs Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Mount Lewis — DATE OF BURIAL Jan 14 1921

20. UNDERTAKER Ed Wheeler — ADDRESS Soda Springs

SYMS - YORK CO., PTRS. & BOKS. 24654

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 32844
Registered No. 1

1. PLACE OF DEATH
County of Lemhi Registration District No. 7
City of Owens (No. ..... St.) Primary Registration District No. 2148
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Fredrick Ladd

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
male	white	married

6. DATE OF BIRTH Feb 8 1854
(Month) (Day) (Year)

7. AGE 66 Yrs. 11 Mos. 23 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Ill.

10. NAME OF FATHER Henry Ladd

11. BIRTHPLACE OF FATHER (State or Country) Ill

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER (State or Country) —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Kenneth Ladd
(Address) Owens Idaho

15. Filed Jan 19 21 J. M. Tinsley Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan 16 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jany 9 1921, to Jany 16 1921, that I last saw h.. alive on Jany 16 1921, and that death occurred on the date stated above, at ..... A.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ..... Yrs. ..... mos. 8 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Tinsley M. D.
1/16 1921 (Address) Drafus Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Wesseman Cemetery	Jan 19 21

20. UNDERTAKER	ADDRESS
Kenneth Ladd	Owens

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 90
Primary Registration District No. 2168
File No. 32845
Registered No.

1. PLACE OF DEATH
County of Clearwater
City of Orofino
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Julia Donath
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	white	Married

6. DATE OF BIRTH: May 9 (Month) (Day) 1866 (Year)

7. AGE: 54 Yrs. 10 Mos. 19 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Hungary

10. NAME OF FATHER: A Milleckn

11. BIRTHPLACE OF FATHER (State or Country): Hungary

12. MAIDEN NAME OF MOTHER: Blokser

13. BIRTHPLACE OF MOTHER (State or Country): Hungary

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Edward Donath
(Address) Orofino Idaho

15. Filed Jan 29 1921 J McDaniels Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 28 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from about Jan 13 1921, to Jan 28 1921, that I last saw her alive on Jan 28 1921 and that death occurred on the date stated above, at 11:30 P.M.

The CAUSE OF DEATH* was as follows:
Pneumonia complicating fracture of neck of femur
(Duration) ..... Yrs. ..... mos. 15 ds.
Contributory (Secondary) Fracture, hip
(Duration) ..... yrs. ..... mos. 14 ds.
(Signed) Eula M Horswell M. D.
1/29 1921 (Address) Orofino Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Orofino Idaho DATE OF BURIAL: Jan 30 1921

20. UNDERTAKER: Bollard Bros ADDRESS: Orofino

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. [illegible]

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 90
Primary Registration District No. 2168
File No. 32846
Registered No. 3

1. PLACE OF DEATH
County of Shoshone
City of Cœur d'Alene
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George Washington Snyder

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): married

6. DATE OF BIRTH: Oct (Month) 11 (Day) 845 (Year)

7. AGE: 75 Yrs. 3 Mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): West Virginia

10. NAME OF FATHER: John Snyder

11. BIRTHPLACE OF FATHER (State or Country): West Virginia

12. MAIDEN NAME OF MOTHER: ———

13. BIRTHPLACE OF MOTHER (State or Country): ———

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. M. Snyder
(Address) Cœur d'Alene Idaho

15. Filed Jan 31 1921 J. McGinty Local Registrar

SYMS-YORK CO. PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 31 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....
and that death occurred on the date stated above, at 1 A.M.

The CAUSE OF DEATH* was as follows:
Chronic Myocarditis
(Duration) Not known yrs. mos. ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Earle Moorwell M. D.
Feb 1 1921 (Address) Cœur d'Alene Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Cœur d'Alene Idaho
DATE OF BURIAL: Feb 2 1921

20. UNDERTAKER: Bobo and Son
ADDRESS: Cœur d'Alene Idaho

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 35

County of Elmore — Primary Registration District No. 2021

City of Glenns Ferry (No. ....., ... St.)

File No. 32847

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Maryanna Rosevear

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): At Home

6. DATE OF BIRTH: Nov (Month) 24th (Day) 1919 (Year)

7. AGE: 1 yrs. 2 mos. 3 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business or establishment in which employed (or employer) At Home

9. BIRTHPLACE (State or Country): Elmore County

10. NAME OF FATHER: George H. Rosevear

11. BIRTHPLACE OF FATHER (State or Country): Kansas

12. MAIDEN NAME OF MOTHER: Effie Pigg

13. BIRTHPLACE OF MOTHER (State or Country): Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) George H Rosevear
(Address) Glenns Ferry,

15.
Filed Jan 29 1921 — J. W. Davis — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. (Month) 27. (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 16 1921, to Jan 27 1921, that I last saw her alive on Jan 27, 1921, and that death occurred on the date stated above, at 9 30 P M.

The CAUSE OF DEATH* was as follows:
Bronchial Pneumonia

(Duration) ..... yrs. ..... mos. 10 ds.

Contributory (Secondary) Pertusis

(Duration) ..... yrs. 3 mos. ..... ds.

(Signed) J. W. Davis M. D.

Jan 28 1921 (Address) Glenn's Ferry Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and 2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Glenns Ferry Ida — DATE OF BURIAL: Jan 29 1921

20. UNDERTAKER: J W Pinkham #185 — ADDRESS: Glenns Ferry Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32848

Registered No.

1. PLACE OF DEATH.
County of Elmore
City of Glenns Ferry (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 35
Primary Registration District No. 2021

2. FULL NAME Claude Ray Melvee

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Dec 16th 1918 (Month) (Day) (Year)

7. AGE: 2 yrs. 1 mos. 3 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business or establishment in which employed (or employer) At Home

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: L. J. Melvee

11. BIRTHPLACE OF FATHER (State or Country): N. Carolina

12. MAIDEN NAME OF MOTHER: Bertha Townsend

13. BIRTHPLACE OF MOTHER (State or Country): N Carolina

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) * L. J. Melvee (Father)
(Address) Glenns Ferry Ida

15.
Filed Jan. 20 1921 J. W. Davis Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan 19th 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 19 1920, to Jan 19 1920 that I last saw her alive on Jan 19 191..., and that death occurred on the date stated above, at 1:10 P. M.

The CAUSE OF DEATH* was as follows:
Acute dilatation of heart.
(Duration) ..... yrs. few hrs. ds.
Contributory (Secondary) Hypostatic Pneumonia
(Duration) ..... yrs. 1 mos. ..... ds.
(Signed) J J Pond M. D.
Jan 20 1921 (Address) Glenns Ferry

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and 2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Glenns Ferry
DATE OF BURIAL: Jan 20 1921

20. UNDERTAKER: J W Buchanan #185
ADDRESS: Glenns Ferry

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

EVANS-YORK CO., PRINTERS & BINDERS, BOISE 16672

FORM V. S. No. 5-25 M. 1-16-13

32849

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2119 27

Primary Registration District No. 27 2119

File No. 4

Registered No. ____

1. PLACE OF DEATH.

County of Franklin

City of Preston

(No. ____, ____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs Preston

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
male	white	Married

6. DATE OF BIRTH. Feb (Month) 15 (Day) 1860 (Year)

7. AGE 60 Yrs. 11 Mos. 6 ds.

IF LESS than 1 day how many ____ hrs. or ____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)... Preston Bro Co

9. BIRTHPLACE (State or Country) Canada

10. NAME OF FATHER Samuel Preston

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER Louisa Coe

13. BIRTHPLACE OF MOTHER (State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thomas Preston

(Address) Weston Idaho

15. Filed Feb. 2 1911 — Dr A P Rutter, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan (Month) 6 (Day) 1911 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 5, 1911, to Jan 6 1911, that I last saw him alive on Jan 6 1911 and that death occured on the date stated above, at 7.00 P.M.

The CAUSE OF DEATH* was as follows:

Hemarrhage of Brain

(Duration) ____ Yrs. ____ mos. ____ ds.

Contributory (Secondary)

(Duration ____ yrs. ____ mos. 1 ds.

(Signed) Thos B Holder M. D.

19____ (Address) Preston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Brigham City Utah — DATE OF BURIAL: Jan 7 1911

20. UNDERTAKER: H C Skidmore — ADDRESS: Preston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

Every item of information should be carefully supplied. AGE should be stated EXACTLY, FULL DATE should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

32850

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2119 27
Primary Registration District No. 27 2119
File No.
Registered No. 12

1. PLACE OF DEATH
County of Franklin
City of Dairview
(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Pearl Haslam.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Feb (Month) 1 (Day) 1921 (Year)

7. AGE: — Yrs. — Mos. — ds.
IF LESS than 1 day how many 13 hrs. or 25 min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: George J. Haslam

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Orella Smith

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) George J. Haslam
(Address) Dairview Ida.

15. Filed Feb. 7 1921 Dar R Cutler Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 1 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 1 1921, to Feb 1 1921 that I last saw h[illegible] alive on Feb 1 1921, and that death occurred on the date stated above, at 6:30 P M.

The CAUSE OF DEATH* was as follows:

6 h Gastritis

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Curtis Hansen M. D.

Feb 1921 (Address) Preston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Wellsville Utah — DATE OF BURIAL: Feb. 2 1921

20. UNDERTAKER: A. L. Sandquist — ADDRESS: Logan Utah

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32851

Registered No. 14

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

Registration District No. 2117

Primary Registration District No. 24 2119

County of Franklin

City of Fairview (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs Haslam

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
W	W	Single

6. DATE OF BIRTH: Feb. (Month) 1 (Day) 1921 (Year)

7. AGE: ✓ yrs. ✓ mos. ✓ ds.

IF LESS than 1 day how many ..... hrs. or 30 mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry business, or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Fairview Idaho

10. NAME OF FATHER: George J. Haslam

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Orda Smith

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) George J Haslam
(Address) Fairview. Ida.

15. Filed Feb 7 1921 D A Curtis Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb (Month) 1 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 1 1921, to Feb 1 1921, that I last saw him alive on Feb 1 1921 and that death occurred on the date stated above, at 10:15 A.M.

The CAUSE OF DEATH* was as follows:
6½ mo. gestation

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Curtis Bland M. D.
2/7/1921 (Address) Preston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Hillsdale, Utah	Feb. 7 1921

20. UNDERTAKER	ADDRESS
G. A. Lindquist	Logan, Utah

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

GYMS - YORK CO., PTRS. & BDRS. 19750

FORM V. S. No. 5-25 M. 1-19.

32852

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2119 27

Primary Registration District No. 27 2119

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Franklin

City of Preston

(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Parley Leonidus Carver Jr.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.):

6. DATE OF BIRTH: Dec (Month) 29 (Day) 1920 (Year)

7. AGE: Yrs. Mos. 14 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Preston Idaho

10. NAME OF FATHER: P. L. Carver

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Hazel Smith

13. BIRTHPLACE OF MOTHER (State or Country): Preston Ida.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) P. L. Carver

(Address) Preston Ida

15. Filed Feb 2 1921

D. A. R. Cutler
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 12 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 30 1920, to Jan 12 1921, that I last saw him alive on Jan 12 1921, and that death occurred on the date stated above, at 2-30 P.M.

The CAUSE OF DEATH* was as follows:

Not Known — probably obstruction of Circulation due to heart — by Blue baby at birth —

(Duration) Yrs. mos. ds.

Contributory (Secondary) Spinal bifida — with Atelectasis

(Duration) yrs. mos. 14 ds.

(Signed) P. Cutler M. D.

19 (Address) Preston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR ~~REMOVAL~~: Preston Ida — DATE OF BURIAL: Jan 13 1921

20. UNDERTAKER: W. A. Skidmore — ADDRESS: Preston Ida.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

32854

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2119 27
Primary Registration District No. 27 2 19
File No. 1
Registered No.

1. PLACE OF DEATH
County of Franklin
City of Preston
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Chalinder Bowen
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): —

6. DATE OF BIRTH: Jan (Month) 7 (Day) 1921 (Year)

7. AGE: ..... Yrs. ..... Mos. ..... ds. IF LESS than 1 day how many 1 hrs. or 30 min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Preston Ida

10. NAME OF FATHER: John Chalinder Bowen

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Maud Gunnell

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Chalinder Bowen
(Address) Preston Idaho

15. Filed Feb 2 1921 D.A. Culley Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: January (Month) 7 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 7 1921, to Jan 7 1921, that I last saw h. [illegible] alive on Jan 7 1921, and that death occurred on the date stated above, at 8.45 P.M.

The CAUSE OF DEATH* was as follows:

Asphyxiation — result of premature separation of placenta

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Curtis Blank M. D.

1/8/1921 (Address) Preston, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Wellsville Utah — DATE OF BURIAL: Jan 9 1921

20. UNDERTAKER: W.S. Henderson — ADDRESS: Preston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

32855

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2 Fort 27
Primary Registration District No. 7 2119
File No. 11
Registered No.

1. PLACE OF DEATH
County of Franklin
City of Mink Creek
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lynn Joseph Jensen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.):

6. DATE OF BIRTH: November (Month) 17 (Day) 1920 (Year)

7. AGE: Yrs. 1 Mos. 27 ds.
IF LESS than 1 day, how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Mink Creek Idaho.

10. NAME OF FATHER Hans C. Jensen

11. BIRTHPLACE OF FATHER (State or Country) Mink Creek Idaho

12. MAIDEN NAME OF MOTHER Dora P. Christensen

13. BIRTHPLACE OF MOTHER (State or Country) Mink Creek Ida.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Hans C. Jensen
(Address) Mink Creek Ida.

15. Filed Feb 3 1921 D. A. Rulon
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. (Month) 14 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 12 1921, to Jan 14 1921, that I last saw h..... alive on ..... 19....., and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows: Broncho Pneumonia
I have never seen this case but was consulted over phone two days before its death - Treated by nurse.
(Duration) ..... Yrs. ..... mos. 11 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G W States M. D.
Jan 15 1921 (Address) Preston Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mink Creek Ida. DATE OF BURIAL: Jan 16 1921

20. UNDERTAKER: Mink ADDRESS: —

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully and fully recorded. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

32856

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 27
Primary Registration District No. 27 2119
File No. 10.
Registered No.

1. PLACE OF DEATH

County of Franklin
City of Preston
(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Nathaniel Howard Eames

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	W	Married

6. DATE OF BIRTH: Aug (Month) 13 (Day) 1892 (Year)

7. AGE: 28 Yrs. ~~28~~ 5 Mos. ~~24~~ 5 ds. 24

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Preston Ida

10. NAME OF FATHER: David C. Eames

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Elizabeth Greaves

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Orval D Eames
(Address) Preston Idaho

15. Filed Feb 3 1921 Dr A R Cutler
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 27 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 15 1920, to Jan 27 1921, that I last saw him alive on Jan 27 1921, and that death occurred on the date stated above, at 7-40 A.M.

The CAUSE OF DEATH* was as follows:
Lobar Pneumonia

(Duration) ..... Yrs. ..... mos. 3 ds.
Contributory (Secondary) Pulmonary abscess
(Duration) ..... yrs. 5 mos. ..... ds.

(Signed) A. R. Cutler M. D.
19 ..... (Address) Preston Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Preston Idaho	Jan 30 1921
20. UNDERTAKER: W. A. Skidmore	ADDRESS: Preston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

32857

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2119 27
Primary Registration District No. 27, 2119
File No. 9
Registered No.

1. PLACE OF DEATH
County of Franklin
City of Banida
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ina Alice

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.):

6. DATE OF BIRTH: May (Month) 29 (Day) 1918 (Year)

7. AGE: 2 Yrs. 7 Mos. 25 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: at home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Banida Ida

10. NAME OF FATHER: Ether Esplin

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: E. Alice Hardy

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H. Esplin
(Address) Banida Ida

15. Filed Feb 3 1921
Dr A R Cutler
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 23 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 18 1921 to Jan 23 1921 that I last saw her alive on Did not See Her, 19—, and that death occurred on the date stated above, at 3:15 P.M.

The CAUSE OF DEATH* was as follows:
Bronchial Pneumonia

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A R Cutler M. D.
1 27 1921 (Address) Preston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Banida — DATE OF BURIAL: Jan 25 1921

20. UNDERTAKER: H. C. Steidmore — ADDRESS: Preston Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

32858

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2119 27
Primary Registration District No. 27 2119
File No. 8
Registered No.

1. PLACE OF DEATH
County of Franklin
City of Whitney
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Clarice Hull
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Apr (Month) 5 (Day) 1919 (Year)

7. AGE: 1 Yrs. 9 Mos. 22 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Whitney Ida

10. NAME OF FATHER: LeRoy Hull

11. BIRTHPLACE OF FATHER (State or Country): Whitney Ida

12. MAIDEN NAME OF MOTHER: Alabell Weaver

13. BIRTHPLACE OF MOTHER (State or Country): Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) .....
(Address) Lelar H. Beckstead Whitney

15. Filed Feb 3 1921
Dr. A. R. Rulon
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: January (Month) 26 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1/22 1921, to 1/26 1921 that I last saw her alive on Jan 26 1921, and that death occurred on the date stated above, at 3a M.

The CAUSE OF DEATH* was as follows:
Acute Meningitis

(Duration) ..... Yrs. ..... mos. 8 ds.
Contributory (Secondary) Grip
(Duration) ..... yrs. ..... mos. 10 ds.

(Signed) Dr. A. R. Caufield M. D.
1/26 1921 (Address) Preston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Whitney Ida — DATE OF BURIAL: Jan. 28 1921

20. UNDERTAKER: W. A. Skidmore — ADDRESS: Preston Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

32859

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2 9 27

Primary Registration District No. 27 2 19

File No. 7

Registered No.

1. PLACE OF DEATH

County of Franklin

City of Preston

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Vera Radford

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH: Dec (Month) 8 (Day) 1920 (Year)

7. AGE: Yrs. 1 Mos. 7 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business or establishment in which employed (or employer) —

9. BIRTHPLACE (State or Country) Preston

10. NAME OF FATHER Stephen L. Radford

11. BIRTHPLACE OF FATHER (State or Country) U.S.

12. MAIDEN NAME OF MOTHER Mary L. Nelson

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Stephen L. Radford

(Address) .....

15. Filed Feb. 3 1921

D. A. Rustin
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 14 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 8 1920, to Jan 14 1921, that I last saw her alive on Jan 14 1921, and that death occurred on the date stated above, at 1130 P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia - Bronchs

(Duration) ..... Yrs. ..... mos. 3 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Curtis Rand M. D.

1/15 1921 (Address) Preston Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Preston Ida — DATE OF BURIAL: Jan 16 1921

20. UNDERTAKER: W. A. Steidmore — ADDRESS: Preston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

32860

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 214 27
Primary Registration District No. 27 214
File No. 4
Registered No.

1. PLACE OF DEATH
County of Franklin
City of Fairview Ida
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jane Johnson
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F	W	Married

6. DATE OF BIRTH: June (Month) 1 (Day) 1852 (Year)

7. AGE: 69 Yrs. 7 Mos. 14 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: James Gilbert

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Sarah Crowder

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) George Johnson
(Address) Preston Ida

15. Filed Feb 3 1921
D. A. Cutler
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 15 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from at times past 5 years - 19 , to 19
that I last saw h alive on 19 ,
and that death occurred on the date stated above, at 2 45 P.M.
The CAUSE OF DEATH* was as follows: So far as known heart failure - Death sudden - Been ailing several years. Probably fatty heart.
(Duration) Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) G W. Sales M. D.
Jan 15 1921 (Address) Preston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Fairview Ida	Jan 17 1921
20. UNDERTAKER	ADDRESS
W. A. Skidmore	Preston Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

1. STATE OF IDAHO — Registration District No. 77

County of Fremont — Primary Registration District No. 2176 — File No.

City of Lamont — (No. ..... St.) — Registered No. 2

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Adolph Swanson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH. Dont Know (Month) (Day) 1 (Year)

7. AGE: Abt 34 Yrs. Mos. ds. — IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): Farming

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Dont know

11. BIRTHPLACE OF FATHER (State or Country): Dont know

12. MAIDEN NAME OF MOTHER: Dont know

13. BIRTHPLACE OF MOTHER (State or Country): Dont know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J.A.Litton
(Address) Lamont, Idaho.

15. Filed Jan 20 - 1921 — Martha Marker, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 19 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1919, to Jan 19 1921
that I last saw him alive on Jan 12 1921
and that death occured on the date stated above, at 10 P.M.
The CAUSE OF DEATH* was as follows:
Acute Bright's disease
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) E.L. Hanson, M. D.
Jan 14 1921 (Address) Ashton Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Ashton, Idaho. — DATE OF BURIAL: Jan 16 1921

20. UNDERTAKER: W.J.King — ADDRESS: Driggs

SYMS - YORK CO., PTRS. & BKBS. 24654

FORM V. S. No. 5-25 Rev. 1-20.

32862

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 6

Primary Registration District No.

File No.

Registered No.

1. PLACE OF DEATH

County of Canyon

City of Emmett (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Unnamed Infant

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
male	white	

6. DATE OF BIRTH: Jan (Month) 12 (Day) 1921 (Year)

7. AGE: Yrs. Mos. 1 day

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business or establishment in which employed (or employer) —

9. BIRTHPLACE (State or Country) Emmett Ida

10. NAME OF FATHER A. J. Peterson

11. BIRTHPLACE OF FATHER (State or Country) Sweden

12. MAIDEN NAME OF MOTHER Irene Brown

13. BIRTHPLACE OF MOTHER (State or Country) Iowa.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A. J. Peterson

(Address)

15. Filed Jan 14 1921 J. L. Reynolds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 13 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 12 1921, to Jan 13 1921

that I last saw h[illegible] alive on Jan 12 1921

and that death occurred on the date stated above, at 8 9 M.

The CAUSE OF DEATH* was as follows:

Unknown

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Burton O Clark M. D.

Jan 13 1921 (Address) Emmett

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: C D Buchanan | DATE OF BURIAL 19

20. UNDERTAKER | ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 32863
Registered No.

1. PLACE OF DEATH
County of Gem
City of Emmett
(No. , St.)
Registration District No.
Primary Registration District No. 6
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Carl Marvin Zimmerman
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Infant (Write the word.)

6. DATE OF BIRTH: Jan 8 1921 (Month) (Day) (Year)

7. AGE: — Yrs. — Mos. 1 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country)

10. NAME OF FATHER: Carl C. Zimmerman

11. BIRTHPLACE OF FATHER (State or Country): Kansas

12. MAIDEN NAME OF MOTHER: Emmah B. Lathrop

13. BIRTHPLACE OF MOTHER (State or Country): Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Carl C. Zimmerman
(Address): Emmett Idaho

15. Filed Feb 1 1921
J. L. Reynolds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan 9 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 5 1921, to Jan 9 1921, that I last saw him alive on Jan 9 1921, and that death occurred on the date stated above, at 4 P M.

The CAUSE OF DEATH* was as follows:
Unknown

(Duration) Yrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) Burton O Clark M. D.
Jan 10 1921 (Address) Emmett Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Emmett Idaho	1/10 1921
20. UNDERTAKER: C. Buckner	ADDRESS: Emmett Idaho

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No.
Primary Registration District No.
File No. 32864
Registered No.

1. PLACE OF DEATH
County of Gem
City of Emmett (City) (No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Eleanor Jamieson
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): married

6. DATE OF BIRTH: Feb (Month) 16 (Day) 1832 (Year)

7. AGE: 88 Yrs. 11 Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Penn

10. NAME OF FATHER: Geo Mc. Connell

11. BIRTHPLACE OF FATHER (State or Country): dont know

12. MAIDEN NAME OF MOTHER: Stark

13. BIRTHPLACE OF MOTHER (State or Country): dont know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. J. Dickson
(Address) Emmett Idaho

15. Filed Jan 19 1921 J. J. Reynolds Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 15 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 10, 1921, to 1921
that I last saw h[er] alive on Jan 10 1921
and that death occurred on the date stated above, at 10 P M.
The CAUSE OF DEATH* was as follows:
Myocarditis
(Duration) Yrs. mos. ds.
Contributory (Secondary): Empyema
(Duration) yrs. mos. ds.
(Signed) B. O. Clark M. D.
Jan 27 1921 (Address) Emmett Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Emmett Idaho
DATE OF BURIAL: 1/18 1921

20. UNDERTAKER: C. A. Buckner
ADDRESS: Emmett Idaho

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32866

Registered No.

Registration District No.

Primary Registration District No.

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Gem

City of Ola (Ola County)

2. FULL NAME William Henry Otto

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH

November (Month) 4 (Day) 1854 (Year)

7. AGE

66 Yrs. 2 Mos. 28 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Germany.

10. NAME OF FATHER Chris Otto.

11. BIRTHPLACE OF FATHER (State or Country) Germany.

12. MAIDEN NAME OF MOTHER not known.

13. BIRTHPLACE OF MOTHER (State or Country) not known.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Sarah Otto

(Address) Ola. Ida.

15.

Filed 2/7 1921

J. L. Reynolds
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

February (Month) 2 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from

..... 19....., to ..... 19.....,

that I last saw h..... alive on ..... 19.....,

and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Contained Illness of Cancer of Stomach

(Duration) about 2 Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. M. Brown - Coroner ~~M. D.~~

19..... (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL ~~OR REMOVAL~~ Ola Ida.

DATE OF BURIAL 2-5 1921

20. UNDERTAKER

ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 1-16 M. 1-16.

CERTIFICATE OF DEATH

Registration District No. 24

Primary Registration District No. ____

(No. ____, ____ St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32867

Registered No. ____

1. PLACE OF DEATH

County of Gooding

City of Gooding

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James Elmer Moyer

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH: March (Month) 5th (Day) 1870 (Year)

7. AGE: 50 Yrs. 10 Mos. 3 ds.

IF LESS than 1 day how many ____ hrs. or ____ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farming
(b) General nature of industry, business or establishment in which employed (or employer): ____

9. BIRTHPLACE (State or Country): Casper Co. Indiana

10. NAME OF FATHER: John Moyer

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Rachel H. Freeland

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Susie L. Moyer
(Address) Gooding Ida.

15. Filed 1 — 10 1921 — F. J. Caymond. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 8th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 30 1920, to Jan 8 1921, that I last saw h[illegible] alive on Jan 8 1921, and that death occurred on the date stated above, at 930 A.M.

The CAUSE OF DEATH* was as follows:

Facial Erysipelas.

(Duration) ____ Yrs. ____ mos. 12 ds.

Contributory (Secondary) Cellulates & Meningitis.

(Duration) ____ yrs. ____ mos. 1 ds.

(Signed) J. H. Cromwell M. D.

1/9 1921 (Address) Gooding Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days

Where was disease contracted if not at place of death? ____

Former or usual residence ____

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Esbon Kansas	1/10 1921
20. UNDERTAKER: A E Thompson	ADDRESS: Gooding Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 1-25 M. 1-16.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 105
Primary Registration District No. 2183
(No. ..... St.)

File No. 1
Registered No. 32868

1. PLACE OF DEATH

County of Idaho
City of Cottonwood
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Rosa Lies.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.)
Female	White	Widow

6. DATE OF BIRTH
Jan: (Month) 30 (Day) 1862 (Year)

7. AGE
Yrs. 58 Mos. 11 ds. 2
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Germany

10. NAME OF FATHER Gerhard Goerd Schemel

11. BIRTHPLACE OF FATHER (State or Country) Germany

12. MAIDEN NAME OF MOTHER Sophia Harter

13. BIRTHPLACE OF MOTHER (State or Country) Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Geo Schemel
(Address) Uniontown Wash.

15. Filed Jany 2nd 1921 H B Blake Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Jan (Month) 1 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1920 to Jan 1 1921
that I last saw h.. alive on Jan 1 1921,
and that death occurred on the date stated above, at 10 M.
The CAUSE OF DEATH* was as follows:
Chronic interstitial nephritis
(Duration) 2 Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) J. A. Shinnick M. D.
Jan 1 1921 (Address) Cottonwood Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Cottonwood Ida	1-3 1921

20. UNDERTAKER	ADDRESS
A A Nau	Cottonwood Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. ~~5-36 M. 1-10.~~

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 105
Primary Registration District No. 2183
File No. 2 32869
Registered No.

1. PLACE OF DEATH
County of Idaho
City of Ferdinand
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Emmit B Cummings

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED: Widow (Write the word.)

6. DATE OF BIRTH: Sept (Month) 17 (Day) 1826 (Year)

7. AGE: 94 Yrs. 3 Mos. 18 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER: Issac Cleveland

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Anna Drake

13. BIRTHPLACE OF MOTHER (State or Country): New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jenny E Morris
(Address) Ferdinand

15.
Filed Jany 5 1921
W J Locke
W B Blake Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 4 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....
and that death occurred on the date stated above, at 9 10 P.M.
The CAUSE OF DEATH* was as follows:

Pneumonia
Lobar.

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A. J. Mauzy Coroner M. D.
1/5 1921 (Address) Ferdinand

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF ~~BURIAL~~ OR REMOVAL: Moline Kansas
DATE OF ~~BURIAL~~ Removal: 1/6 1921

20. UNDERTAKER: A H Rau
ADDRESS: Cottonwood

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 105
Primary Registration District No. 2183
File No. 3
Registered No. 32870

1. PLACE OF DEATH
County of Idaho
City of Cottonwood
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lizzie Oeter
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widow (Write the word.)

6. DATE OF BIRTH: Oct (Month) 8 (Day) 1842 (Year)

7. AGE: 78 Yrs. ~~78~~ 3 Mos. ~~3~~ ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: Henry Hermann

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Not Known

13. BIRTHPLACE OF MOTHER (State or Country): Not Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs John Bayer
(Address) Cottonwood Ida

15. Filed Jany 9 1921 H B Blake Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 8 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 7 1921, to Jan 8 1921
that I last saw h[illegible] alive on Jan 8 1921
and that death occurred on the date stated above, at 9 P. M.
The CAUSE OF DEATH* was as follows:
Pneumonia (Broncho Pneumonia)

(Duration) ..... Yrs. ..... mos. 2 ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J D Stevenick M. D.
1-8 1921 (Address) Cottonwood Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Cottonwood Idaho | DATE OF BURIAL: 1-10 1920

20. UNDERTAKER: P H Nau | ADDRESS: Cottonwood Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 103
Primary Registration District No. 1001
(No. ....., ... St.)

File No. 32871
Registered No. 5

1. PLACE OF DEATH.
County of Idaho
City of Grangeville
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Norman Henry Flint

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Sept (Month) 26 (Day) 1906 (Year)

7. AGE: 14 Yrs. 4 Mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Schoolboy
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Fairland Oklahoma

10. NAME OF FATHER: Albert Flint

11. BIRTHPLACE OF FATHER: Oklahoma (State or Country)

12. MAIDEN NAME OF MOTHER: Etta Summerville

13. BIRTHPLACE OF MOTHER: Missouri (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Albert W Flint
(Address) Grangeville

15. Filed Feb 1 1921 G S Stockton Local Registrar

SYMS - YORK CO., PTRS. & BOBS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 29th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 19 1921, to Jan 28 1921, that I last saw him alive on Jan 28 1921, and that death occured on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:
Tuberculosis
(Duration) ..... Yrs. ..... mos. 10 ds.
Contributory (Secondary) Perforation of intestine
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) G Christensen M. D.
1/31 1921 (Address) Grangeville Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Prairie View — DATE OF BURIAL: Jan 30 1921

20. UNDERTAKER: E S Hancock — ADDRESS: Grangeville

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32872

Registered No. 4

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Idaho

City of Grangeville

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 103

Primary Registration District No. 2181

(No. ....., ... St.)

2. FULL NAME W Frank Higgins

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE: 88 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...

(b) General nature of industry, business, or establishment in which employed (or employer)...

9. BIRTHPLACE (State or Country): Coyngs bo York State

10. NAME OF FATHER: ?

11. BIRTHPLACE OF FATHER (State or Country): ?

12. MAIDEN NAME OF MOTHER: ?

13. BIRTHPLACE OF MOTHER (State or Country): ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Walter Rice (Keeper Poor farm

(Address) Grangeville Idaho

15. Filed Feb 1 1921 G S Stockton Local Registrar

SYMS - YORK CO., PTRS. & ENGS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan 21st (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 19 1921, to Jan 21 1921, that I last saw him alive on Jan 20 1921, and that death occured on the date stated above, at 4 A. M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ..... Yrs. ..... mos. 4 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G S Stockton M. D.

1/23 1921 (Address) Grangeville Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Prairie view

DATE OF BURIAL: Jan 23d 1921

20. UNDERTAKER: E S Hancock

ADDRESS: Grangeville

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 103
Primary Registration District No. 2181
(No. ....., ... St.)

File No. 32873
Registered No. 3

1. PLACE OF DEATH.
County of Idaho
City of Grangeville
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William H Griffeth

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE: 71 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Ohio

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Walter Rice (Keeper Poor Farm)
(Address) Grangeville Idaho

15. Filed Feb 1 1921 G S Stockton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 18 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 16 1921, to Jan 18 1921, that I last saw him alive on Jan 17 1921 and that death occured on the date stated above, at 6 A. M.

The CAUSE OF DEATH* was as follows:
Lobar Pneumonia

(Duration) ..... Yrs. ..... mos. 4 ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) G S Stockton M. D.
1/18 1921 (Address) Grangeville Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Prairie View
DATE OF BURIAL: Jan 19th 1921

20. UNDERTAKER: E B Hancock
ADDRESS: Grangeville

EVANS - YORK CO., PTRS. & BKBS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 103
Primary Registration District No. 1001
File No. 32874
Registered No. 2

1. PLACE OF DEATH.
County of Idaho
City of Grangeville
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sarah Amelia Aram

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. (Month) Aug. (Day) 4 (Year) 1832

7. AGE: 89 Yrs. 5 Mos. 7 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House Wife
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Warsaw Wyoming Co New York State

10. NAME OF FATHER: William Barr

11. BIRTHPLACE OF FATHER (State or Country): New Hamshere

12. MAIDEN NAME OF MOTHER: Elisebth Rogers.

13. BIRTHPLACE OF MOTHER (State or Country): New England state

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mary T. Johnson
(Address) Grangeville Idaho

15. Filed Feb 1 1921 — G. S. Stockton, Local Registrar

SYMS - YORK CO., PTRS. & ROBS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. (Month) 11 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 29 1920, to Jan 7 1921, that I last saw her alive on Jan 7 1921 and that death occured on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrage

..... (Duration) ..... Yrs. 2 mos. ..... ds.

Contributory (Secondary): Arteria Sclerosis

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) D. Chipman M. D.

1/14 1921 (Address) Grangeville Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Prarie View — DATE OF BURIAL: Jan 13 1921

20. UNDERTAKER: E S Hancock — ADDRESS: Grangeville

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-~~35~~ M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene
(No. ....., ... St.)
Registration District No. 30
Primary Registration District No. 1057
File No. 32883
Registered No. 882.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John H. Edwards.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M.	W.	Married

6. DATE OF BIRTH: Nov. (Month) 28 (Day) 1860 (Year)

7. AGE: 60 Yrs. 2 Mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Canada

10. NAME OF FATHER: James Edwards

11. BIRTHPLACE OF FATHER (State or Country): Canada

12. MAIDEN NAME OF MOTHER: —— Roe

13. BIRTHPLACE OF MOTHER (State or Country): Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs J. H. Edwards
(Address) Coeur d Alene Idaho

15. Filed Feb 4 1921 D. D. Brennan
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. (Month) 28 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 17 1921, to Jan 28 1921
that I last saw h.im alive on Jan 28 1921,
and that death occurred on the date stated above, at 1130 M.
The CAUSE OF DEATH* was as follows:

Cerebritis, Lethargic

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. D. Brennan M. D.
1/29 1921 (Address) Coeur d Alene Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL, OR REMOVAL	DATE OF BURIAL
Forest C D Alene	1-30 1921

20. UNDERTAKER	ADDRESS
C. Cassedy	C D Alene.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 30
Primary Registration District No. 1051
File No. 32884
Registered No. 881

1. **PLACE OF DEATH**
County of Kootenai
City of Coeur d'Alene
(No. 1203, Front St.)
If death occurs away from usual residence, give facts called for under special information.

2. **FULL NAME** Jacob Hanson Wikes
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. **SEX**: M.
4. **COLOR OR RACE**: W.
5. **SINGLE, MARRIED, WIDOWED OR DIVORCED** (Write the word.): Married

6. **DATE OF BIRTH**: May (Month) 24 (Day) 1846 (Year)

7. **AGE**: 60 Yrs. 8 Mos. 24 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. **OCCUPATION**
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. **BIRTHPLACE** (State or Country): Norway

10. **NAME OF FATHER**: Jacob Hanson

11. **BIRTHPLACE OF FATHER** (State or Country): Norway

12. **MAIDEN NAME OF MOTHER**: Marie Larson

13. **BIRTHPLACE OF MOTHER** (State or Country): Norway.

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**
(Informant) David L. Wikes
(Address) 1203 - Front Ave

15. Filed Feb 4 1921 — D D Drennan, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH**: Jan. (Month) 26 (Day) 1921 (Year)

17. **I HEREBY CERTIFY**, That I attended deceased from Jan. 26 1921 to Jan. 26 1921
that I last saw h. alive on Jan. 26 1921
and that death occurred on the date stated above, at 10 P. M.
The CAUSE OF DEATH* was as follows:
Cerebral hemorrhage.

..... (Duration) ..... Yrs. ..... mos. 1 ds.
Contributory (Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John Allwood M. D.
Jan. 28 1921 (Address) Coeur d'Alene, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. **PLACE OF BURIAL OR REMOVAL**: Forest Cem. — **DATE OF BURIAL**: 1-30 1921

20. **UNDERTAKER**: Cassedy — **ADDRESS**: CdAlene,

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Kootenai — Registration District No. 30

City of Coeur d'Alene — Primary Registration District No. 1051

(No. 606 Sherman St.)

File No. 32885

Registered No. 880

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Nancy Kirchevel

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Mar (Month) 26 (Day) 1920 (Year)

7. AGE: — Yrs. 10 Mos. ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: R F Kirchevel

11. BIRTHPLACE OF FATHER (State or Country): Washington U. S.

12. MAIDEN NAME OF MOTHER: Katheryn Hawaam

13. BIRTHPLACE OF MOTHER (State or Country): Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) R F Kirchevel

(Address) Coeur d'Alene

15. Filed Feb. 4 1921 D D Drennan Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 26 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 20 1921, to Jan 26 1921, that I last saw h[illegible] alive on Jan 26 1921, and that death occurred on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(Duration) Yrs. mos. 7 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) J C Bryan M. D.

Jan 27 1921 (Address) Coeur d'Alene Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State — yrs. 10 mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR ~~REMOVAL~~: St Thomas Cem — DATE OF BURIAL: Jan 28 1921

20. UNDERTAKER: R B Mooney — ADDRESS: Coeur d'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 30
Primary Registration District No. 1051
File No. 32886
Registered No. 879

1. PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene (No. 802 Sixth St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Libbie Kennedy Barstow

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Mar (Month) 27 (Day) 1893 (Year)

7. AGE: 27 Yrs. 8 Mos. 28 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmers Wife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wis

10. NAME OF FATHER: Angus Kennedy

11. BIRTHPLACE OF FATHER (State or Country): Canada

12. MAIDEN NAME OF MOTHER: Sarah Allard

13. BIRTHPLACE OF MOTHER (State or Country): New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Angus Kennedy
(Address) Coeur d'Alene, Ida

15. Filed Feb 4, 1921 D D Dreman, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 26 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 18 1921, to Jan 25 1921, that I last saw h. alive on Jan 25 1921, and that death occurred on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:

Puerperal Eclampsia

(Duration) ..... Yrs. ..... mos. 7 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J C Clay M. D.

Jan 27 1921 (Address) Coeur d'Alene Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State 18 yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR ~~REMOVAL~~: Forest Cemetery — DATE OF BURIAL: Jan 27 1921

20. UNDERTAKER: C B Moore — ADDRESS: Coeur d'Alene

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 30
Primary Registration District No. 1051
File No. 32887
Registered No. 878

1. PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene (No. 802, 6th St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Dorft [illegible] Dr R N Barstow
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Jan (Month) 18 (Day) 1921 (Year)

7. AGE: — Yrs. — Mos. — ds.
IF LESS than 1 day how many — hrs. or — min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: R N Barstow

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Lillian Kennedy

13. BIRTHPLACE OF MOTHER (State or Country): Wis.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): E H Miles
(Address): Coeur d'alene. Ida.

15. Filed Feb. 4 1921 D D Dremon
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: January (Month) 18 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from [illegible] 19..., to Jan 18 1921
that I last saw h[illegible] alive on Jan 18 1921
and that death occurred on the date stated above, at [illegible] M.
The CAUSE OF DEATH* was as follows:

Asphyxia due to forceps delivery during Cephalopelvic ca
(Duration) ... Yrs. ... mos. ... ds.
Contributory (Secondary)
(Duration) ... yrs. ... mos. ... ds.

(Signed) J D Mayo M. D.
Jan 19 1921 (Address) Coeur d Alene Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetery
DATE OF BURIAL: Jan 19 1921

20. UNDERTAKER: C B Mooney
ADDRESS: Coeur d'alene

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 30
Primary Registration District No. 1057
File No. 32888
Registered No. 899

1. PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene
(No. 953 Ft 3rd St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ester S Sewell

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widow

6. DATE OF BIRTH: Nov (Month) 15 (Day) 1845 (Year)

7. AGE: 75 Yrs. 2 Mos. 0 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ind.

10. NAME OF FATHER: David S Nigh

11. BIRTHPLACE OF FATHER (State or Country): Ky

12. MAIDEN NAME OF MOTHER: Margret Kerr

13. BIRTHPLACE OF MOTHER (State or Country): Ky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs A E Corey
(Address) Coeur d'Alene Ida.

15. Filed Feb 4 1921 D D Brennan Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 15 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 19 19, to Jan 15 1921 that I last saw h[illegible] alive on Jan 15 1921 and that death occurred on the date stated above, at 11 9 M.

The CAUSE OF DEATH* was as follows: Carcinoma of Thyroid gland.

(Duration) 3 Yrs. ..... mos. ..... ds.

Contributory (Secondary): —

(Duration) — yrs. — mos. — ds.

(Signed) W H Hoeder M. D.

Jan 17 1921 (Address) Coeur d Alene Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State 2 yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetery — DATE OF BURIAL: Jan 17 1921

20. UNDERTAKER: C B Mooney — ADDRESS: Coeur d'Alene Ida

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 30

Primary Registration District No. 1001

File No. 32889

County of Kootenai

City of Coeur d'Alene (No. ....., ... St.)

Registered No. 816

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Freda Anderson.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: 7 (Month) 15 (Day) 1897 (Year)

7. AGE: 23 Yrs. 5 Mos. 29 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: School teacher
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Minn.

10. NAME OF FATHER: Chas. Anderson

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Annette Benson

13. BIRTHPLACE OF MOTHER (State or Country): Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chas Anderson
(Address) Culps Landing, Coeur d'Alene

15. Filed Feb. 4 1921 D D Drenna, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan 13 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 29 1920, to Jan 13 1921, that I last saw h.. alive on Jan 13 1921, and that death occurred on the date stated above, at 10 M.

The CAUSE OF DEATH* was as follows:

Encephalitis Lethargica

..... (Duration) ..... Yrs. ..... mos. 20 ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J D Drenna M. D.

Jan 15 1921 (Address) Coeur d'Alene Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetary — DATE OF BURIAL: Jan. 17 1921

20. UNDERTAKER: E Cassedy — ADDRESS: 209 2nd

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 30
Primary Registration District No. 1061
File No. 32890
Registered No. 875

1. PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene (No. 322 Indiana Ave. St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Annie Elizabeth Leely

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widow

6. DATE OF BIRTH: Feb (Month) 8 (Day) 1863 (Year)

7. AGE: 57 Yrs. 11 Mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New Hampshire

10. NAME OF FATHER: John McAlister

11. BIRTHPLACE OF FATHER (State or Country): England.

12. MAIDEN NAME OF MOTHER: Susie Mason

13. BIRTHPLACE OF MOTHER (State or Country): New Brunswick

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Frank Leely
(Address) Coeur d'alene Ida

15. Filed Feb. 7 1921 D D Drenna Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 11 (Day) 1920 (Year) 21

17. I HEREBY CERTIFY, That I attended deceased from Aug. 1920, to Jan. 11 1921
that I last saw h[er] alive on Jan. 10 1921
and that death occurred on the date stated above, at 4:50 A.M.
The CAUSE OF DEATH* was as follows:
Carcinoma of uterus.

(Duration) 2 Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John Wood M. D.
Jan. 11 1921 (Address) Coeur d'Alene. Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State 7 yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetery — DATE OF BURIAL: Jan 13 1920

20. UNDERTAKER: [illegible] — ADDRESS: Post Falls

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32891

Registered No. 874

1. **PLACE OF DEATH**

County of Kootenai

City of Coeur d'Alene (No. 611, Hubbard St.)

Registration District No. 30

Primary Registration District No. 1051

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. **FULL NAME** Fred A. Olson

PERSONAL AND STATISTICAL PARTICULARS

3. **SEX**: M.

4. **COLOR OR RACE**: W.

5. **SINGLE, MARRIED, WIDOWED OR DIVORCED** (Write the word.): Married

6. **DATE OF BIRTH**: 2 (Month) 15 (Day) 1868 (Year)

7. **AGE**: 52 Yrs. 10 Mos. 23 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. **OCCUPATION**

(a) Trade, profession or particular kind of work: Mill worker

(b) General nature of industry, business or establishment in which employed (or employer):

9. **BIRTHPLACE** (State or Country): Sweden

10. **NAME OF FATHER**: Geo. A. Olson

11. **BIRTHPLACE OF FATHER** (State or Country): Sweden

12. **MAIDEN NAME OF MOTHER**:

13. **BIRTHPLACE OF MOTHER** (State or Country): Sweden

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**

(Informant) Mrs Helen E. Olson

(Address) Coeur d Alene Ida.

15. Filed Feb. 4 1921 D D Dresman, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH**: Jan. (Month) 8 (Day) 1921 (Year)

17. **I HEREBY CERTIFY**, That I attended deceased from Jan. 2 1921, to Jan. 8 1921 that I last saw h.im alive on Jan. 7 1921, and that death occurred on the date stated above, at 3 P M.

The CAUSE OF DEATH* was as follows:

Chronic parenchymatous nephritis

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Broncho-pneumonia

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John Allwood M. D.

Jan. 10 1921 (Address) Coeur d'Alene. Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. **PLACE OF BURIAL OR REMOVAL**: Forest Cemetery — **DATE OF BURIAL**: 1/11 1921

20. **UNDERTAKER**: C. Cassidy. — **ADDRESS**: Coeur d Alene Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. [illegible] M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32893

Registered No. 872

1. PLACE OF DEATH

County of Kootenai

City of Coeur d'Alene (No. 1071, Government Way St.)

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 30

Primary Registration District No. 1057

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Robt White

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Feb. (Month) 13 (Day) 1844 (Year)

7. AGE: 76 Yrs. 10 Mos. 21 ds.

IF LESS than 1 day: how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Musician

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ivythorne, England.

10. NAME OF FATHER: Thomas R. White

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Elizabeth Scott

13. BIRTHPLACE OF MOTHER (State or Country): England.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) [illegible]

(Address) 1071 Govt Way

15. Filed Feb 4 1921 D D Drennan Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 4 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 12 1920 to Jan 4 1921, that I last saw h[illegible] alive on Jan 3 1921, and that death occurred on the date stated above, at 7 P M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach with perforation

(Duration) Yrs. 6 mos. ds.

Contributory (Secondary) American Staircase Co

(Duration) yrs. mos. ds.

(Signed) D. D. Drennan M. D.

1/4 1921 (Address) Coeur d'Alene

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Forest Cem. CDAlene — DATE OF BURIAL: 2-6 1921

20. UNDERTAKER: Cassedy — ADDRESS: CDAlene,

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 30
Primary Registration District No. 1051
File No. 32895
Registered No. 887

1. **PLACE OF DEATH**
County of Kootenai
City of Coeur d Alene
(No. 316 Indiana St.)
If death occurs away from usual residence, give facts called for under special information.

2. **FULL NAME** William Britton
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male.	White	

6. **DATE OF BIRTH**
December (Month) 3 (Day) 1837 (Year)

7. **AGE**
84 Yrs. ... Mos. ... ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. **OCCUPATION**
(a) Trade, profession or particular kind of work: Mechanic
(b) General nature of industry, business or establishment in which employed (or employer):

9. **BIRTHPLACE** (State or Country): New York

10. **NAME OF FATHER**: Edmond Britton

11. **BIRTHPLACE OF FATHER** (State or Country): England

12. **MAIDEN NAME OF MOTHER**: Anna Kenyon

13. **BIRTHPLACE OF MOTHER** (State or Country): England

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**
(Informant) Mrs Grace Britton
(Address) 316 Indiana

15. Filed Feb 7 1921 — D D Drema, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH**
Jan (Month) 28 (Day) 1921 (Year)

17. **I HEREBY CERTIFY, That I attended deceased from** ... 19... to ... 19...
that I last saw h.m. alive on Jan. 28 1921,
and that death occurred on the date stated above, at 8 P.M.
The CAUSE OF DEATH* was as follows:

Cancer of Stomach

(Duration) ... Yrs. 6 mos. ... ds.

Contributory (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) J H Mayo M. D.
Jan 31 1921 (Address) Coeur d Alene Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. **PLACE OF BURIAL OR REMOVAL**: Forest Cem. C D A. | **DATE OF BURIAL**: 1-31 1921

20. **UNDERTAKER**: C. Cassedy | **ADDRESS**: C D Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 66
Primary Registration District No. 2146
File No. 32900
Registered No.

1. PLACE OF DEATH
County of Jatoh
City of Borell
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Robert Conley
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX ~~Female~~ Male

4. COLOR OR RACE White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.) Single

6. DATE OF BIRTH Jan (Month) 14 (Day) 21 (Year)

7. AGE 23 hrs
~~23~~ Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many 23 hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Infant
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Charles Sylvester Conley

11. BIRTHPLACE OF FATHER (State or Country) Iowa

12. MAIDEN NAME OF MOTHER Ellen Frances McDonald

13. BIRTHPLACE OF MOTHER (State or Country) Washington

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) .....
(Address) .....

15. Filed Jan 15 — 1921 Mrs F.C. Gibson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan 15 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 14 — 1921, to Jan 15 1921 that I last saw h~~er~~ alive on Jan 14 — 1921, and that death occurred on the date stated above, at 7:30 A.M.
The CAUSE OF DEATH* was as follows:

Thymus Enlargement

(Duration) ..... Yrs. ..... mos. 1 ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Miles Hopkins M. D.
Jan 15 1921 (Address) Borell Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. 1 days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Borell Idaho — DATE OF BURIAL Jan 16 1921

20. UNDERTAKER Father of Child — ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 65.
Primary Registration District No. 2145.
(No. ....., ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 32903
Registered No. .....

1. PLACE OF DEATH.
County of Latah
City of Potlatch
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Leon George Moody.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single.
6. DATE OF BIRTH. July (Month) 15 (Day) 1919. (Year)
7. AGE: ..1.. Yrs. 6 Mos. ..... ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
9. BIRTHPLACE (State or Country) Everett - Wash.
10. NAME OF FATHER Spencer Moody.
11. BIRTHPLACE OF FATHER (State or Country) Vermont.
12. MAIDEN NAME OF MOTHER Mary Austen.
13. BIRTHPLACE OF MOTHER (State or Country) N Y.
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Spencer Moody.
(Address) Potlatch.
15. Filed Jan. 24th 1921 J. J. Thompson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Jan. (Month) 23 (Day) 1921 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Jan. 20 1921, to Jan 23 1921, that I last saw him alive on Jan 23 1921, and that death occured on the date stated above, at 8:30 P.M.
The CAUSE OF DEATH* was as follows:
Broncho - pneumonia.
(Duration) ..... Yrs. ..... mos. 2 ds.
Contributory (Secondary) Whooping Cough.
(Duration ..... yrs. 1 mos. 12 ds.
(Signed) J. J. Thompson M. D.
1/24 1921 (Address) Potlatch

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Potlatch Cemetery — DATE OF BURIAL: Jan 25 1921
20. UNDERTAKER: Parents. — ADDRESS: Potlatch.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24654

FORM V. S. No. 5-25 M. 1-16-13

1921 3 8

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32904

Registered No. .....

Registration District No. 65

Primary Registration District No. 2145

1. PLACE OF DEATH.

County of Latah

City of Potlatch

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Charley Edgerton

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH. April (Month) 16 (Day) 1848 (Year)

7. AGE: 73 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION

(a) Trade, profession or particular kind of work: Butcher

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: Charley Edgerton

11. BIRTHPLACE OF FATHER (State or Country): Ill.

12. MAIDEN NAME OF MOTHER: Not known.

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs L C Potter

(Address) Potlatch

15.

Filed Jan 25th 1921 J. J. Thompson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 24 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 15 1920, to Jan 23 1920, that I last saw him alive on Jan 23 1921, and that death occured on the date stated above, at 6 9 M.

The CAUSE OF DEATH* was as follows:

Chronic Lepes

(Duration) 5 Yrs. — mos. — ds.

Contributory (Secondary) nervous Exhaustion

(Duration 1 7 yrs. — mos. — ds.

(Signed) Ernest H Fenn M. D.

1. 24 1921. (Address) Potlatch Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Palouse Wash. DATE OF BURIAL: Jan 27 1921

20. UNDERTAKER: E A Gruwin ADDRESS: Palouse

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24854

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 65
Primary Registration District No. 2145
(No. ....., ... St.)

File No. 32905
Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Latah
City of Palouse
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elizabeth Kamm

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH.
June (Month) 17 (Day) 1841 (Year)

7. AGE
79 Yrs. 6 Mos. 21 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE
(State or Country) Switzerland

10. NAME OF FATHER
Not Known

11. BIRTHPLACE OF FATHER
(State or Country) X X

12. MAIDEN NAME OF MOTHER
X X

13. BIRTHPLACE OF MOTHER
(State or Country) X X

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) John Kamm
(Address) Palouse

15.
Filed Jan 10th 1921 D. Jo. Thompson Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24854

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Jan (Month) 7 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 3 1921, to Jan 6 1921, that I last saw h[illegible] alive on Jan 6 1921, and that death occured on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia
(Duration) ..... Yrs. ..... mos. 5 ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) E. K. Wells M. D.
1/9 1921 (Address) Palouse, Wash.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Palouse
DATE OF BURIAL: Jan 9 1920

20. UNDERTAKER: E. M. Irwin
ADDRESS: Palouse.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 65
Primary Registration District No. 2145
(No. ....., ... St.)

File No. 32906
Registered No. .....

1. PLACE OF DEATH
County of Latah
City of Potlatch.
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John A. Summerford
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH.
Nov (Month) 28 (Day) 1847 (Year)

7. AGE
73 Yrs. 2 Mos. 18 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Shoe Salesman
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): N. D.

10. NAME OF FATHER: Patrick Summerford

11. BIRTHPLACE OF FATHER (State or Country): Canada.

12. MAIDEN NAME OF MOTHER: Elizabeth Pahalen

13. BIRTHPLACE OF MOTHER (State or Country): Canada.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. A. Summerford
(Address) Potlatch Ida.

15.
Filed Jan 11th 1921 Dr. J. M. Thompson
Local Registrar

BYMB - YORK CO., PTRS. & BOBS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Jan (Month) 10th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at 7 A. M.

The CAUSE OF DEATH* was as follows:
Gun Shot Wound in left-breast
from own hands. Without
evidence of suicidal intent
Jury's Verdict
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Vlen Price Coroner M. D.
1/10 1920 (Address) Moscow

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Palouse Wash. | DATE OF BURIAL: Jan. 13th 1921

20. UNDERTAKER: E M Dennis | ADDRESS: Palouse

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 61
Primary Registration District No. 1011
File No. 32917
Registered No. 2

1. PLACE OF DEATH
County of Latah
City of Moscow (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Louisa Riley.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Fem	White	Widowed

6. DATE OF BIRTH: May (Month) 11 (Day) 1843 (Year)

7. AGE: 75 Yrs. 8 Mos. 5 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Monroe Co. Iowa.

10. NAME OF FATHER: Iva Beebe

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Louisa Andrews

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Fred A. Flora
(Address) Moscow

15. Filed Jan 17 1921 W. H. Barithers Local Registrar

SUNSET-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 16 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 9 1920, to Jan 16th 1921, that I last saw h.. alive on Jan 16th 1921, and that death occurred on the date stated above, at 1:50 A.M.

The CAUSE OF DEATH* was as follows:
Catarrhal Jaundice

(Duration) Yrs. 2 mos. 7 ds.
Contributory (Secondary) Hemorrhage of bowels
(Duration) yrs. mos. 1 ds.

(Signed) F. M. Leitch M. D.
1/17 1921 (Address) Moscow Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: McLellan Wash — DATE OF BURIAL: Jan 18 1921

20. UNDERTAKER: Glen Price — ADDRESS: Moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 61
Primary Registration District No. 101
File No. 32908
Registered No. 1

1. PLACE OF DEATH
County of Latah
City of Moscow
(No. ..... , ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Harry Arthur Rader
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
M.	White	Married

6. DATE OF BIRTH: Oct (Month) 6 (Day) 1895 (Year)

7. AGE: 42 Yrs. 3 Mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Carpenter
(b) General nature of industry, business or establishment in which employed (or employer): Millwright-Flour Mill

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: W H Rader

11. BIRTHPLACE OF FATHER (State or Country): West Virginia

12. MAIDEN NAME OF MOTHER: ?

13. BIRTHPLACE OF MOTHER (State or Country): ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Harry Rader
(Address) Moscow

15. Filed Jan 12 1921 W H Barthers Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 11 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 11 1921, to Jan 11 1921, that I last saw h.. alive on Jan 11 1921 and that death occurred on the date stated above, at 3:00 P.M.

The CAUSE OF DEATH* was as follows:

Accidental - Caught in machinery at Flouring Mill.

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas. L. Gutman M. D.

1/12 1921 (Address) Moscow

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Moscow | DATE OF BURIAL: 1/14 1921

20. UNDERTAKER: Glen Funeral Home | ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Latah
City of Troy
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 24
Primary Registration District No. 2144
(No. ....., ... St.)

File No. 32909
Registered No. .....
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Alfred Boyd Kallberg

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Caucasian
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Mar 28 1917 (Month) (Day) (Year)

7. AGE: 3 yrs. 9 mos. 7 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Latah Co. Idaho

10. NAME OF FATHER: Albert Kallberg

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Gertie Swan

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Albert Kallberg
(Address) Troy Idaho

15. Filed Jan 5 1920 J. E. Pickard Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan 4th 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 29 1920, to Jan 4th 1921 that I last saw h[illegible] alive on Jan 4th 1920, and that death occurred on the date stated above, at 8. P M.

The CAUSE OF DEATH* was as follows:

Tubercular Meningitis

(Duration) ..... yrs. ..... mos. 21 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W A Rothwell M. D.
Jan 5th 1920 (Address) Kendrick Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and 2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Bronte Ridge — DATE OF BURIAL: Jan 7 1921

20. UNDERTAKER: J. E. Pickard — ADDRESS: Troy Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Exact statements of OCCUPATION is very important. See instructions on back of certificate.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 16
Primary Registration District No. 1016
(No. ....., ... St.)

File No. 32911
Registered No. 5

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Lincoln
City of Shoshone

2. FULL NAME Porter Osborne Clemens

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Oct (Month) 15 (Day) 1920 (Year)

7. AGE: Yrs. 3 Mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Lincoln County Idaho

10. NAME OF FATHER Henry J. E. Clemens

11. BIRTHPLACE OF FATHER (State or Country) Lexington Mo.

12. MAIDEN NAME OF MOTHER Ruth L. Brigham

13. BIRTHPLACE OF MOTHER (State or Country) Randolph Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Henry J. E. Clemens
(Address) Shoshone Ida.

15. Filed January 18 1921 J. L. Green Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 15 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 15 1921, to Jan 15 1921, that I last saw h— alive on Jan 15 1921, and that death occured on the date stated above, at 6 30 P.M.
The CAUSE OF DEATH* was as follows:

Intussusception.

..... (Duration) ..... Yrs. ..... mos. few hrs. ds.
Contributory (Secondary) Not known
..... (Duration ..... yrs. ..... mos. — ds.
(Signed) ..... M. D.
19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Shoshone — DATE OF BURIAL: .....191.....

20. UNDERTAKER: D. F. Brennan — ADDRESS: Shoshone

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRNS - YORK CO., PTRS. & ENGS. 24655

FORM V. S. No. 5-25 M. 1-16-18

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 16
Primary Registration District No. 10 16
File No. 32912
Registered No. 2

1. PLACE OF DEATH.
County of Lincoln
City of Shoshone
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James Holmes
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. ~~SINGLE~~, MARRIED, ~~WIDOWED OR DIVORCED~~. (Write the word.): marrd

6. DATE OF BIRTH. Sept (Month) 29 (Day) 1870 (Year)

7. AGE: 40 Yrs. 3 Mos. 12 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Michigan

10. NAME OF FATHER: Jos. G. Holmes

11. BIRTHPLACE OF FATHER (State or Country): Canada

12. MAIDEN NAME OF MOTHER: Francis Breeland

13. BIRTHPLACE OF MOTHER (State or Country): Michigan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Dan. Holmes
(Address) Shoshone Idaho

15. Filed January 15 1924
J. L. Fuller Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 11 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased ~~from~~ on Jan 11 1921, to ..... 191....., that I last saw him alive on Jan 10 1921, and that death occured on the date stated above, at 5 P M.

The CAUSE OF DEATH* was as follows:
Electrocuted when working on light pole

(Duration) Instantaneous Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) C. P. Jones M. D.
19.... (Address) Shoshone

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL ..... 191.....

20. UNDERTAKER: D. J. Brennan | ADDRESS: Shoshone

SYMS-YORK CO., PTRS. & BOOKS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

32914

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 92
Primary Registration District No. 2170
(No. ....., ... St.)

File No. 5
Registered No. 16

1. PLACE OF DEATH.
County of Nez Perce
City of Gifford
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ann Sophia Denham

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH. Sept (Month) 6 (Day) 1848 (Year)

7. AGE ..72.. Yrs. ..4.. Mos. ..7.. ds.
IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Indiana

10. NAME OF FATHER John Cowen

11. BIRTHPLACE OF FATHER (State or Country) —

12. MAIDEN NAME OF MOTHER Luanda Stonebraker

13. BIRTHPLACE OF MOTHER (State or Country) —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Pearl Rice
(Address) Gifford Idaho

15.
Filed 1-13 1921
E E Watts
Local Registrar

SVMS - YORK CO., PTRS. & BOBS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jany (Month) 13 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Paralysis

.....(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Senile decay
.....(Duration ..... yrs. ..... mos. ..... ds.
(Signed) E E Watts M. D.
.....19..... (Address) Gifford

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Hillcrest | DATE OF BURIAL ....191....

20. UNDERTAKER: W E Stoddard | ADDRESS Gifford

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

32915 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 92
Primary Registration District No. 2170
(No. ....., ... St.)

File No. 60
Registered No. 17

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Jefferson
City of Gifford
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Williams Simmons

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. January (Month) 10 (Day) 1844 (Year)

7. AGE: 77 Yrs. — Mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Farmer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Iowa

10. NAME OF FATHER Thomas Simmons

11. BIRTHPLACE OF FATHER (State or Country) Ohio

12. MAIDEN NAME OF MOTHER Elizabeth Mallett

13. BIRTHPLACE OF MOTHER (State or Country) Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Harriett E. Lowary
(Address) Holbrook Idaho

15. Filed 1-13 1921 E. E. Watts Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January (Month) 14 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from September 1920 to January 1921, that I last saw h alive on January 17 1921, and that death occured on the date stated above, at 12 N.

The CAUSE OF DEATH* was as follows:

Carcinoma of liver

(Duration) ? Yrs. 3 mos. ds.

Contributory (Secondary) General Carcinomatosis

(Duration ? yrs. 3 mos. - ds.

(Signed) H. Lloyd Gore M. D.

1/14 1920 (Address) Rexburg, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Melrose Ida — DATE OF BURIAL: Jany 16 1921

20. UNDERTAKER: J. R. Woodland — ADDRESS: Gifford

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Boise
City of Cherry Creek
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 26
Primary Registration District No. 206 d
(No. ....., ... St.)

File No. 32916
Registered No. 1
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Elizebeth Moore

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH: Apr (Month) 17 (Day) 1838 (Year)

7. AGE: 83 yrs. 8 mos. 29 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) Home Work

9. BIRTHPLACE (State or Country) Maryland

10. NAME OF FATHER Charles Kunnuck

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER Sarah Hilkil

13. BIRTHPLACE OF MOTHER (State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E W Bell
(Address) Cherry Creek Ida

15.
Filed Feb 2 1921 F M Mayes M.D. Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Jan (Month) 15 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 4 1921 to Jan 15 1921, that I last saw h[illegible] alive on Jan 4 1921 and that death occurred on the date stated above, at 9 P.M.

The CAUSE OF DEATH* was as follows:

General debility due to old age

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E. E. Allen M. D.
Jan 22 1921 (Address) Malad Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Malad Ida | DATE OF BURIAL: Jan 19 1921

20. UNDERTAKER: J. Guy Benson | ADDRESS: Malad Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & SDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 26
Primary Registration District No. 2064
File No. 32917
Registered No. 2

1. PLACE OF DEATH.
County of Oneida
City of Malad
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Linda Price

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH: Jan. 17 (Month) (Day) 1917 (Year)

7. AGE: 4 yrs. 0 mos. 1 ds.
IF LESS than 1 day how many .....hrs. or .....mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) Child

9. BIRTHPLACE (State or Country): Malad, Idaho

10. NAME OF FATHER: Jenkin E Price

11. BIRTHPLACE OF FATHER (State or Country): Malad Idaho

12. MAIDEN NAME OF MOTHER: Sarah Blanche Chavez

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) .....
(Address) L H Chavez

15.
Filed Feb 2 1921
R. M. Manes M.D.
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan. (Month) 18 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 17 1921 to Jan 18 1921
that I last saw her alive on Jan 18 1921
and that death occurred on the date stated above, at 4:9 A.M.
The CAUSE OF DEATH* was as follows:
Pneumonia

(Duration) 1 yrs. 0 mos. 1 ds.
Contributory (Secondary) Grip
(Duration) yrs. mos. ds.
(Signed) J. M. Ferris M.D.
1/21 1921 (Address) Malad Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Gay Cemetery | DATE OF BURIAL: Jan. 20 1921

20. UNDERTAKER: Malad Idaho | ADDRESS: Malad Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

BYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Owyhee
City of Murad
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 26
Primary Registration District No. 2069
(No. ..... St.)

File No. 32918
Registered No. 3
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ralph Larsen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	white	single

6. DATE OF BIRTH
Jan (Month) 19 (Day) 1920 (Year)

7. AGE
..... yrs. ..... mos. 1 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) Child

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Oscar Larsen

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Sarah Peterson

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Oscar Larsen
(Address) Murad

15.
Filed Feb 2 1921 R. T. Maxwell
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Jan (Month) 21 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 19 1921, to Jan 21 1921, that I last saw h..... alive on ..... 191..., and that death occurred on the date stated above, at 9 A M.

The CAUSE OF DEATH* was as follows:

Instantly injury auto collision

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory .....
(Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. F. Miller M. D.
Jan 22 1921 (Address) Murad Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: St. John — DATE OF BURIAL: Jan 22 1921

20. UNDERTAKER: J. Guy Bowman — ADDRESS: Murad Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Oneida Co
City of Malad (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 26
Primary Registration District No. 2069

File No. 32919
Registered No. 4
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Beatrice F. Jones

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word)
Female	White	Married

6. DATE OF BIRTH: Feb. (Month) 22 (Day) 1858 (Year)

7. AGE: 62 yrs. 11 mos. 2 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) Home Work

9. BIRTHPLACE (State or Country) Grand Rock, Vt.

10. NAME OF FATHER John Smith

11. BIRTHPLACE OF FATHER (State or Country) Scotland

12. MAIDEN NAME OF MOTHER Sophia Fortune

13. BIRTHPLACE OF MOTHER (State or Country) Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Louis D. Jones
(Address) Malad Ida.

15. Filed Feb 2 1921 R M Lauer M.D. Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan (Month) 24 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 22 1921, to Jan 24 1921, that I last saw h er alive on Jan 24 1921, and that death occurred on the date stated above, at 2 P M.

The CAUSE OF DEATH* was as follows:
Apoplexy.

(Duration) ..... yrs. ..... mos. 3 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Kerns M. D.
19 ..... (Address) Malad Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Malad | DATE OF BURIAL: Jan 27 1921

20. UNDERTAKER: J. Guy Benson | ADDRESS: Malad Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

AYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 32920
Registered No. 2

1. PLACE OF DEATH
County of Shoshone
City of Caldera
(No. ..... St.)
Registration District No. 2
Primary Registration District No. 2049

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Royal D Rummerfield

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: May (Month) 5 (Day) 1845 (Year)

7. AGE: 76 Yrs. 8 Mos. 7 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): N. Y.

10. NAME OF FATHER: Friedrich Rummerfield

11. BIRTHPLACE OF FATHER (State or Country): N. Y.

12. MAIDEN NAME OF MOTHER: Delila Irish

13. BIRTHPLACE OF MOTHER (State or Country): N York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs R D Rummerfield
(Address) Caldera

15. Filed Jan 13 1921 H E Hunt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 13 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1/6 1921, to 1/13 1921, that I last saw him alive on 1/6 1921, and that death occurred on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:
Interstitial Nephritis
(Duration) 4 Yrs. — mos. — ds.
Contributory (Secondary) Cerebral Hemorrhage
(Duration) 4 yrs. 6 mos. ds.

(Signed) J B Shoemaker M. D.
1/15 1921 (Address) Caldera Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: St Maries — DATE OF BURIAL: 1-14 1921

20. UNDERTAKER: H E Hunt Co. — ADDRESS: St Maries

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 92
Primary Registration District No. 2049
File No. 32921
Registered No. 1

1. PLACE OF DEATH
County of Shoshone
City of Pleasina
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Oscar Anderson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: June (Month) 21 (Day) 1874 (Year)

7. AGE: 46 Yrs. 7 Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Woodsman
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) .....
(Address) .....

15. Filed Jan 12 1921 H E Hunt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 11 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....
and that death occurred on the date stated above, at 2.30 P.M.

The CAUSE OF DEATH* was as follows:
Accidently Struck by Limb from Falling Tree and Instantly Killed
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas R Mowery M. D.
1/12 1921 (Address) Wallace Coroner

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: St Maries — DATE OF BURIAL: 1/17 1921

20. UNDERTAKER: H E Hunt Co — ADDRESS: St Maries

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32922

Registered No. 4

1. PLACE OF DEATH

County of Benewah

City of St. Maries

(No. ..... St.)

Registration District No. 32

Primary Registration District No. 2049

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lawrence Elmer Harter

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Male	White	Married (Write the word.)

6. DATE OF BIRTH: March (Month) 11 (Day) 1861 (Year)

7. AGE: 59 Yrs. 10 Mos. 13 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Civil Engineer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Indiana

10. NAME OF FATHER George Harter

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER Mary Baker

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. L. E. Harter

(Address) Plummer Idaho

15. Filed Jan 25 1921

H E Hunt
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 24 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 4 1920 to Jan 26 1921 that I last saw h.. im.... alive on Jan 24 1921, and that death occurred on the date stated above, at 9-45 A.M.

The CAUSE OF DEATH* was as follows:

Uraemia

(Duration) ..... Yrs. ..... mos. 1 ds.

Contributory (Secondary) Subphrenic abscess

(Duration) ..... yrs. 1 mos. 22 ds.

(Signed) H E Hunt M. D.

1/24 1921 (Address) St Maries

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Gotrove work. DATE OF BURIAL: Jan 27 1921

20. UNDERTAKER: H Hunt Co ADDRESS: St. Maries Id

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32923

Registered No. 5

1. PLACE OF DEATH.

County of Coeur d'Alene

City of Wardner (No. ....., ... St.)

Registration District No. 32

Primary Registration District No. 2049

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Warbinton

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fe

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. June (Month) 16 (Day) 1842/3 (Year)

7. AGE: 78 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Indiana

10. NAME OF FATHER: Thomas Cassady

11. BIRTHPLACE OF FATHER (State or Country): .....

12. MAIDEN NAME OF MOTHER: Elizabeth Bushman

13. BIRTHPLACE OF MOTHER (State or Country): .....

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Gravelle

(Address) Coeur d'Alene

15. Filed Jan 13 1921 H Elbert Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 13 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1 1920, to Jan 13 1921, that I last saw her alive on Dec 1 1920, and that death occured on the date stated above, at 12 - M.

The CAUSE OF DEATH* was as follows:

Nephritis and
General Senility

(Duration) 1 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) A D Platt M. D.

Jan 13 1921 (Address) D Marcus Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Wardner — DATE OF BURIAL: 1/15 1921

20. UNDERTAKER: H Elbert Co — ADDRESS: St Maries

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD. SPACE RESERVED FOR BINDING

BYRNS - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 39.
Primary Registration District No. 7087
File No. 32926
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of Buhl
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Baby Gray

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write word.): Single
6. DATE OF BIRTH: Jan (Month) 17 (Day) 1921 (Year)
7. AGE: ✓ Yrs. 4 Mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work ✓
(b) General nature of industry, business or establishment in which employed (or employer) ✓
9. BIRTHPLACE (State or Country): Buhl
10. NAME OF FATHER: Frank E Gray
11. BIRTHPLACE OF FATHER (State or Country): Germany
12. MAIDEN NAME OF MOTHER: Katherine Weigert
13. BIRTHPLACE OF MOTHER (State or Country): Germany
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Frank E. Gray
(Address) Buhl Ida.
15. Filed 1-21 1921 J. H. Murphy Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 1 (Month) – 20 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1-17 1921, to 1-20- 1921 that I last saw him alive on 1-20- 1921 and that death occurred on the date stated above, at 4P M.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease

(Duration) ..... Yrs. ..... mos. 3 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo. Jennings M. D.

1-21- 1921 (Address) Buhl, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Buhl Cemetery	1/21 1921
20. UNDERTAKER: Hamilton & Long	ADDRESS: Buhl

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 39

Primary Registration District No. 2067

File No. 32927

County of Twin Falls

City of Buhl (No. ....., ... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Infant of J. D. Beltz

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE:

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.):

6. DATE OF BIRTH: Jan (Month) 21 (Day) 1921 (Year)

7. AGE: ..... yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..15.. *hrs. or* ..30.. *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work: X
(b) General nature of industry business, or dstablishment in which employed (or employer): X

9. BIRTHPLACE (State or Country): Buhl Idaho

10. NAME OF FATHER: J. D. Beltz

11. BIRTHPLACE OF FATHER (State or Country): U.S.A.

12. MAIDEN NAME OF MOTHER: Grace Thompson

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. D. Beltz

(Address) Buhl Ida

15. Filed 1-22- 1921 J. H. Merkley Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan (Month) 22 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1/9/1921, to 1/22/1921, that I last saw her alive on 1/22/1921, and that death occurred on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:

Broke neck born at 6½ months gestation

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. D. Beltz M. D.

1/22 1921 (Address) Buhl Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Kageaman valley | DATE OF BURIAL: Jan. 23 1921

20. UNDERTAKER: None | ADDRESS: Buhl Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 39
Primary Registration District No. 7087
File No. 32928
Registered No.

1. PLACE OF DEATH
County of Blaine
City of Bellevue
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James H. Boatman
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Male	White	Widowed

6. DATE OF BIRTH
Jan (Month) 15 (Day) 1863 (Year)

7. AGE
58 Yrs. 0 Mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Elias Boatman

11. BIRTHPLACE OF FATHER (State or Country): Not known

12. MAIDEN NAME OF MOTHER: Lucy Hanson

13. BIRTHPLACE OF MOTHER (State or Country): Not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. O. Boatman
(Address) .....

15.
Filed 1-24 1921
J. N. Murphy
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
January (Month) 23 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 3 1920, to Dec 24 1920, that I last saw him alive on Dec 24 1920 and that death occurred on the date stated above, at 7 A.M.

The CAUSE OF DEATH* was as follows:
Pulmonary tuberculosis.
Tubercular peritonitis.
Tubercular enteritis.
(Duration) 10 Yrs. — mos. — ds.
Contributory (Secondary) Asthenia
(Duration) Do not know. yrs. mos. ds.

(Signed) F. A. Irmen. M. D.
Jan 24 1921 (Address) Buhl Idaho. See other side.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Buhl Cemetery	1/24 1921
20. UNDERTAKER	ADDRESS
Neville & Pugh	Buhl Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 39
Primary Registration District No. 2087
File No. 32929
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of Buhl
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Geo M Barber
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widower

6. DATE OF BIRTH: July (Month) 27 (Day) 1833 (Year)

7. AGE: 87 Yrs. 6 Mos. [illegible] ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Carpenter
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): St Reyns Canada

10. NAME OF FATHER: Not Known

11. BIRTHPLACE OF FATHER (State or Country): Not Known

12. MAIDEN NAME OF MOTHER: Not Known

13. BIRTHPLACE OF MOTHER (State or Country): Not Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W Hyde
(Address) Buhl Idaho

15. Filed Jan 28 1921
J S Murphy
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 1 (Month) 27 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11-1-1920, to 1-27-1921, that I last saw h[illegible] alive on 1-27-1921, and that death occurred on the date stated above, at 6 P M.
The CAUSE OF DEATH* was as follows:
Chronic Nephritis
(Duration) Yrs. 3 mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Geo. [illegible] M. D.
1-28 1921 (Address) Buhl, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Buhl Cemetery
DATE OF BURIAL: 1/29 1921
20. UNDERTAKER: [illegible]
ADDRESS: Buhl Idaho

FORM V. S. No. 5-25 M. 1-19.

32930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 31
File No. 1 [redacted]
Registered No. 28

1. PLACE OF DEATH
County of Bannock
City of De Smet
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Clark Francis Bass

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Oct (Month) 4 (Day) 1917 (Year)

7. AGE: 3 Yrs. 2 Mos. 28 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country):

10. NAME OF FATHER: Roy Bass

11. BIRTHPLACE OF FATHER (State or Country): Mo.

12. MAIDEN NAME OF MOTHER: Grace Pallin

13. BIRTHPLACE OF MOTHER (State or Country): Ill Sanga Co

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Roy Bass
(Address) De Smet Ida

15. Filed Jan 1 1921 V. Y. Le Bilman Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 1 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Accidental Gun Shot
wound of head Coeiden 22

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Dr C Bleiler M. D.
1/1 1920 (Address) Detroit Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Golden Rod Tekoa — DATE OF BURIAL: 1-3 1921

20. UNDERTAKER: C L Schuleveld — ADDRESS: Tekoa Wa

FORM V. S. No. 5-25 M. 1-19.

D D Drennan

32933

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 30

Primary Registration District No. 1051

File No. [redacted]

Registered No. 883

1. PLACE OF DEATH

County of Kootenai

City of Coeur d'Alene (No. 933 North 7th St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Frank Scott Ferguson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word.): Single

6. DATE OF BIRTH: Jan (Month) 26 (Day) 1921 (Year)

7. AGE: 0 Yrs. 0 Mos. 2 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Frank S Ferguson

11. BIRTHPLACE OF FATHER (State or Country): Mich

12. MAIDEN NAME OF MOTHER: Emily Bishop

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Frank S Ferguson

(Address) Coeur d'Alene, Ida.

15. Filed Feb. 4 1921 D D Drennan Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 30 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 29, 1921, to Jan 30 1921, that I last saw him alive on Jan 29 1921, and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Melena neonatorum

(Duration) ..... Yrs. ..... mos. 1 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. D. Drennan M. D.

Jan. 31 1921 (Address) Coeur d'Alene Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. 2 days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetery — DATE OF BURIAL: Jan 31 1921

20. UNDERTAKER: R B Mooney — ADDRESS: Coeur d'Alene Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

MAR 20 1921

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 2935
Registered No.

Registration District No. 8
Primary Registration District No. 2004

1. PLACE OF DEATH
County of Ada
City of Mar Boise (No. Soldiers Home St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Minor M. Webb
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	White	Married

6. DATE OF BIRTH: Nov (Month) 2 (Day) 1846 (Year)

7. AGE: 74 Yrs. 3 Mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Veteran Civil War
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Clyde E. Summers
(Address) Boise Idaho

15. Filed Feb 10 1921 P. A. Pratt Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 10 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 5 1921, to Feb 10 1921
that I last saw h[illegible] alive on Feb 10 1921,
and that death occurred on the date stated above, at 4 P. M.
The CAUSE OF DEATH* was as follows:

Hemiplegia

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Uremia Sclerosis
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. Fleming M. D.
2/11 1921 (Address) Boise

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Feb 12 1921
20. UNDERTAKER: Summers & Trefz — ADDRESS: Boise Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

Pelton

MAR 10 1921

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32936

Registered No. 29

1. PLACE OF DEATH

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 3

Primary Registration District No. 1115

(No. 410, State St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Sarah Grisham

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F.	White	Married

6. DATE OF BIRTH: April 24 (Month) 1892 (Day) (Year)

7. AGE: 28 Yrs. 9 Mos. 8 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mo.

10. NAME OF FATHER: Charles Clark.

11. BIRTHPLACE OF FATHER (State or Country): Mo

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) F. M. Grisham

(Address) 523 So 16 St

15. Filed 2/4/21 19.....

P. H. Pratt
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 2 (Month) 2 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12/7 1920 to 2/2 1921

that I last saw h.. alive on 2/2 1921

and that death occurred on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

Peritonitis Typhoid

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Ruptured ulcer of Typhoid fever

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. Mullenger M. D.

2/3 1921 (Address) Boise Id

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Morris Hill Cemetery	Feb 4 1921

20. UNDERTAKER: Summers & Tros ADDRESS: Boise Id

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

MAR 10 1921

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 32937
Registered No. 741

1. PLACE OF DEATH

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No. 1004

(No. 410 W. State St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Emma Irene Coats

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
F	White	Married

6. DATE OF BIRTH: Mar. (Month) 30 (Day) 1895 (Year)

7. AGE: 25 Yrs. 8 Mos. 9 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: James Yoren

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Annie Wise

13. BIRTHPLACE OF MOTHER (State or Country): Idaho,

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. R. Coats

(Address) 517 North 5th Boise

15. Filed Feb 10, 1921 R. H. Pratt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 2 (Month) 9 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 31 1921 to Feb 9 1921

that I last saw he alive on Feb 9 1921

and that death occurred on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

Typhoid

(Duration) Yrs. 2 mos. ds.

Contributory (Secondary) Intestinal hemorrhage

(Duration) yrs. mos. ds.

(Signed) H. Ewing Jr. M. D.

2/10 1921 (Address) Overland

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Morris Hill Cemetery	Feb 11 1921
20. UNDERTAKER	ADDRESS
Summers & Kirtley	Boise Idaho.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

Pettingill

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

MAR 1 1921

Registration District No. ____
Primary Registration District No. 10 1
File No. 3235
Registered No. 38

1. PLACE OF DEATH
County of Ada
City of Boise
(No. St. Alphonsus Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Gertrud Gowdy.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write one word.)

6. DATE OF BIRTH: Oct 20 (Month) (Day) 1895 (Year)

7. AGE: 25 Yrs. 3 Mos. 19 ds.
IF LESS than 1 day how many ____ hrs. or ____ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Clerk.
(b) General nature of industry, business or establishment in which employed (or employer): ____

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: John W. Gowdy

11. BIRTHPLACE OF FATHER (State or Country): Illinois.

12. MAIDEN NAME OF MOTHER: Mattie Cayton

13. BIRTHPLACE OF MOTHER (State or Country): Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John W. Gowdy
(Address) ____

15. Filed 2/9/1921 — R. F. Pratt, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb 8 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1/15 1921, to 2/8 1921
that I last saw h.. alive on 2/8 1921
and that death occurred on the date stated above, at 11:10 P.M.
The CAUSE OF DEATH* was as follows:

Typhoid

(Duration) ____ Yrs. ____ mos. ____ ds.
Contributory (Secondary) Thrombosis of Sinus Cavernosum.
(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) Fred A. Pettingill M. D.
2/9 1921 (Address) Overland Bldg.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days
Where was disease contracted if not at place of death? ____
Former or usual residence ____

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL ____ 19____

20. UNDERTAKER: Summers & Webs. — ADDRESS Boise Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

Formy.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 1
Primary Registration District No. 1004
(No. St Lukes Hospital St.)
File No. 32959
Registered No. 37
MAR 10 1921

1. PLACE OF DEATH
County of Ada
City of Boise.
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Della M. Hoyle

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (or widow)

6. DATE OF BIRTH: Nov 3 (Month) (Day) 1886 (Year)

7. AGE: 34 Yrs. 3 Mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Nebraska

10. NAME OF FATHER: Elmer E. Weaver.

11. BIRTHPLACE OF FATHER (State or Country): Wisconsin

12. MAIDEN NAME OF MOTHER: Ella Matheny.

13. BIRTHPLACE OF MOTHER (State or Country): Ohio.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Elmer E. Weaver
(Address) Boise Idaho.

15. Filed Feb 8 1921
P. H. Pratt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb 8 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 5 1921, to Feb 8 1921, that I last saw her alive on Feb 7 1921 and that death occurred on the date stated above, at 12.25 A.M.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

(Duration) ..... Yrs. ..... mos. 40 ds.

Contributory (Secondary) Peritonitis + perforation

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Thos Mooney M. D.

1921 (Address) Boise Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cem. DATE OF BURIAL: Feb 9 1921

20. UNDERTAKER: Summers & Webb. ADDRESS: Boise Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 1 MAR 10 1921
Primary Registration District No. 1004
File No. 32940
Registered No. 932

1. PLACE OF DEATH

County of Ada
City of Boise
(No. 410 State St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Celestina Solasabal

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: April 6th (Month) (Day) 1898 (Year)

7. AGE: 23 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife, House Keeper
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Spain, Jemein, Vizcaya

10. NAME OF FATHER: Domingo Garmendia

11. BIRTHPLACE OF FATHER (State or Country): Jemein, Vizcaya, Spain.

12. MAIDEN NAME OF MOTHER: Maria Josefa Jayo.

13. BIRTHPLACE OF MOTHER (State or Country): Jemein, Vizcaya, Spain

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Domingo Solasabal
(Address) Boise, Idaho

15. Filed Feb 7 1921 — W. K. Pratt, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 4th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 29 1920, to Feb 3 1921, that I last saw h-- alive on Feb 3 1921, and that death occurred on the date stated above, at 7.A. M.
The CAUSE OF DEATH* was as follows:
Typhoid Fever
(Duration) Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) W. Collister M. D.
19 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence Boise - Idaho

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
St Johns Cemetery	3/7 1921
20. UNDERTAKER: Schreiber & Siebenfaden	ADDRESS: Boise, Idaho

Collister

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

MAR 1 1921

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 32941
Registered No. 58

1. **PLACE OF DEATH**

County of Ada

City of Boise

(No. 1008 Main St.)

Registration District No.

Primary Registration District No. 1007

If death occurs away from usual residence, give facts called for under special information.

2. **FULL NAME** Seymour Glenn Caldwell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
M	W.	married (Write the word.)

6. **DATE OF BIRTH** X August (Month) 21 (Day) 1862 (Year)

7. **AGE** 59 Yrs. 4 Mos. ds. 3

IF LESS than 1 day how many hrs. or min.?

8. **OCCUPATION**

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer):

9. **BIRTHPLACE** (State or Country) Iowa

10. **NAME OF FATHER** Levi Caldwell

11. **BIRTHPLACE OF FATHER** (State or Country) Ohio or Michigan

12. **MAIDEN NAME OF MOTHER** Louisa Curtis

13. **BIRTHPLACE OF MOTHER** (State or Country) Ohio

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**

(Informant) Gilbert Caldwell

(Address)

15. Filed Feb 25 1921 R. L. Oatt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH** Feb. (Month) 24 (Day) 1921 (Year)

17. **I HEREBY CERTIFY**, That I attended deceased from July 1920, to Feb. 1921 that I last saw him alive on Feb. 20 1921, and that death occurred on the date stated above, at 1 p M.

The **CAUSE OF DEATH*** was as follows:

Carcinoma of stomach

(Duration) — Yrs. 11 mos. — ds.

Contributory (Secondary) None

(Duration) yrs. mos. ds.

(Signed) Ralph Falk M. D.

2/24/1921 (Address) Boise

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. **PLACE OF BURIAL OR REMOVAL** Morris Hill Cemetery — **DATE OF BURIAL** 3/27 1921

20. **UNDERTAKER** Schreiber & Sidenfaden — **ADDRESS** Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

MAR 10 1921

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7 — File No. 32942

Primary Registration District No. 1004 — Registered No. 26

1. PLACE OF DEATH

County of Ada

City of Boise

(No. 711, Idaho St. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Louie Doon

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Chinese

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): married.

6. DATE OF BIRTH: Oct — 27 — 1864
(Month) (Day) (Year)

7. AGE: 56 Yrs. 3 Mos. 3 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Cook.

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): China

10. NAME OF FATHER: Louie Lamhurn

11. BIRTHPLACE OF FATHER (State or Country): China

12. MAIDEN NAME OF MOTHER: Lam Shee

13. BIRTHPLACE OF MOTHER (State or Country): China.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm McBratney

(Address) Boise Idaho.

15. Filed Feb 1 — 1921 — P. H. Smith, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan — 30 — 1921 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 2 1920, to Jan 25 1921, that I last saw h... alive on 1-25-21 19..... and that death occurred on the date stated above, at 6.30 P.M.

The CAUSE OF DEATH* was as follows:

Cancer of stomach

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo Callister M. D.

1/31 1921 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Chinese Cemetery, Morris Hill — DATE OF BURIAL: 2/1/21 19

20. UNDERTAKER: W McBratney — ADDRESS: Boise Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

McCalla

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

MAR 1 1921

File No. 32545

Registered No. 27

1. PLACE OF DEATH

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 7

Primary Registration District No. 1004

(No. 410 State St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Evelyn Eileen Boone

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6. DATE OF BIRTH: Dec 27 (Month) (Day) 1920 (Year)

7. AGE: Yrs. 1 Mos. 4 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Boise Idaho

10. NAME OF FATHER: Jafe Boone

11. BIRTHPLACE OF FATHER (State or Country): Mo

12. MAIDEN NAME OF MOTHER: Nora E. Hardy

13. BIRTHPLACE OF MOTHER (State or Country): Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jafe Boone

(Address) R. Fifth St. Boise Idaho

15. Filed Feb 2 1921

P. H. Pratt
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 1 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 29 1921, to Feb 1st 1921, that I last saw h.e alive on Feb 1 1921, and that death occurred on the date stated above, at 2.30 P. M.

The CAUSE OF DEATH* was as follows:

Convulsions. Unable to determine Cause. Was premature (7 months) baby.

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) L. A. McCalla M. D.

2/1 1921 (Address) Boise, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery | DATE OF BURIAL: Feb 2 1921

20. UNDERTAKER: Summers & Kreps | ADDRESS: Boise Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

MAR 10 1921

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Ada

City of Boise.

Registration District No. ____

Primary Registration District No. 1004

(No. 1818 No 12. St.)

File No. 32945

Registered No. 32

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John T. Adams.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M.	White	Married

6. DATE OF BIRTH: Sep 3 (Month) (Day) 1864 (Year)

7. AGE: 63 Yrs. 5 Mos. 1 ds. IF LESS than 1 day how many ____ hrs. or ____ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer): ____

9. BIRTHPLACE (State or Country): Missourri

10. NAME OF FATHER: Richard Adams.

11. BIRTHPLACE OF FATHER (State or Country): Unknown.

12. MAIDEN NAME OF MOTHER: Anna Hutchins

13. BIRTHPLACE OF MOTHER (State or Country): Unknown.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Clinton R. Adams
(Address) Boise Idaho

15. Filed Feb 5 1921 R. H. Pratt Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb 4 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I Saw deceased from Feb 4 1921, to ____ 19____ that I last saw him alive on Feb 4 1921 and that death occurred on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:
Valvular Heart disease

(Duration) ____ Yrs. ____ mos. ____ ds.

Contributory (Secondary) ____

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) Clyde E Summers Coroner
2/5 1921 (Address) Boise Idaho Ada County

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days

Where was disease contracted if not at place of death? ____

Former or usual residence ____

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Star Idaho.	Feb 6 1921.
20. UNDERTAKER	ADDRESS
Summers & Webb.	Boise Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7 MAR 10 1921
Primary Registration District No. 1007
File No. 32946
Registered No. 93

1. PLACE OF DEATH

County of Ada
City of Boise
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Dorothy E. Crawford.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F.	White.	Single

6. DATE OF BIRTH: Oct 16 - 1920. (Month) (Day) (Year)

7. AGE: — Yrs. 3 Mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: Henry M. Crawford.

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Osha Hill.

13. BIRTHPLACE OF MOTHER (State or Country): Arkansas.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Henry Mathyous Crawford
(Address) Emmett Idaho

15. Filed Feb 5 1921 — O. H. Pratt, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb 4 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 4 1921, to Feb. 4 1921 that I last saw h.. alive on Feb. 4 1921, and that death occurred on the date stated above, at 11 A M.

The CAUSE OF DEATH* was as follows:
Pneumonia (Bronchial)

(Duration) ..... Yrs. ..... mos. 7 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Rose C Ward M. D.
2-5 1921 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cem. — DATE OF BURIAL: Feb 6 1921

20. UNDERTAKER: Lemmon & Webb. — ADDRESS: Boise Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. ____ MAR 10 1921
Primary Registration District No. 1014
File No. 32947
Registered No. 39

1. PLACE OF DEATH
County of Ada
City of Boise
(No. 110 East Bannock St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME David Oscar Castater
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: January (Month) 13th (Day) 1856 (Year)

7. AGE: 65 Yrs. ____ Mos. 25 ds.
IF LESS than 1 day how many ____ hrs. or ____ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Postmaster
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: Dont Know

11. BIRTHPLACE OF FATHER (State or Country): American

12. MAIDEN NAME OF MOTHER: Dont Know

13. BIRTHPLACE OF MOTHER (State or Country): American

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ralph M. Castater
(Address) Parma Idaho

15. Filed Feb 10 1921 — R. H. Crate, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 10 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1-25 1921, to 2-10 1921, that I last saw h[im] alive on 2-10 1921, and that death occurred on the date stated above, at ____ M.

The CAUSE OF DEATH* was as follows:
Septicaemia

(Duration) ____ Yrs. ____ mos. ____ ds.

Contributory (Secondary)

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) R J Cluen M. D.
2-10 1921 (Address) Boise Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days
St Lukes Hospital
Where was disease contracted if not at place of death?
Former or usual residence Parma, Idaho

19. PLACE OF BURIAL OR REMOVAL: Parma Idaho
DATE OF BURIAL: 2/12 1921

20. UNDERTAKER: Schreiber & Hidenfeldt
ADDRESS: Boise Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

Filed

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

Registration District No. 7 MAR 10 1921

Primary Registration District No. 1004

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32948

Registered No. 40

1. PLACE OF DEATH

County of Ada

City of Boise.

(No. St Lukes Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William Merkuel Yaden

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write word): Single

6. DATE OF BIRTH: Feb 11 (Month) (Day) 1921 (Year)

7. AGE: — Yrs. — Mos. — ds.

IF LESS than 1 day how many 12 hrs. or — min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: Byron W. Yaden

11. BIRTHPLACE OF FATHER (State or Country): Idaho.

12. MAIDEN NAME OF MOTHER: Edna Merkuel

13. BIRTHPLACE OF MOTHER (State or Country): Wisconsin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Byron W. Yaden

(Address)

15. Filed Feb 11 1921

R. H. Pratt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb 11 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12.15 P.M. 2/11/1921 to 12.30 P.M. 2/11/21 19..., that I last saw him alive on 2/11/21 19..., and that death occurred on the date stated above, at 12.30 P.M.

The CAUSE OF DEATH* was as follows:

Premature,

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) Earl Hill, M. D.

2/11 1921 (Address) Boise, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Shoshone Idaho. DATE OF BURIAL ... 19...

20. UNDERTAKER: Summers & Kirk ADDRESS Boise Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

MAR 10 1921

Registration District No. 7

Primary Registration District No. 1004

File No. 32949

Registered No. 421

1. PLACE OF DEATH

County of Ada.

City of Boise

(No. 1301 N. 22 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Rebecca J Snider

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F	White	Widow

6. DATE OF BIRTH May. 14-1840 (Month) (Day) (Year)

7. AGE 80 Yrs. 8 Mos. 27 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Virginia

10. NAME OF FATHER John Snider

11. BIRTHPLACE OF FATHER (State or Country) Virginia

12. MAIDEN NAME OF MOTHER Elizabeth Strickler

13. BIRTHPLACE OF MOTHER (State or Country) Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mabel E. Emmett

(Address) Genesee Idaho

15. Filed Feb 12 1921 R H Pratt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 11 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 3 1920 to Feb 11 1921 that I last saw her alive on Feb 8 1921, and that death occurred on the date stated above, at 1300 M.

The CAUSE OF DEATH* was as follows:

Pyonephrosis & Debility

(Duration) Yrs. 4 mos. ds.

Contributory (Secondary) Toxaemia

(Duration) yrs. 2 mos. ds.

(Signed) T. N. Braxton M. D.

Feb 12 1921 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Carrollton Mo.	Feb 15 1921
20. UNDERTAKER	**ADDRESS**
Summers & Trebs	Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

Gunaway

CERTIFICATE OF DEATH

MAR 10 1921

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32951

Registered No. 45

1. PLACE OF DEATH

County of Ada

City of Boise.

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No. 1004

(No. St Lukes Hospital St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME James L. Graham.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: W (Widowed)

6. DATE OF BIRTH: Apr. (Month) [illegible] (Day) 1838 (Year)

7. AGE: 82 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer.

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio.

10. NAME OF FATHER: Lewis Graham

11. BIRTHPLACE OF FATHER (State or Country): Unknown.

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Lewis H Graham

(Address)

15. Filed Feb 14 1921

R. F. Udall
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 13 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 3 1921, to Feb 13 1921 that I last saw h[illegible] alive on Feb 13 1921, and that death occurred on the date stated above, at 8:45 P.M.

The CAUSE OF DEATH* was as follows:

Valvular Heart
with Chronic Nephritis

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Chas V Greenaway M. D.

1921 (Address) Garland Bldg.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery

DATE OF BURIAL: Feb 16 1921

20. UNDERTAKER: Simmons & Krebs.

ADDRESS: Boise Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

MAR 10 1921

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 3295.1

Registered No. 44

1. PLACE OF DEATH

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2

Primary Registration District No. 1004

(No. St. Alphonsus Hospital, St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME James Cole Loyd

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH: Feb (Month) 17 (Day) 1856 (Year)

7. AGE: 64 Yrs. 11 Mos. 26 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer and

(b) General nature of industry, business or establishment in which employed (or employer): Stockman

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Benson Loyd

11. BIRTHPLACE OF FATHER (State or Country): Not Known

12. MAIDEN NAME OF MOTHER: Cole

13. BIRTHPLACE OF MOTHER (State or Country): Not Known.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm McBratney

(Address) Boise Idaho.

15. Filed Feb 14 1921

R. H. Coats
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 13 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 22 1921, to Feb 13 1921, that I last saw him alive on Feb 13 1921, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Carcinoma of large bowel (Descending Colon)

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Hypostatic congestion Lungs

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) L. P. McCalla M. D.

2/14 1921 (Address) Boise Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Emmett, Idaho. DATE OF BURIAL: 2/15 1921

20. UNDERTAKER: W McBratney ADDRESS: Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

MAR 10 1921

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1107
File No. 32053
Registered No. 41

1. PLACE OF DEATH
County of Ada
City of Boise
(No. 1811, Washington St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Emma Footman Turner

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
female	White	married

6. DATE OF BIRTH: March (Month) 12 (Day) 1848 (Year)

7. AGE: 72 Yrs. 11 Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): London, England

10. NAME OF FATHER: William Footman

11. BIRTHPLACE OF FATHER (State or Country): London England

12. MAIDEN NAME OF MOTHER: Emma Gray

13. BIRTHPLACE OF MOTHER (State or Country): London England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Mrs J. E. Hawes
(Address): Bruneau Idaho

15. Filed Feb 14 1921 R. F. Davis
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 13 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1/1/21 19..., to 2/10/21 19..., that I last saw h[illegible] alive on 2/13 1921, and that death occurred on the date stated above, at 2 P M.
The CAUSE OF DEATH* was as follows:

Pyonephrosis,

(Duration) Yrs. 2 mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) H. T. Smith by J. Earl Hess, M. D.

2/14 1921 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence Bruneau Ida

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Bruneau Idaho	2/16 1921
20. UNDERTAKER: Schreiber & Heidenfadens	ADDRESS: Boise Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

MAR 10 1921 Boise

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 1004
File No. 32055
Registered No. 48

1. PLACE OF DEATH

County of Ada.
City of Boise
(No. 708 Pueblo St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Joseph Stanford Wilcox

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	White	Single

6. DATE OF BIRTH: May (Month) 25 (Day) 1893 (Year)

7. AGE: 27 Yrs. 7 Mos. 20 ds.
IF LESS than 1 day: how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Bank Clerk
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: J. W. Wilcox

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Marion Stanford

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. W. Wilcox
(Address) 708 Pueblo St. Boise Idaho

15. Filed Feb 16 1921 A. H. Pratt Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 15 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from year 1918, to Feb 15 1921, that I last saw him alive on Feb 14 1921, and that death occurred on the date stated above, at 5a. M.

The CAUSE OF DEATH* was as follows:
Dilatation of Heart
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Valvular Heart Disease
(Duration) Years ..... mos. ..... ds.

(Signed) Edw Bierbaum M. D.
2-16 1921 (Address) Boise Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Morris Hill Cemetery	Feb. 17 1921
20. UNDERTAKER	ADDRESS
Summers & Krebs	Boise Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

Titus

CERTIFICATE OF DEATH

MAR 10 1921

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 4

Primary Registration District No. 1104

File No. 3205

Registered No. 49

1. PLACE OF DEATH

County of Ada

City of Boise

(No. 2207 State St. St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Jeremiah Cunningham

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
M.	White.	Married.

6. DATE OF BIRTH

May 15 1835
(Month) (Day) (Year)

7. AGE

85 Yrs. 9 Mos. 1 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business or establishment in which employed (or employer) —

9. BIRTHPLACE (State or Country) Canada.

10. NAME OF FATHER Joshua Cunningham

11. BIRTHPLACE OF FATHER (State or Country) New York.

12. MAIDEN NAME OF MOTHER unknown

13. BIRTHPLACE OF MOTHER (State or Country) Unknown.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Arch Cunningham

(Address) Boise

15. Filed Feb 17 1921 P. H. Ball Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb 16 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 14 1921, to Feb 15 1921 that I last saw h[illegible] alive on Feb 15 1921 and that death occurred on the date stated above, at 12:30 A.M.

The CAUSE OF DEATH* was as follows:

Cardiac Stasis.

Exact nature undetermined.

(Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary) Senility.

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W S Titus M. D.

2-16 1921 (Address) Boise Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Morris Hill Cem	Feb 17 1921
20. UNDERTAKER	**ADDRESS**
Summers & Kebo.	Boise Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

MAR 10 1921

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 32957
Registered No. 50

1. PLACE OF DEATH

County of Ada

City of Boise

(No. 410 State St.)

Registration District No. 7

Primary Registration District No. 1004

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lovinia Mc Neilly

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR, DIVORCED (Write the word.)
F	White	Married

6. DATE OF BIRTH ..... (Month) ..... (Day) 1845 (Year)

7. AGE 76 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Housekeeper

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) England

10. NAME OF FATHER Dont Know

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER Dont Know.

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) James Mc Neilly

(Address) Boise Idaho

15. Filed Feb 19 1921 R. H. Coale Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 18th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 17 1921, to Feb 18 1921, that I last saw h. alive on Feb 18 1921, and that death occurred on the date stated above, at 11 P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia & Valvular Heart

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas. V. Gurney M. D.

..... 19..... (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence Boise Idaho

19. PLACE OF BURIAL OR REMOVAL Morris Hill Cemetery | DATE OF BURIAL 3/20 1921

20. UNDERTAKER Schreiber & Sidenfaden | ADDRESS Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

Collister

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

MAR 1 1921

File No. 32958

Registered No. 57

1. PLACE OF DEATH

County of Ada

City of Boise

Registration District No. 2

Primary Registration District No. 1004

(No. 1818 No 12. St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Harry E. Adams.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
M.	White.	Married (Write the word)

6. DATE OF BIRTH: May 28 (Month) (Day) 1881 (Year)

7. AGE: 39 Yrs. 8 Mos. 22 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Carpenter

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Virginia

10. NAME OF FATHER: Lindsey Adams.

11. BIRTHPLACE OF FATHER (State or Country): Virginia

12. MAIDEN NAME OF MOTHER: Hanna N. Adams.

13. BIRTHPLACE OF MOTHER (State or Country): Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Alice M. Adams

(Address)

15. Filed Feb 19 1921 A. M. Coates Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb 19 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jany 14 1921, to Feb 19 1921, that I last saw h[illegible] alive on Feb 18 1921 and that death occurred on the date stated above, at 5 A. M.

The CAUSE OF DEATH* was as follows:

acute nephritis

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo Collister M. D.

19..... (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Seattle Wash — DATE OF BURIAL: ..... 19.....

20. UNDERTAKER: Summers & Cobbs. — ADDRESS: Boise Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

Braxton

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

MAR 1 1921

File No. 32962

Registered No. 56

1. PLACE OF DEATH

County of Ada.

City of Boise.

Registration District No. 3

Primary Registration District No. 1004

(No. 2169 Ellis Ave St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Marion W. Ketchen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widow (Write word.)

6. DATE OF BIRTH: Aug 18 (Month) 1829 (Day) (Year)

7. AGE: 91 Yrs. 6 Mos. 13 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business or establishment in which employed (or employer): ——

9. BIRTHPLACE (State or Country): Scotland.

10. NAME OF FATHER: William Watson

11. BIRTHPLACE OF FATHER (State or Country): Scotland

12. MAIDEN NAME OF MOTHER: Janet Ansley.

13. BIRTHPLACE OF MOTHER (State or Country): Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Arthur Ketchen

(Address) Boise

15. Filed Feb 23 1921

P. H. Pratt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb 21 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 1 1914, to Feb 21 1921, that I last saw her alive on Feb 21 1921, and that death occurred on the date stated above, at 8 P.M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis.

(Duration) 10 Yrs. mos. ds.

Contributory (Secondary) Pulmonary Oedema

(Duration) yrs. mos. 3 ds.

(Signed) J. N. Braxton M. D.

Feb 22 1921 (Address) Boise, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cem. DATE OF BURIAL: Feb 23 1921

20. UNDERTAKER: Summers & Kibbe. ADDRESS: Boise Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

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SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

MAR 1 1921

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 3296

Registered No. 57

1. PLACE OF DEATH

County of Ada

City of Boise (No. 410 State St.)

Registration District No.

Primary Registration District No. 571

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs Della Gray

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Married

6. DATE OF BIRTH About 1893
(Month) (Day) (Year)

7. AGE 28 Yrs. 0 Mos. 0 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Utah

10. NAME OF FATHER not obtainable

11. BIRTHPLACE OF FATHER " " (State or Country)

12. MAIDEN NAME OF MOTHER " "

13. BIRTHPLACE OF MOTHER " " (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A Schreiber

(Address) Boise Ida

15. Filed Feb 23 1921 R. H. Pratt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb (Month) 21 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1 1920 to Feb. 20 1921 that I last saw h.. alive on Feb. 20 1921 and that death occurred on the date stated above, at 9.30 A.M.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) 3 Yrs. ..... mos. ..... ds.

Contributory (Secondary) Syphilis

(Duration) 2 yrs. ..... mos. ..... ds.

(Signed) Roscoe C Ward M. D.

2/21 1921 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. 3 mos. 0 days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? Utah

Former or usual residence Ogden Utah

19. PLACE OF BURIAL OR REMOVAL Morris Hill Cemetery Ada Co Ida | **DATE OF BURIAL** 2/24/21

20. UNDERTAKER A Schreiber & Sidenfaden | **ADDRESS** Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. ____ MAR 10 1921

Primary Registration District No. ____ File No. 32964

Registered No. 54

1. PLACE OF DEATH

County of Ada

City of Boise (No. 410, State St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Wong Linn

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M.	Yellow	Married

6. DATE OF BIRTH ____ (Month) ____ (Day) 1852 (Year)

7. AGE 68 Yrs. ____ Mos. ____ ds.

IF LESS than 1 day how many ____ hrs. or ____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Gardner

(b) General nature of industry, business or establishment in which employed (or employer): ____

9. BIRTHPLACE (State or Country): China

10. NAME OF FATHER: Dont Know

11. BIRTHPLACE OF FATHER (State or Country): China

12. MAIDEN NAME OF MOTHER: Dont Know

13. BIRTHPLACE OF MOTHER (State or Country): China

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wong Linn

(Address) ____

15. Filed Feb 25 1921 P. H. Coate Local Registrar

Collister

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 24th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 7 1921, to Feb 23 1921, that I last saw h[illegible] alive on Feb 23 1921, and that death occurred on the date stated above, at 6 A M.

The CAUSE OF DEATH* was as follows:

Cancer of Stomach

(Duration) ____ Yrs. ____ mos. ____ ds.

Contributory (Secondary) ____

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) Fred Collister M. D.

19____ (Address) ____

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days

Where was disease contracted if not at place of death? ____

Former or usual residence: Boise, Idaho

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Chinese Cemetery	3/26 1921

20. UNDERTAKER	ADDRESS
Schreiber & Siebenfaden	Boise, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

MAR 1921

Registration District No. 7
Primary Registration District No. 1054
File No. 32965
Registered No. 40

1. PLACE OF DEATH
County of Ada
City of Boise.
(No. 2216 Ada St., St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Tressa Hawley.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Feb 7 1893 (Month) (Day) (Year)

7. AGE: 28 Yrs. — Mos. 17 ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business or establishment in which employed (or employer): None.

9. BIRTHPLACE (State or Country): Oregon

10. NAME OF FATHER: R. D. Hawley.

11. BIRTHPLACE OF FATHER (State or Country): Oregon.

12. MAIDEN NAME OF MOTHER: Mary Hillegas

13. BIRTHPLACE OF MOTHER (State or Country): Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. McBratney
(Address) Boise Idaho.

15. Filed Feb 25 1921 P. H. Peale Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb, 24, 1921 (Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 19 16, to Feb 24 1921 that I last saw h. alive on Feb 22 1921, and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) Chas V. Feaveary M. D.

2/25 1921 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 2/26 1921

20. UNDERTAKER: W McBratney — ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

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FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

MAR 10 1921

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1774
File No. 32966
Registered No. 67

1. PLACE OF DEATH

County of Ada
City of Boise
(No. 410 Alice St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Norbert Daniel Murphy

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widower

6. DATE OF BIRTH: July (Month) 22 (Day) 1888 (Year)

7. AGE: 32 Yrs. 7 Mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Mining Engineer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mich

10. NAME OF FATHER: Daniel D. Murphy

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Ella Sullivan

13. BIRTHPLACE OF MOTHER (State or Country): Ireland.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Robert S. Lee
(Address) Mountain House Idaho

15. Filed Feb 26 1921 — A. V. Neale, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 26 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 2 1921, to Feb 26 1921, that I last saw h.xx. alive on Feb 25 1921, and that death occurred on the date stated above, at 5:30 P.M.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis
(Chronic)

(Duration) Several Yrs. mos. ds.

Contributory (Secondary) Pulmonary edema

(Duration) yrs. mos. 7 ds.

(Signed) Ralph Falk M. D.

2/26 1921 (Address) Boise

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence Calumet Mich

19. PLACE OF BURIAL OR REMOVAL: Calumet Mich — DATE OF BURIAL: 3/26/1921

20. UNDERTAKER: Schreiber & Hidenfadem — ADDRESS: Boise

Falk

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

MAR 1 1921

File No. 32967
Registered No. 62

1. PLACE OF DEATH

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No. 1074

(No. 612, Front St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Kong Wii

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: Yellow

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: 1874 (Month) (Day) (Year)

7. AGE: 47 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Cook

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): China

10. NAME OF FATHER: Don't Know

11. BIRTHPLACE OF FATHER (State or Country): China

12. MAIDEN NAME OF MOTHER: Don't Know

13. BIRTHPLACE OF MOTHER (State or Country): China Hong Hoo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15. Filed Feb 28 1921 R. H. Pratt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb 25th 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 23 1921, to Feb 25 1921, that I last saw h— alive on Feb 24 1921, and that death occurred on the date stated above, at 4 P M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Larynx

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Geo Collister M. D.

19 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence Boise, Idaho

19. PLACE OF BURIAL OR REMOVAL: Chinese Cemetery — DATE OF BURIAL: 2/28 1921

20. UNDERTAKER: Schreiber & Sidenfaden — ADDRESS: Boise, Idaho

Collister

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

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FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

MAR 1 1921

File No. 32968

Registered No. 43

1. PLACE OF DEATH

County of Ada

City of Boise

(No. 144, East Idaho St.)

Registration District No. 2

Primary Registration District No. 1

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John H. Fleck

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M

4. COLOR OR RACE White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married (Write the word.)

6. DATE OF BIRTH June 2nd 1861 (Month) (Day) (Year)

7. AGE 59 Yrs. 9 Mos. 24 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Mining operator

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Ohio

10. NAME OF FATHER Valentine Fleck

11. BIRTHPLACE OF FATHER (State or Country) Pa.

12. MAIDEN NAME OF MOTHER Susan

13. BIRTHPLACE OF MOTHER (State or Country) Pa.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Guy Fleck.

(Address) Boise, Idaho

15. Filed Feb 28 1921 G. H. Bate Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb 26 2 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 23 1921, to Feb 26 1921, that I last saw him alive on Feb 26 1921, and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

Myocarditis

(Duration) 5 Yrs. mos. ds.

Contributory (Secondary) Pulmonary Oedema

(Duration) yrs. mos. 3 ds.

(Signed) T. N. Braxton M. D.

Feb 28 1921 (Address) Boise Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence Boise Ida. 21 Yrs

19. PLACE OF BURIAL OR REMOVAL Morris Hill Cemetery — **DATE OF BURIAL** 2/28 1921

20. UNDERTAKER Schreiber & Siebenfaden — **ADDRESS** Boise. Idaho

Dr. Braxton

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

MAR 20 1921

File No. 32969

Registered No. 65

1. PLACE OF DEATH

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2

Primary Registration District No. 4

(No. 410 State St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Andres Monasterio

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	White	Single

6. DATE OF BIRTH

..... (Month) ..... (Day) 1894 (Year)

7. AGE

27 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Camp Tender

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country) Spain

10. NAME OF FATHER Ycidro Monasterio

11. BIRTHPLACE OF FATHER (State or Country) Spain

12. MAIDEN NAME OF MOTHER Estafana Atela

13. BIRTHPLACE OF MOTHER (State or Country) Spain

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A Andersen

(Address) Boise, Idaho

15. Filed Feb 28 1921 R. H. Teal Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb (Month) 26th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....

that I last saw h..... alive on ..... 19.....,

and that death occurred on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Fracture of skull

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo Callen M. D.

..... 19..... (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
St. Johns Cemetery	3/1 1921

20. UNDERTAKER	ADDRESS
Schreiber & Sidenfaden	Boise

Geo Callen

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

MAR 16 1921

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32970

Registered No. 5

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Ada

City of

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No. 4 West of Boise St.)

2. FULL NAME Wava Roulands

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F	White	Single

6. DATE OF BIRTH: Jan. (Month) 9 (Day) 1921 (Year)

7. AGE: Yrs. Mos. 22 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Boise Idaho.

10. NAME OF FATHER: Edwin R. Roulands

11. BIRTHPLACE OF FATHER (State or Country): Mo.

12. MAIDEN NAME OF MOTHER: Edith Glory

13. BIRTHPLACE OF MOTHER (State or Country): Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Edwin R Roulands

(Address) Rout 1 Boise Ida.

15. Filed Feb 1, 1921 R. H. Pratt Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. (Month) 31 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 9 1921 to Jan 31 1921 that I last saw her alive on Jan. 30 1921 and that death occurred on the date stated above, at 5 P M.

The CAUSE OF DEATH* was as follows:

Broncho - pneumonia

(Duration) Yrs. mos. 4 ds.

Contributory (Secondary) Cremations

(Duration) yrs. mos. ds.

(Signed) J. Earl Krebs, M. D.

2/1 1921 (Address) Boise, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Morris Hill Cemetery	Feb 1 1921

20. UNDERTAKER: Summers & Krebs — ADDRESS: Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

MAR 10 1921

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 3251

Registered No. 7

1. PLACE OF DEATH

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 8

Primary Registration District No. 7004

(No. near Cole School St.)

If death occurred in a hospital, institution or camp, write its NAME instead of street and number.

2. FULL NAME Virgil Ronald Frazier

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Dec 4th 1920 (Month) (Day) (Year)

7. AGE: — Yrs. 2 Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Eagle Ada Co. Idaho

10. NAME OF FATHER: D. J. Frasier

11. BIRTHPLACE OF FATHER (State or Country): Neb.

12. MAIDEN NAME OF MOTHER: Edith Harriet Snider

13. BIRTHPLACE OF MOTHER (State or Country): Kans.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) D. J. Frasier

(Address)

15. Filed 2/7 1921

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb 4th 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 31 1921 to Feb 4 1921, that I last saw him alive on Feb 3 1921, and that death occurred on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:

Abscess of Antrum of Highmore

(Duration) Yrs. mos. 6 ds.

Contributory (Secondary): Septicaemia

(Duration) yrs. mos. 3 ds.

(Signed) T. N. Braxton M. D.

Feb 5 1921 (Address) Empire Bldg Boise.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former, or usual residence Eagle Ada Co. Ida.

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 2/5 1921

20. UNDERTAKER: Schreiber & Sidenfaden — ADDRESS: Boise Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

MAR 10 1921

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32972

Registered No. 8

1. PLACE OF DEATH

County of Ada

City of So. Boise

(No. So Boise near Oaks. St.)

Registration District No. 8

Primary Registration District No. 2004

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Henry A. Dalrymple

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Oct 13th 1870 (Month) (Day) (Year)

7. AGE: 50 Yrs. 3 Mos. 21 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Cloud Co. Kans.

10. NAME OF FATHER: H. H. Dalrymple

11. BIRTHPLACE OF FATHER (State or Country): Ann

12. MAIDEN NAME OF MOTHER: Mary O Conner

13. BIRTHPLACE OF MOTHER (State or Country): Ann

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs H.A. Dalrymple

(Address) near Eighth Ave. So.

15. Filed 2/7 1921

R H Roads
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb 5th 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 3 1921, to Feb 5 1921, that I last saw him alive on Feb 3 1921, and that death occurred on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Oedema of the lungs
and mitral insufficiency

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. M. Halverson M. D.

Feb 5 1921 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence Ada Co. Idaho

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 2/7 1921

20. UNDERTAKER: Schreiber & Sidenfaden — ADDRESS: Boise, Idaho

Dr. Halverson

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

MAR 10 1921

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 8
Primary Registration District No. 2754
File No. 32973
(No. Soldiers Home Hospital) Registered No. 9

1. PLACE OF DEATH

County of Ada
City of Boise.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Addison F. Callison

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
M.	White.	Widowed

6. DATE OF BIRTH: Febs — (Month) (Day) 1841 (Year)

7. AGE: 80 Yrs. — Mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chas E. Callison
(Address) Boise Idaho.

15. Filed Feb 7 1921 R. H. Coats
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb 5 1921 (Month) (Day) (Year)
Feb 1 [illegible]

17. I HEREBY CERTIFY, That I attended deceased from Feb 1 1921, to Feb 5 1921
that I last saw h~~e~~ alive on Feb 5 1921
and that death occurred on the date stated above, at 4 P.M.
The CAUSE OF DEATH* was as follows:

Senility

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Fred A Tuttle M. D.
2/7 1921 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Meridian Idaho.	Feb 7 1921
20. UNDERTAKER	**ADDRESS**
Summers & Gebs	Boise Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

MAR 10 1921

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 8
Primary Registration District No. 2007
File No. 32974
Registered No. 10

1. PLACE OF DEATH
County of Ada
City of Boise.
(No. Soldiers Home Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ezekiel Hayward.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH: Feb 14 1832 ~~1841~~
(Month) (Day) (Year)

7. AGE: 89 Yrs. 11 Mos. 22 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired Soldier
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): ~~Unknown~~ Ohio.

10. NAME OF FATHER: Ezekiel Hayward.

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. G. Burnett
(Address) Boise Idaho

15. Filed Feb 8 1921 P. H. Peate
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb 6 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1 1921 to Feb 6 1921
that I last saw him alive on Feb 5 1921
and that death occurred on the date stated above, at 5 A M.
The CAUSE OF DEATH* was as follows:

Senility

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. 1 ds.

(Signed) Fred A Peterson M. D.
2/7 1921 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Feb 9 1921

20. UNDERTAKER: Summers & Trubs — ADDRESS: Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 8 MAR 1 '21
Primary Registration District No. 2004
File No. 22075
Registered No. 11

1. PLACE OF DEATH
County of Ada
City of Boise,
(No. Soldiers Home St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George W. Bass (Bass)
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.):

6. DATE OF BIRTH: Feb 5 (Month) (Day) 1837 (Year)

7. AGE: 84 Yrs. — Mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farming.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: Thomas Bass.

11. BIRTHPLACE OF FATHER (State or Country): Unknown.

12. MAIDEN NAME OF MOTHER: Nancy Compton

13. BIRTHPLACE OF MOTHER (State or Country): Unknown.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Thomas Bass
(Address) Woods Cross Utah

15. Filed Feb 8 1921 R H Bracco
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 2 (Month) 7 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1/5 1921 to 2/7 1921 that I last saw h~~e~~ alive on 2/6 1921, and that death occurred on the date stated above, at 2 P.M.
The CAUSE OF DEATH* was as follows:

Hemiplegia

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) H. Fellows M. D.
2/8 1921 (Address) Boise Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cem — DATE OF BURIAL: Feb 9 1921

20. UNDERTAKER: Summers & Grebe. — ADDRESS: Boise Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

MAR 10 1921

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32976

Registered No. 11

1. PLACE OF DEATH

County of Ada

City of

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No. 27

(No. Bench S. W. of City St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME M. E. Wood

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widower

6. DATE OF BIRTH: October 21 (Month) (Day) 1846 (Year)

7. AGE: 74 Yrs. 3 Mos. 17 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): M. Y.

10. NAME OF FATHER: E. C. Wood

11. BIRTHPLACE OF FATHER (State or Country): M. Y.

12. MAIDEN NAME OF MOTHER: — Black

13. BIRTHPLACE OF MOTHER (State or Country): M. Y.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Harry M. Wood

(Address) R 2 Boise

15. Filed Feb 11 — 1921 R. H. Pratt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 7 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 7 1921 to Feb 7 1921, that I last saw h~~e~~ ~~alive on~~ 19..., and that death occurred on the date stated above, at 9 A M.

The CAUSE OF DEATH* was as follows:

Undetermined

(Duration) Yrs. mos. ds.

Contributory (Secondary) Old age

(Duration) yrs. mos. ds.

(Signed) W S Lutes M. D.

2-7 1921 (Address) Boise

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence Shipment

19. PLACE OF BURIAL OR REMOVAL: Eldora Idaho | DATE OF ~~BURIAL~~: 2/11/1921

20. UNDERTAKER: Schreiber & Sidenbender | ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

MAR 10 19

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 8
Primary Registration District No. 2024
(No. Joplin and Boise Add.)

File No. 22077
Registered No. 13

1. PLACE OF DEATH

County of Ada
City of Boise
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Joyce W. Barnes

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Nov 10th 1919 (Month) (Day) (Year)

7. AGE: 1 Yrs. 3 Mos. 1 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Boise Idaho

10. NAME OF FATHER: Ora T. Barnes

11. BIRTHPLACE OF FATHER (State or Country): Oklahoma

12. MAIDEN NAME OF MOTHER: Alice Agle

13. BIRTHPLACE OF MOTHER (State or Country): Texas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ora T Barnes
(Address) RR # 4 Boise Ida

15. Filed Feb 12 1921 R H Pratt Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb 11th 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 9th 1921 to Feb 10th 1921 that I last saw h.. alive on Feb 10th 1921 and that death occurred on the date stated above, at 2 A. M.

The CAUSE OF DEATH* was as follows:
Broncho Pneumonia
+ Convulsion

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary): Nephritis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John Baack M. D.
Feb 12 1921 (Address) Boise Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 2/12 1921

20. UNDERTAKER: Schreiber & Heidenfadel — ADDRESS: Boise

Dr. Baack

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

MAR 10 1921

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32978

Registered No. 14

1. PLACE OF DEATH

County of Ada

City of So Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No. 1 Mile E of Garfield Shool St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary Frances Le Clark

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widow

6. DATE OF BIRTH: Mar 13th (Month) 1840 (Day) (Year)

7. AGE: 70 Yrs. 11 Mos. 4 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: retired housekeeper

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Nova Scotia

10. NAME OF FATHER: Robt Jobe

11. BIRTHPLACE OF FATHER (State or Country): Nova Scotia

12. MAIDEN NAME OF MOTHER: Dont Know

13. BIRTHPLACE OF MOTHER (State or Country): Nova Scotia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Lottie Workman

(Address) So Boise Idaho

15. Filed Mch 18 1921

R H Pratt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 17 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 4 1921, to Feb 17 1921, that I last saw h.. alive on Feb 17 1921, and that death occurred on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows: Chronic interstitial nephritis

(Duration) 10 Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) M. H. Gallman M. D.

1921 (Address) 2-17-21 Boise

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence Elmore Co. Idaho

19. PLACE OF BURIAL OR REMOVAL: Mountain Home Ida

DATE OF BURIAL: 2/18 1921

20. UNDERTAKER: Schreiber & Sidenfaden

ADDRESS: Boise, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

MAR 10 1921

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2

Primary Registration District No. 2

File No. 32979

Registered No. 15

1. PLACE OF DEATH

County of Ada

City of Boise.

(No. Near Perkins Hatrack St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lawrence Andrew Allen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH Dec, 21, 1919
(Month) (Day) (Year)

7. AGE 1 Yrs. 1 Mos. 29 ds.

IF LESS than 1 day how many ____ hrs. or ____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Burley, Idaho.

10. NAME OF FATHER N. I. Allen

11. BIRTHPLACE OF FATHER (State or Country) California

12. MAIDEN NAME OF MOTHER Luella Snyder

13. BIRTHPLACE OF MOTHER (State or Country) Washington

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. McBratney

(Address) Boise Idaho,

15. Filed Feb 21 1921 R. H. Pratt
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb 20, 1921
(Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 5 1921 to Feb 19th 1921, that I last saw him alive on Feb 19th 1921, and that death occurred on the date stated above, at 10 A. M.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

Feb 3rd to Feb 20th.

(Duration) ____ Yrs. ____ mos. 17 ds.

Contributory (Secondary) Gastro Enteritis

(Duration) ____ yrs. ____ mos. 5 ds.

(Signed) W. L. Traynis M. D.

2/21 1921 (Address) Boise, Idaho,

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Morris Hill Cemetery	2/21 1921

20. UNDERTAKER	ADDRESS
W. McBratney	Boise Idaho,

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

MAR 10 1921

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 8
Primary Registration District No. 2004
File No. 32080
Registered No. 57

1. PLACE OF DEATH

County of Ada
City of near Boise

(No. Lea Hill Road St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Martha Candace Newland.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: August (Month) 19-4 (Day) 1852 (Year)

7. AGE: 68 Yrs. 6 Mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House Wife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Indiana

10. NAME OF FATHER: Matthew Stewart

11. BIRTHPLACE OF FATHER (State or Country): Indiana

12. MAIDEN NAME OF MOTHER: Nancy Harlan

13. BIRTHPLACE OF MOTHER (State or Country): Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Frank Newland
(Address)

15. Filed Feb 28 1921 — Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb 27 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 19 1921, to Feb 26 1921, that I last saw h.r alive on Feb 26 - 1921, and that death occurred on the date stated above, at 1 A M.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J O Springer M. D.

Feb 28 1921 (Address) Boise Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence Ada County, Idaho.

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Morris Hill Cemetery	3/1 1921

20. UNDERTAKER	ADDRESS
Schreiber & Sedenfaden	Boise, Idaho

J O Springer M.D.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

MAR 10 1921

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Ada

City of Meridian

If death occurs away from usual residence, give facts called for under special information.

Registration District No. ____

Primary Registration District No. 11

(No. ____, ____ St.)

File No. 32981

Registered No. 7

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Margaret Jane Atkinson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: January (Month) 2 (Day) 1870 (Year)

7. AGE: 51 Yrs. 1 Mos. 17 ds.

IF LESS than 1 day how many ____ hrs. or ____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer): ____

9. BIRTHPLACE (State or Country): Virginia

10. NAME OF FATHER: C. L. Thompson

11. BIRTHPLACE OF FATHER (State or Country): Virginia

12. MAIDEN NAME OF MOTHER: Martha Spencer

13. BIRTHPLACE OF MOTHER (State or Country): Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) O. Jet Atkinson

(Address) Meridian, Idaho.

15. Filed Febr. 20 1921

I. H. Neal
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 19 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 20 1921, to Febr 16 1921 that I last saw h.er alive on Febr - 16 1921 and that death occurred on the date stated above, at 7:30 A.M.

The CAUSE OF DEATH* was as follows:

Cystitis & General debility

(Duration) ____ Yrs. ____ mos. 30 ds.

Contributory (Secondary) ____

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) I. Halbert F. Neal M. D.

Feb 20 1921 (Address) Meridian

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days

Where was disease contracted if not at place of death? ____

Former or usual residence ____

19. PLACE OF BURIAL OR REMOVAL: Joplin Cemetery — DATE OF BURIAL: Feb. 20, 1921

20. UNDERTAKER: W. D. Matlock — ADDRESS: Meridian

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

1. PLACE OF DEATH

County of Ada

City of Meridian

If death occurs away from usual residence, give facts called for under special information.

CERTIFICATE OF DEATH.

Registration District No.

Primary Registration District No. 11

(No. St.)

2. FULL NAME Theodore F. Holstor

DEPARTMENT OF PUBLIC WELFARE.
Bureau of Vital Statistics
File No. 32982
Registered No. 6

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

The information on this certificate is an exact COPY of the official certificate at place of death.

PERSONAL AND STATISTICAL PARTICULARS.

3. SEX. Male.

4. COLOR OR RACE. White

5. Single, Married, Widowed or Divorced. Widower (Write the Word.)

6. DATE OF BIRTH. Dec (Month) 25 (Day) 1843 (Year)

7. AGE. 77 Yrs. 1 Mos. 22 ds.

IF LESS than 1 day, how many hrs. or min.?

8. OCCUPATION.
(a) Trade, profession or particular kind of work. Working Salesman
(b) General nature of industry, business, or establishment in which employed (or employer) Derring & Co

9. BIRTHPLACE. (State or Country) Riley Ind.

10. NAME OF FATHER David Holstor

11. BIRTHPLACE OF FATHER. (State or Country.) Unknown

12. MAIDEN NAME OF MOTHER. Unknown

13. BIRTHPLACE OF MOTHER. (State or County.) Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Arletta M. Martin
(Address) Meridian Idaho

15. Filed 2-19, 1921. H.F. Neal Local Registrar.

Place Where Remains are to be Sent Terre Haute Ind.

Date of Shipment Feb 21, 1921.

SHIPPING UNDERTAKER Idaho

ADDRESS Meridian Firm Name [illegible]

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH. Feb (Month) 18 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Febr-12, 1921, to Febr 18, 1921; that I last saw h. in alive on Feb-18, 1921 and that death occurred on the date stated above, at 3 P. M.

The CAUSE OF DEATH was as follows:

Paralysis
(Cerebr. Hemorrage)

(Duration) Years mos. 6 ds.

Contributory (Secondary.) Cereb. Hemorage

(Duration) Years mos. ds.

Signed H. F. Neal M. D.

Feb 19, 1921. (Address) Meridian Idaho

* State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transient or Recent Residents.)

At place in the

of death yrs mos days State yrs mos ds

Where was disease contracted

if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL | Date of Burial , 19

20. UNDERTAKER | Address

1. PLACE OF DEATH

CERTIFICATE OF DEATH.

State of Idaho.
DEPT. OF PUBLIC WELFARE.
Bureau of Vital Statistics
File No. 32385
Registered No. 8

County of Ada

City of Meridian Id

Registration District No.

Primary Registration District No.

If death occurs away from usual residence, give facts called for under special information.

(No. St.)

2. FULL NAME Samuel Thorpe

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS.

3. SEX. Male
4. COLOR OR RACE. White
5. Single, Married, Widowed or Divorced. (Write the Word.) Single

6. DATE OF BIRTH. Aug. (Month) 9. (Day) 1843. (Year)

7. AGE. 77 Yrs. 6 Mos. 18 ds.
IF LESS than 1 day, how many hrs. or min.?

8. OCCUPATION.
(a) Trade, profession or particular kind of work Commercial
(b) General nature of industry, business, or establishment in which employed (or employer) Broker

9. BIRTHPLACE. (State or Country.) Westmoreland Mass.

10. NAME OF FATHER John M. Thorpe

11. BIRTHPLACE OF FATHER. (State or Country.) England

12. MAIDEN NAME OF MOTHER. Unknown

13. BIRTHPLACE OF MOTHER. (State or County.) Ireland

14. THE ~~ABOVE~~ IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) [signature]
(Address) Meridian Idaho

15. Filed 3 8, 1921. H.F. Neal Local Registrar.

Place Where Remains are to be Sent: New York City N.Y.
Date of Shipment: Mar 2, 1921
SHIPPING UNDERTAKER
Address Meridian Firm Name W.B. Butler

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH. Feb (Month) 27 (Day), 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 26, 1921, to Feb 27, 1921; that I last saw him alive on Feb 26, 1921, and that death occurred on the date stated above, at 8 A M.

The CAUSE OF DEATH was as follows:

Cardiac failure
Senility

(Duration) Years mos. ds.

Contributory (Secondary.) Chronic nephritis

(Duration) Years mos. ds.

Signed J.R. Kunnes Jr. M. D.
Mar 1 1921 (Address) Meridian Ida

* State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transient or Recent Residents.)
At place Meridian in the Ada
of death 1 yrs. 6 mos days State yrs mos ds
Where was disease contracted
if not at place of death?
Former or usual residence Zanesville Ohio

19. PLACE OF BURIAL OR REMOVAL — Date of Burial, 19

20. UNDERTAKER — Address

The information on this certificate is an exact COPY of the official certificate at place of death.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 9
Primary Registration District No.
File No. 32984
Registered No.

1. PLACE OF DEATH
County of Ada
~~City of~~ Ranch
(No. St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Joshua Andrews

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): ~~Married~~ Widowed

6. DATE OF BIRTH: 7 day of May 1852 (Month) (Day) (Year)

7. AGE: 69 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Painter
(b) General nature of industry, business or establishment in which employed (or employer): ~~same~~

9. BIRTHPLACE (State or Country): St Louis Mo.

10. NAME OF FATHER: Joshua Andrews

11. BIRTHPLACE OF FATHER (State or Country): Missouri - St Louis

12. MAIDEN NAME OF MOTHER: Miss Ella Thornton

13. BIRTHPLACE OF MOTHER (State or Country): Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): W C Andrews
(Address): Boise R.D. No 3

Filed Feb. 24 1921 Frederic L. Lyon Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb 26 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1230 P.M. Feb 25 1921, to 1215 A.M. Feb 26 1921 that I last saw him alive on Feb. 26 - 1215 A.M. 1921, and that death occurred on the date stated above, at 5 A.M.

The CAUSE OF DEATH* was as follows:
Valvular Heart Disease

(Duration) Several Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) Frederic K. Lyon M. D.
Feb. 26 1921 (Address) Boise - Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Removal — DATE OF BURIAL: Feb. 25 1921

20. UNDERTAKER: McGrahney — ADDRESS: Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 1-25 M. 1-19.

CERTIFICATE OF DEATH

MAR 10 1921

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 9

County of Ada

Primary Registration District No.

File No. 32985

City of Star (No. , St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME CharlesA. Johnson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Male	White	Married (Write the word.)

6. DATE OF BIRTH

March 22 1862
(Month) (Day) (Year)

7. AGE

58 Yrs. 11 Mos. 7 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Dairyman

(b) General nature of industry, business or establishment in which employed (or employer) **********

9. BIRTHPLACE

(State or Country) Pennsylvania

10. NAME OF FATHER

Horace Johnson

11. BIRTHPLACE OF FATHER

(State or Country) Pennsylvania

12. MAIDEN NAME OF MOTHER

Delilia Smith

13. BIRTHPLACE OF MOTHER

(State or Country) Pennsylvania

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs C. A. Johnson

(Address) Star, Idaho

15.

Filed Mch 9 1921 Frederick K. Lewis Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mar 1. 21
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 19 20 to Mar 1 19 21

that I last saw h[illegible] alive on Feby 26 19 21

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows: Apoplexy — Cerebral Hemorrhage

(Duration) Yrs. 9 mos. ds.

Contributory (Secondary) Obesity

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.

Mch 9 1921 (Address) Star Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF ~~BURIAL OR~~ REMOVAL Boise Idaho

DATE OF BURIAL Mar 6 1921

20. UNDERTAKER Summers & Krebs

ADDRESS Boise, Idaho

MARGIN RESERVED FOR BINDING RECORD

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMA[illegible]

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very im[portant]. See instructions on back of certificate. CAUSE OF DEATH should state

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 9

Primary Registration District No.

File No. 32560

Registered No.

1. PLACE OF DEATH

County of Ada

City of

(No 2 mi. N.W. of Linder Station. St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Frances A. Plain

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F	White	Widow

6. DATE OF BIRTH: Sept 30 (Month) 1849 (Day) 1 (Year)

7. AGE: 71 Yrs. 5 Mos. 3 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: At home

(b) General nature of industry, business or establishment in which employed (or employer): **********

9. BIRTHPLACE (State or Country) Kentucky

10. NAME OF FATHER: George Bryant

11. BIRTHPLACE OF FATHER (State or Country) Kentucky

12. MAIDEN NAME OF MOTHER: Mary Ann Dale

13. BIRTHPLACE OF MOTHER (State or Country) Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) O. E. Plain

(Address) Eagle

15. Filed Mch 4 1921 Fredric K. Lewis Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 3 (Month) 1921 (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mch. 2 1921, to 19, that I last saw h.s alive on Mch. 2 1921, and that death occurred on the date stated above, at 11:35 M.p.

The CAUSE OF DEATH* was as follows:

Valvular, Heart trouble
Senility.

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Fredric K. Lewis M. D.

Mch 4 1921 (Address) Eagle, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Springdale Arkansas	19
20. UNDERTAKER	**ADDRESS**
Summers & Krebs	Boise, Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MAR 10 1924

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 32087
Registered No.

1. PLACE OF DEATH.
County Ada
City of Boise
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 9
Primary Registration District No.
(No. , St.)
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Sarah Penney Abbott.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (or Widow)
6. DATE OF BIRTH: Feby 20 1842 (Month) (Day) (Year)
7. AGE: 79 yrs. — mos. — ds. IF LESS than 1 day how many ..... hrs. or ..... mins.
8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer)
9. BIRTHPLACE (State or Country): Schuyler, Mo,
10. NAME OF FATHER: Charles Cooper,
11. BIRTHPLACE OF FATHER (State or Country): Indiana
12. MAIDEN NAME OF MOTHER: Betsy Cooper
13. BIRTHPLACE OF MOTHER (State or Country): Indiana
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R. J. Mathews
(Address) Kuna Idaho
15.
Filed Mch 1- 1924 Fredric K. Lewis Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feby 20 1924 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from Mch 1924, to July 20 1924, that I last saw her alive on Feby 20 1924, and that death occurred on the date stated above, at 9 P.M.
The CAUSE OF DEATH* was as follows:
Senile Degeneration,
(Duration) 4 years mos. ds.
Contributory (Secondary) None
(Duration) yrs. mos. ds.
(Signed) W. A. Hall M. D.
2-21-1924 (Address) Boise, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Star Cemetery — DATE OF BURIAL: Feb. 22 1924
20. UNDERTAKER: Schreiber & Sidenfaden — ADDRESS: Boise Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & SDRS. 19760

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

32991

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 21 (MAR 1 1921)
Primary Registration District No. 21
File No. 37
Registered No. 3303

1. PLACE OF DEATH
County of Bannock
City of Pocatello
(No. General Hosp. St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Anton Jacka

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): W

6. DATE OF BIRTH: Mat Known (Month) (Day) (Year)

7. AGE: About 45 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Labor in Lumber
(b) General nature of industry, business or establishment in which employed (or employer): Mill Lumber Sorter

9. BIRTHPLACE (State or Country): Austria

10. NAME OF FATHER: Mat Known

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) General Hosp
(Address) and Papers in his Bank

15. Filed Feb 12 1921
J. Young
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan 30 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 30 1921, to Jan 30 1921, that I last saw h. alive on Jan 30 1921, and that death occurred on the date stated above, at 3.0 P. M.

The CAUSE OF DEATH* was as follows: Myelogenous Leykemia with Bronchial asma.

(Duration) Unknown mos. ds.

Contributory (Secondary): Pulmonary Tuberculosis

(Duration) Unknown yrs. mos. ds.

(Signed) C. W. Clark M. D.

2/1 1921 (Address) Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death — yrs. — mos. 1 days. In the State — yrs. — mos. 1 days
Where was disease contracted if not at place of death?
Former or usual residence Spokane Wash.

19. PLACE OF BURIAL OR REMOVAL: Chicago Ill. DATE OF BURIAL: Feb 21 1921

20. UNDERTAKER: J. C. Kaw Undertaking Co. ADDRESS: Pocatello Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

32992

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 28
Primary Registration District No. 2161
File No. 37
Registered No. 3504

MAR 10 1921

1. PLACE OF DEATH

County of Bannock
City of Pocatello
(No. 1731 Taft ave. St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Infant Fingerlas

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Feb (Month) 2 (Day) 1921 (Year)

7. AGE: lived 5 hours. Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Pocatello, Idaho

10. NAME OF FATHER: Henry E. Fingerlas

11. BIRTHPLACE OF FATHER (State or Country): Ill.

12. MAIDEN NAME OF MOTHER: Cora Hawthorn

13. BIRTHPLACE OF MOTHER (State or Country): South Dakota

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Henry E. Fingerlas
(Address): 1731 Taft ave.

15. Filed Feb 3, 1921 — J. P. Manning, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 2 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 2 1921, to Feb 2 1921, that I last saw h[illegible] alive on Feb 2 1921, and that death occurred on the date stated above, at 3:20 P. M.
The CAUSE OF DEATH* was as follows:
Premature birth
4 hours (Duration)
Contributory (Secondary) (Duration)
(Signed) J. J. Rood M. D.
Feb 1921 (Address) Pocatello

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death [illegible] yrs. [illegible] mos. [illegible] days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mt View Cem. Pocatello — DATE OF BURIAL: Feb 3 1921

20. UNDERTAKER: H. L. McClain — ADDRESS: Pocatello Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 6-A—25 M. 1-19.

32993

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 28 MAR 10 1921
Primary Registration District No. 2161
File No. 38
Registered No. 3505

1. PLACE OF DEATH
County of Bannock
City of Pocatello
(No. 1319 So 5th Ave St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Infant Lee Morin
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6. DATE OF BIRTH: January (Month) 17 (Day) 1921 (Year)

7. AGE: Yrs. ..... Mos. 17 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Pocatello

10. NAME OF FATHER: Leo G Morin

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Edna Bair

13. BIRTHPLACE OF MOTHER (State or Country): Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Leo M. Bair
(Address) 1319 So 5th Ave

15. Filed 2/4 1921
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: February (Month) 9 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 17 1921, to Feb 3 1921
that I last saw him alive on Feb 3 1921
and that death occurred on the date stated above, at 8:30 P.M.
The CAUSE OF DEATH* was as follows:
Atelectasis pulmonum.
(Duration) ..... Yrs. ..... mos. 17 ds.
Contributory (Secondary) Prematurity birth.
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) W. W. Brotherton M. D.
Feb 4 1921 (Address) Pocatello

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mt Lawn Cemetery — DATE OF BURIAL: 2/5 1921

20. UNDERTAKER: H. H. Mackey — ADDRESS: Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

32995

Registration District No. 28
Primary Registration District No. 2161
File No. 38
Registered No. 3107

1. PLACE OF DEATH

County of Bannock
City of Pocatello
(No. 358 N. Hayes St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Walter Henry Cleare

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Dec. (Month) 10 (Day) 1918 (Year)

7. AGE: 2 Yrs. 1 Mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Pocatello, Idaho

10. NAME OF FATHER: Walter H. Cleare

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Fanny R. Walters

13. BIRTHPLACE OF MOTHER (State or Country): Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Walter H. Cleare Jr.
(Address) 358 N. Hayes Pocatello Ida.

15. Filed Feb 5 1921
J. Rowe
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 5 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 10 1921, to Feb. 5 1921, that I last saw h. alive on Feb. 4 1921, and that death occurred on the date stated above, at 3:45 A.M.

The CAUSE OF DEATH* was as follows:
Broncho-pneumonia

(Duration) ..... Yrs. ..... mos. 2 ds.
Contributory (Secondary) measles
(Duration) ..... yrs. ..... mos. 04 ds.

(Signed) F. Rowe M. D.
2/5 1921 (Address) Pocatello

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death Life yrs. ..... mos. ..... days. In the State Life yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mt View Cem. DATE OF BURIAL: Feb 6 1921

20. UNDERTAKER: McFarland Undertaking Co. ADDRESS: Pocatello Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

32996

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 38
Registered No. 3508

1. PLACE OF DEATH
County of Bannock
City of Pocatello
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 28
Primary Registration District No. 2161
(No. 525 W. Hayden St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary Alice Brathers

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write one word.): Single

6. DATE OF BIRTH: Nov 25 1917 (Month) (Day) (Year)

7. AGE: 3 Yrs. 2 Mos. 12 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: William W. Brathers

11. BIRTHPLACE OF FATHER (State or Country): Nebraska

12. MAIDEN NAME OF MOTHER: Mildred a Chandler

13. BIRTHPLACE OF MOTHER (State or Country): Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wm. W. Brathers
(Address) 525 W. Hayden Pocatello

15. Filed Feb 7 1921
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. 5 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2-4 1921, to 2-5 1921 that I last saw h[illegible] alive on 2-5 1921, and that death occurred on the date stated above, at 8:40 P.M.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia

(Duration) ..... Yrs. ..... mos. 1 ds.

Contributory (Secondary) Influenza & measles

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [signature] M. D.

Feb 7 1921 (Address) Pocatello

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 1 yrs. 6 mos. ..... days. In the State 1 yrs. 6 mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence Malad Idaho.

19. PLACE OF BURIAL OR REMOVAL: Mt View Cem. DATE OF BURIAL: Feb 7 1921

20. UNDERTAKER: H. L. McClain ADDRESS: Pocatello Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-A—25 M. 1-19.

32997

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 28
Primary Registration District No. 2161
File No. 38
Registered No. 3509

1. PLACE OF DEATH
County of Bannock
City of Pocatello (No. Lyons Bros Hospital St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs Nettie Randolph
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Married

6. DATE OF BIRTH: Nov 14 1
(Month) (Day) (Year)

7. AGE: 47 Yrs. 7 Mos. 24 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Galesburg Ills

10. NAME OF FATHER: Charles Wesley Kramer

11. BIRTHPLACE OF FATHER (State or Country): Cincinnati Ohio

12. MAIDEN NAME OF MOTHER: Elizabeth Mather

13. BIRTHPLACE OF MOTHER (State or Country): Ills.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Charles Randolph
(Address) Gooding Ida

15. Filed 2/7 1921
J. W. Young
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feby 7 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jany 29 1921, to Feby 7 1921
that I last saw her alive on Feby 7 1921
and that death occurred on the date stated above, at 6 a. M.
The CAUSE OF DEATH* was as follows:
Cancer of the uterus.
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Diabetes Vomiting
(Duration) ..... yrs. ..... mos. 4 ds.
(Signed) Arthur M. D.
Feb 7 1921 (Address) Pocatello Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. 10 days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? Twin Falls Ida.
Former or usual residence Twin Falls Ida.

19. PLACE OF BURIAL OR REMOVAL: Gooding Ida — DATE OF BURIAL: 2/9 1921

20. UNDERTAKER: W. W. Walker — ADDRESS: Pocatello Ida

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

32998

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 28

Primary Registration District No. 4161

(No. Lynn Boss Hospital St.)

File No. 38

Registered No. 3370

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Bannock

City of Pocatello

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Earl J Eaton

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: ~~Married~~ Divorced

6. DATE OF BIRTH: Dont Know (Month) (Day) 1 (Year)

7. AGE: About 58 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Rancher

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Dont Know

10. NAME OF FATHER: " "

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Last Information

(Address)

15. Filed 1-7 1921

Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jany 3 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 20 1921, to Feb 3 1921, that I last saw him alive on Feb 3 1921, and that death occurred on the date stated above, at 9 P.M.

The CAUSE OF DEATH* was as follows:

Cancer of Stomach -

(Duration) 6 Yrs. 7 mos. — ds.

Contributory (Secondary) Operation Peritonitis Cancer of Stomach and

(Duration) yrs. mos. 8 ds.

(Signed) J. V. Hagman M. D.

Feb 4 1921 (Address) Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. 8 days. In the State 6 yrs. — mos. — days

Where was disease contracted if not at place of death? Cancer of Stomach

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: New Cemetery | DATE OF BURIAL: 2/9 1921

20. UNDERTAKER: P. A. Parker ADDRESS: Pocatello Ida

FORM V. S. No. 5-25 M. 1-19.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

MAR 32999

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 38

Registered No. 3571

Registration District No. 28

Primary Registration District No. 214

1. **PLACE OF DEATH**

County of Bannock

City of Pocatello

(No.) Lynn Bros Hospital (St.)

If death occurs away from usual residence, give facts called for under special information.

2. **FULL NAME** Catherine R. McGowan

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. **SEX** Female

4. **COLOR OR RACE** White

5. **SINGLE, MARRIED, WIDOWED OR DIVORCED** (Write the word.) Married

6. **DATE OF BIRTH** Dec 24 1873
(Month) (Day) (Year)

7. **AGE** 47 Yrs. 2 Mos. 9 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. **OCCUPATION**

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business or establishment in which employed (or employer)

9. **BIRTHPLACE** (State or Country) Canada

10. **NAME OF FATHER** Alexander Milne

11. **BIRTHPLACE OF FATHER** (State or Country) Canada

12. **MAIDEN NAME OF MOTHER** unknown

13. **BIRTHPLACE OF MOTHER** (State or Country) unknown

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**

(Informant) Ben M. Gowan

(Address) 645 W. Bridge

15. Filed 2/11 1921

J. P. Young
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH** Feb 11 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 16th 1921 to Feb 11th 1921 that I last saw her alive on Feb 11th 1921 and that death occurred on the date stated above, at 7 A. M.

The CAUSE OF DEATH* was as follows:

Insanition

(Duration) ..... Yrs. ..... mos. 2½ ds.

Contributory (Secondary) Gastro-enterostomy for ulcer of stomach

(Duration) ..... yrs. ..... mos. 14 ds.

(Signed) C. V. Lynn M. D.

Feb 11th 1921 (Address) Pocatello Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State 1 yrs. ..... mos. 14 days

Where was disease contracted if not at place of death?

Former or usual residence Pocatello Ida

19. **PLACE OF BURIAL OR REMOVAL** Mountain View — **DATE OF BURIAL** Feb 12 1921

20. **UNDERTAKER** Schumacher — **ADDRESS** Pocatello

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 8A—25 M. 1-19.

33000

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 24
Primary Registration District No. 2161
File No. 38
Registered No. 3512

1. PLACE OF DEATH
County of Bannock
City of Pocatello
If death occurs away from usual residence, give facts called for under special information.

(No. 340 E. Garfield St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Dorothy Chatterton

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Widow

6. DATE OF BIRTH March 4 1840
(Month) (Day) (Year)

7. AGE 80 Yrs. 11 Mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE Denmark
(State or Country)

10. NAME OF FATHER ✓

11. BIRTHPLACE OF FATHER ✓
(State or Country)

12. MAIDEN NAME OF MOTHER ✓

13. BIRTHPLACE OF MOTHER ✓
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Nancy Petersen
(Address) 340 E. Garfield

15. Filed 2/13 1921
J. M. Young
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Feby 12 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 1 1920 to Feb. 12 1921
that I last saw her alive on Feb. 12 1921
and that death occurred on the date stated above, at 11 A.M.
The CAUSE OF DEATH* was as follows:

Coronary Thrombosis

(Duration) Yrs. 3 mos. ..... ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.
2/13/1921 (Address) Pocatello

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Monmouth Ill	2/16 1921

20. UNDERTAKER P. L. Mallett ADDRESS Pocatello Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

33001

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 28
Primary Registration District No. 2161
F No. 58
Registered No. 3513

1. PLACE OF DEATH
County of Bannock
City of Pocatello
(No. Fredonia St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elmer Ray Payne

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: ~~Married~~ (Write the word.)

6. DATE OF BIRTH: February 5 1921 (Month) (Day) (Year)

7. AGE: ___ Yrs. ___ Mos. 7 ds.
IF LESS than 1 day how many ____ hrs. or ____ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Pocatello Idaho.

10. NAME OF FATHER: William E Payne

11. BIRTHPLACE OF FATHER (State or Country): Wyoming

12. MAIDEN NAME OF MOTHER: Luella Hayes

13. BIRTHPLACE OF MOTHER (State or Country): Plain City Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) William E Payne
(Address) City.

15. Filed 2/14 1921 J. H. Mooney, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: February (Month) 12 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2-3 1921 to 2-10 1921 that I last saw h[illegible] alive on 2-10 1921, and that death occurred on the date stated above, at ____ M.

The CAUSE OF DEATH* was as follows:
Premature birth.
Convulsions.

(Duration) ____ Yrs. ____ mos. ____ ds.

Contributory (Secondary)

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) D Ray M. D.
2/14 1921 (Address) Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mt View Cemetery Schumacher & Hall | DATE OF BURIAL: Feb 14 1921

20. UNDERTAKER: Pocatello Ida | ADDRESS: Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 28
Primary Registration District No. 2141
File No. 38
Registered No. 3514

1. PLACE OF DEATH
County of Bannock
City of Pocatello
(No. Lynn & Iron Horse St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mauldin Roby (Jeff) Davis

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6. DATE OF BIRTH: Oct 28 1857 (Month) (Day) (Year)

7. AGE: 63 Yrs. 4 Mos. 16 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Virginia

10. NAME OF FATHER: Wm Davis

11. BIRTHPLACE OF FATHER (State or Country): Virginia

12. MAIDEN NAME OF MOTHER: Alista McGuire

13. BIRTHPLACE OF MOTHER (State or Country): Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs M. L. Davis
(Address) Pocatello

15. Filed 2/14 1921
Local Registrar J. W. Young

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feby 13 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 10 1918 to Feby 13 1921 that I last saw him alive on Feby 13 1921 and that death occurred on the date stated above, at 9 a M.
The CAUSE OF DEATH* was as follows:
Mitral Insufficiency
Myocarditis.
(Duration) 2 Yrs. ..... mos. ..... ds.
Contributory (Secondary) Rheumatism
(Duration) 8 yrs. ..... mos. ..... ds.
(Signed) J. V. Tyson M. D.
Feb 13 1921 (Address) Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. 1 mos. 14 days. In the State 20 yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? 10 to 20 6 the city.
Former or usual residence Came to Idaho.

19. PLACE OF BURIAL OR REMOVAL: Mt View Cemetery — DATE OF BURIAL: 2/15 1921

20. UNDERTAKER: H. H. Walker — ADDRESS: Pocatello Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-25 M. 1-19.

33003

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 28
Primary Registration District No. 2141
File No. 38
Registered No. 3815

1. PLACE OF DEATH
County of Bannock
City of Pocatello
(No. 806 South 7th St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Dorothy Marie Lewis

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Infant

6. DATE OF BIRTH
November 5 1919
(Month) (Day) (Year)

7. AGE
1 Yrs. 3 Mos. 10 ds.
IF LESS than 1 day how many ____ hrs. or ____ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Infant
(b) General nature of industry, business or establishment in which employed (or employer) —

9. BIRTHPLACE
(State or Country) Pocatello Idaho

10. NAME OF FATHER
Charles H Lewis

11. BIRTHPLACE OF FATHER
(State or Country) Ohio

12. MAIDEN NAME OF MOTHER
Tillie Atzbach

13. BIRTHPLACE OF MOTHER
(State or Country) Nebraska

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Charles H Lewis
(Address) Pocatello

15.
Filed 2/16 1921
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
February 15 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2-1 1921, to 2-15 1921 that I last saw her alive on 2-15 1921, and that death occurred on the date stated above, at 1:45 A.M.

The CAUSE OF DEATH* was as follows:

Bronchial pneumonia

(Duration) Yrs. ____ mos. 14 ds.

Contributory (Secondary) Measles

(Duration) ____ yrs. ____ mos. 5 ds.

(Signed) D C Ray M. D.
2/16 1921 (Address) Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Provo Utah	Feb 17 19
20. UNDERTAKER	ADDRESS
Schumacher & Hall	Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

33004

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 28
Primary Registration District No. 7161
File No. 38
Registered No. 3516

1. PLACE OF DEATH
County of Bannock
City of Pocatello
(No. Lynn Rd Hospital St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Monnie Fisher

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: (Write word) Single

6. DATE OF BIRTH: Feby 28 (Month) (Day) 1903 (Year)

7. AGE: 17 Yrs. 11 Mos. 19 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: School Girl
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): North Carolina

10. NAME OF FATHER: Howard Fisher

11. BIRTHPLACE OF FATHER (State or Country): North Carolina

12. MAIDEN NAME OF MOTHER: Maggie Fisher

13. BIRTHPLACE OF MOTHER (State or Country): North Carolina

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Howard Fisher
(Address) Blackfoot Ida

15. Filed 2/14 1921
J. H. Young (Local Registrar)

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feby (Month) 16 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feby 9 1921, to Feby 16 1921, that I last saw her alive on Feby 16 1921 and that death occurred on the date stated above, at 11 a M.

The CAUSE OF DEATH* was as follows:
Pneumonia

(Duration) ... Yrs. — mos. 6 ds.

Contributory (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) ... M. D.
Feb 16 1921 (Address) Deceased

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. 6 days. In the State 5 yrs. ... mos. ... days
Where was disease contracted if not at place of death? Did not know
Former or usual residence Blackfoot Ida

19. PLACE OF BURIAL OR REMOVAL: Blackfoot Ida — DATE OF BURIAL: 2/17 1921

20. UNDERTAKER: W. B. Baker — ADDRESS: Pocatello Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

33005

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

MAR 10

Registration District No. 28

Primary Registration District No. 2161

File No. 38

Registered No. 3817

1. PLACE OF DEATH

County of Bannock

City of Pocatello

(No. 330 No 4 St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mrs Paul Alexander

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: Colored

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): M

6. DATE OF BIRTH: Dec 3 1861 (Month) (Day) (Year)

7. AGE: 60 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Brownville Mo

10. NAME OF FATHER: Thomas Nave

11. BIRTHPLACE OF FATHER (State or Country): /

12. MAIDEN NAME OF MOTHER: /

13. BIRTHPLACE OF MOTHER (State or Country): /

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Paul Alexander
(Address) Pocatello Ida.

15. Filed 2/14 1921

J H Young
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feby 14 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feby 11 1921, to Feby 14 1921, that I last saw h.er alive on Feby 14 1921, and that death occurred on the date stated above, at 11 a M.

The CAUSE OF DEATH* was as follows:

Bulbar Paralysis

(Duration) Yrs. 3 mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) C H Gregory M. D.

2-14 1921 (Address) Main Bldg

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: M A Pocatello cemetery — DATE OF BURIAL: 2/16 1921

20. UNDERTAKER: P.D. Packer — ADDRESS: Pocatello Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

28

33006

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 38

Registered No. 3518

1. PLACE OF DEATH

County of Bannock

City of Pocatello

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No. 7146

(No. Fair Hospital St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Patrick J. Walsh

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: July 24 1890
(Month) (Day) (Year)

7. AGE: 30 Yrs. 6 Mos. 24 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Blacksmith
(b) General nature of industry, business or establishment in which employed (or employer): O. S. L. R. R.

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Michael J. Walsh

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Sarah Ward

13. BIRTHPLACE OF MOTHER (State or Country): Wales

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Edward P. Moore
(Address) 827 W. 1st N. Salt Lake City Utah

15. Filed 2/18 1921

J. R. Young
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb 18 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 16 1921 to Feb 18 1921
that I last saw ~~him~~ alive on Feb 18 1921
and that death occurred on the date stated above, at 5a M.
The CAUSE OF DEATH* was as follows: Pneumonia Lobar

(Duration) ..... Yrs. ..... mos. 1 ds.

Contributory (Secondary) Mitral regurgitation

(Duration) several Yrs. ..... mos. ..... ds.

(Signed) W. W. Brothers M. D.

2/18 1921 (Address) Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Salt Lake Utah

DATE OF BURIAL: Feb 20 1921

20. UNDERTAKER: Thurnock Bros

ADDRESS: Pocatello Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

33007

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 28
Primary Registration District No. 2161
File No. 38
Registered No. 3519

1. PLACE OF DEATH
County of Bannock
City of Pocatello
(No. Lynn Brothers Hospital St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs. Clevonia Price

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: married. (Write the word.)

6. DATE OF BIRTH: March (Month) 14 (Day) 1877 (Year)

7. AGE: 43 Yrs. 10 Mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Kansas

10. NAME OF FATHER: Charles C. Hale.

11. BIRTHPLACE OF FATHER (State or Country): Wis

12. MAIDEN NAME OF MOTHER: Helen P Beggs

13. BIRTHPLACE OF MOTHER (State or Country): New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) N M Price
(Address) Pocatello

15. Filed 2/19 1921 J F Young Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: February (Month) 18 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 6th 1920 to Feb 18th 1921 that I last saw h.er alive on Feb 16th 1921 and that death occurred on the date stated above, at 6.30 A.M.

The CAUSE OF DEATH* was as follows:
Cancer of uterus

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Shock following operation 24 hours
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C W Lynn M. D.
Feb 19 1921 (Address) Pocatello Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain View Cem. DATE OF BURIAL: Feb 20 1921

20. UNDERTAKER: Schumacher & Hall ADDRESS: Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

33008

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 28
Primary Registration District No. 2141
File No. 38
Registered No. 3520.

1. PLACE OF DEATH
County of Bannock
City of Pocatello
(No.) Mackay Hospital (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Yee Wo.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	Chinaman	Single

6. DATE OF BIRTH Exact Date Unknown 1852.
(Month) (Day) (Year)

7. AGE About 69 years
Yrs. Mos. ds.
IF LESS than 1 day old, how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) China

10. NAME OF FATHER unknown

11. BIRTHPLACE OF FATHER (State or Country) unknown

12. MAIDEN NAME OF MOTHER unknown

13. BIRTHPLACE OF MOTHER (State or Country) unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Frank Louie
(Address) 132 N. 1st

15. Filed 2/19 1921 J. R. Young Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Feb 19 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 19 1921, to Feb 19 1921, that I last saw h. im alive on Feb 19 1921 and that death occurred on the date stated above, at 1:30 P.M.

The CAUSE OF DEATH* was as follows:
Meningitis not epidemic

(Duration) Yrs. mos. 2 to 6 ds.

Contributory (Secondary) Fractured skull

(Duration) yrs. mos. 24 ds.

(Signed) A. M. Newton M. D.

Feb 19 1921 (Address) Pocatello Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Mountain View — DATE OF BURIAL Feb 21 1921

20. UNDERTAKER Schumacher Hdw. — ADDRESS City

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

Dr. Clerk

CERTIFICATE OF DEATH

28

33009

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 88

Registered No. 3521

1. PLACE OF DEATH

County of Bannock Registration District No.

City or Pocatello Primary Registration District No. 2161

(No. 439 E. Wyeth St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sallie Dixon

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: Caucasian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widowed

6. DATE OF BIRTH: Oct 15 1870
(Month) (Day) (Year)

7. AGE: 50 Yrs. 4 Mos. 5 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Texas

10. NAME OF FATHER: [illegible] Yarbrough

11. BIRTHPLACE OF FATHER (State or Country): Texas

12. MAIDEN NAME OF MOTHER: unknown

13. BIRTHPLACE OF MOTHER (State or Country): unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Lillian Kemp
(Address) 439 E. Wyeth

15. Filed 2/21 1921

J. H. Evans
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb 20 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 13 1920, to Jan. 25 1921, that I last saw her alive on Jan 25 1921, and that death occurred on the date stated above, at 1 P. M. (also on Feb 20 1921)

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis,
(She was dead upon arrival Feb 20 1921)

(Duration) 1 Yrs. 6 mos. ds.

Contributory (Secondary): Pulmonary Hemorrhage

(Duration) yrs. 2 mos. ds.

(Signed) Carl W Clark M. D.

Feb 22 1921 (Address) Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain View — DATE OF BURIAL: Feb 24 1921

20. UNDERTAKER: Schumacher Hay — ADDRESS: City

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

33010

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

MAR 10 1921

File No. 38

Registered No. 35-22

1. PLACE OF DEATH

County of Bannock

City of Pocatello

(No. Crow Hotel main St.)

Registration District No. 28

Primary Registration District No. 2161

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Infant Clark

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Male	white	(Write the word) single

6. DATE OF BIRTH: Feb (Month) 4 (Day) 1921 (Year)

7. AGE: — Yrs. — Mos. 18 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Pocatello General Hospital

10. NAME OF FATHER: J. Clark

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Pearl Dallas

13. BIRTHPLACE OF MOTHER (State or Country): Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Pearl Dallas Clark
(Address) Portland Oregon

15. Filed Feb. 22 1921 — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 22 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2-4 1921, to 2-22 1921, that I last saw h~~im~~ alive on 2-22 1921, and that death occurred on the date stated above, at 10 a. M.

The CAUSE OF DEATH* was as follows:

Premature birth

(Duration) ..... Yrs. ..... mos. 18 ds.

Contributory (Secondary): Convulsions

(Duration) ..... yrs. ..... mos. 2 ds.

(Signed) N. Day M. D.

19 ..... (Address) Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. 7 days. In the State Life yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence: General Hospital

19. PLACE OF BURIAL OR REMOVAL: Mt View Cemetery — DATE OF BURIAL: Feb 23 1921

20. UNDERTAKER: McHass Undertaking Co. — ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

33011

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 28
Primary Registration District No. 2161
File No. 38
Registered No. 3523

1. **PLACE OF DEATH**

County of Bannock
City of Pocatello
(No. 937 North Arthur St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. **FULL NAME** Richard August Cox

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Male	White	Infant (Write the word.)

6. **DATE OF BIRTH**
January (Month) 28 (Day) 1921 (Year)

7. **AGE**
— Yrs. — Mos. 22 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. **OCCUPATION**
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business or establishment in which employed (or employer): —

9. **BIRTHPLACE**
(State or Country) Pocatello Ida

10. **NAME OF FATHER**
William Cox

11. **BIRTHPLACE OF FATHER**
(State or Country) New Zealand

12. **MAIDEN NAME OF MOTHER**
Betty Jensen

13. **BIRTHPLACE OF MOTHER**
(State or Country) Logan Utah

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**
(Informant) William Cox
(Address) 937 — No Arthur

15. Filed 2/22 1921
J. H. Young
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH**
February (Month) 20 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feby 21 1921, to Feby 20 1921, that I last saw h— alive on Feby 21 1921, and that death occurred on the date stated above, at 1:30 P.M.

The CAUSE OF DEATH* was as follows: Last Stage of Marasmus Exhaustion Duration Unknown Supposed Cause Cerebral Hemorrhage

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John H. Greene M. D.
Feby 21 1921 (Address) Pocatello Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Mountain View Cem	Feb 24 1921
20. UNDERTAKER	**ADDRESS**
Schumacher & Hall	Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A--25 M. 1-19.

CERTIFICATE OF DEATH

33012

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 28 File No. 38
Primary Registration District No. 461 Registered No. 3524

1. PLACE OF DEATH

County of Bannock
City of Pocatello
(No. 448 Ea. Hayden St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jesus Rodriguez

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	Mex	Single

6. DATE OF BIRTH: Sept. (Month) 25 (Day) 1920 (Year)

7. AGE: Yrs. 4 Mos. 29 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Pocatello

10. NAME OF FATHER: Benigno Rodriguez

11. BIRTHPLACE OF FATHER (State or Country): Mexico

12. MAIDEN NAME OF MOTHER: Maria Allow

13. BIRTHPLACE OF MOTHER (State or Country): Mexico

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Benigno Rodriguez
(Address) Pocatello Rt. 2

15. Filed 2/24 1921 J. P. Young Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 24 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 10 1921 to Feb 24 1921
that I last saw him alive on Feb 23 1921
and that death occurred on the date stated above, at 8 P.M.
The CAUSE OF DEATH* was as follows:
Congenital Syphilis.

(Duration) Yrs. 4 mos. 29 ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) J. P. Young M. D.
2/24 1921 (Address) Pocatello

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mt View Cemetery — DATE OF BURIAL: 2/25 1921

20. UNDERTAKER: N. S. McHan — ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-25 M. 1-19.

33013

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 28
Primary Registration District No. 2161
File No. 38
Registered No. 31-25

1. PLACE OF DEATH
County of Bannock.
City of Pocatello
(No. 721 So. 4th ave St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Oren Dayton
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6. DATE OF BIRTH: April 22 (Month) (Day) 1904 (Year)

7. AGE: 16 Yrs. 10 Mos. 1 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wyoming

10. NAME OF FATHER: Albert L. Dayton

11. BIRTHPLACE OF FATHER (State or Country): Iowa.

12. MAIDEN NAME OF MOTHER: Maude Starr

13. BIRTHPLACE OF MOTHER (State or Country): Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Maude L. Dayton
(Address) 721 So 4th Pocatello Ida.

15. Filed Feb 27 1921 — J. H. Young, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 23. (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 15 1920, to Feb 23 1921, that I last saw h~~im~~ alive on Feb 23 1921, and that death occurred on the date stated above, at 5 a' M.

The CAUSE OF DEATH* was as follows:
Decompensation of heart following acute endocarditis

(Duration) Yrs. 4 mos. ds.
Contributory (Secondary) Acute articular rheumatism (Duration) yrs. 4 mos. ds.

(Signed) A M Newton M. D.
Feb 23 1921 (Address) Pocatello Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 15 yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence Wyoming

19. PLACE OF BURIAL OR REMOVAL: Mt View Cem — DATE OF BURIAL: Feb 27 1921

20. UNDERTAKER: H. L. McHan — ADDRESS: Pocatello Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

33014

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

MAR 10 1921

Registration District No. 28
Primary Registration District No. 2161
File No. 38
Registered No. 3526

1. PLACE OF DEATH

County of Bannock
City of Pocatello
(No. St Anthonys Hosp St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Effie Goldsberry

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Married

6. DATE OF BIRTH: October 19 1898 (Month) (Day) (Year)

7. AGE: 31 Yrs. 4 Mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Fremont Nebraska

10. NAME OF FATHER: Elmer Wilds

11. BIRTHPLACE OF FATHER (State or Country): Blair Nebraska

12. MAIDEN NAME OF MOTHER: Frank Sorghest

13. BIRTHPLACE OF MOTHER (State or Country): Kennard Nebraska

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Edward Goldsberry
(Address) 1216 E Clark

15. Filed Feb 27 1921 J H Young. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb 27 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 5 1921, to Feb 26 1921, that I last saw h.er alive on Feb 26 1921, and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:
Pulmonary tuberculosis

(Duration) 2 Yrs. mos. ds.

Contributory (Secondary): None

(Duration) yrs. mos. ds.

(Signed) A M Newton M. D.
Feb 26 1921 (Address) Pocatello, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 3 yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence Nebraska

19. PLACE OF BURIAL OR REMOVAL: Fremont Nebraska — DATE OF BURIAL: Feb 28 1921

20. UNDERTAKER: MC Hanna Und. Co. — ADDRESS: Pocatello Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

MAR 10 1921

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33015
Registered No.

1. PLACE OF DEATH
County of Bear Lake
City of Paris
(No. ..... St.)
Registration District No. 2132
Primary Registration District No. 53
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Eliza Favre.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Dec. (Month) 26 (Day) 1846 (Year)

7. AGE: 74 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House Wife.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Switzerland

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country): Switzerland

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country): Switzerland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) .....
(Address) .....

15. Filed 2-10-21 19.... D. J. Sutton Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 14 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 10 1921 to Jan 14 1921, that I last saw h.. alive on Jan 12 1921, and that death occurred on the date stated above, at 2 P.M.
The CAUSE OF DEATH* was as follows: Hemiplegia

..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D. J. Sutton M. D.
Jan 16 1921. (Address) Paris Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Paris Ida — DATE OF BURIAL: 1-17 1921

20. UNDERTAKER — ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

MAR 10 1921

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33016

Registered No.

1. PLACE OF DEATH

County of Bear Lake.

City of Paris

(No. ....., ... St.)

Registration District No. 53

Primary Registration District No. 432.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Jame Humpherys.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married.

6. DATE OF BIRTH: Oct (Month) 21 (Day) 1836 (Year)

7. AGE: 84 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer.

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): England.

10. NAME OF FATHER: Thomas Humpherys.

11. BIRTHPLACE OF FATHER (State or Country): England.

12. MAIDEN NAME OF MOTHER: Mary Sudberry.

13. BIRTHPLACE OF MOTHER (State or Country): England.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) X Geo Humpherys Jr

(Address) .....

15. Filed 3-10 1921

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. (Month) 28 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 20 1921, to Jan 28 1921, that I last saw him alive on Jan 27 1921, and that death occurred on the date stated above, at 5-00 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. D. Lutton M. D.

Jan 31 1921. (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Paris Ida — DATE OF BURIAL: Jan 31 1921.

20. UNDERTAKER: Bishop Low — ADDRESS: Paris Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

MAR 10 1921

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 2049
File No. 33018
Registered No. 6

1. PLACE OF DEATH
County of Benewah
City of St Maries
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Edward Goodan

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	widowed

6. DATE OF BIRTH: March (Month) 21 (Day) 1867 (Year)

7. AGE: 54 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Woodsman
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country) Maine

10. NAME OF FATHER .....

11. BIRTHPLACE OF FATHER (State or Country) .....

12. MAIDEN NAME OF MOTHER .....

13. BIRTHPLACE OF MOTHER (State or Country) .....

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Edward C Gooden
(Address) St Maries

15. Filed March 1 1921 — W E Hunt, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 28 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 1920 to Feb 28 1921
that I last saw h[e] alive on Feb 28 1921,
and that death occurred on the date stated above, at 9P M.
The CAUSE OF DEATH* was as follows:

Terminal Infection

(Duration) ..... Yrs. 3 mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

3/12 1921 (Signed) L Edmonds M. D.
(Address) St Maries

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Woodlawn — DATE OF BURIAL ..... 19.....

20. UNDERTAKER: Hunt Co. — ADDRESS St Maries

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

MAR 10 1921

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 32
Primary Registration District No. 2049
File No. 33019
Registered No. 5

1. PLACE OF DEATH

County of Benewah
City of St Maries (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Charles H McGill

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Dec (Month) 29 (Day) 1859 (Year)

7. AGE: 61 Yrs. 1 Mos. 26 ds.
IF LESS than 1 day how many..... hrs. or..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Engineer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Minn.

10. NAME OF FATHER: Charles McGill

11. BIRTHPLACE OF FATHER (State or Country): Scotland

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs C H McGill
(Address) St Maries

15. Filed Feb. 24 1921 — W E Hunt — Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 24 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1920, to Feb 24 1921, that I last saw h... alive on Feb 22 1921, and that death occurred on the date stated above, at 4 A.M.
The CAUSE OF DEATH* was as follows:
Angina Pectoris
Arterio-Sclerosis
(Duration) ? Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) W E Stonewall M. D.
Mar 1921 (Address) St. Maries

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Woodlawn — DATE OF BURIAL: 2/27 1921

20. UNDERTAKER: Hunt Co. — ADDRESS: St Maries

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

33020

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

MAR 10 1921

Registration District No. 21

Primary Registration District No.

File No. 1

Registered No. 32

1. PLACE OF DEATH.

County of Benewah

City of Hennet

(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Anne Gregory

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: Indian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Infant

6. DATE OF BIRTH. July (Month) 15 (Day) 1917 (Year)

7. AGE: 3 Yrs. 7 Mos. 7 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Thomas Gregory

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Christine Zachary

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thomas Gregory

(Address) Hennet, Ida

15.

Filed Feb. 23 1921

J. E. Bithan
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 22 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Croup

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

..... 19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Hennet — DATE OF BURIAL: Feb 23 1921

20. UNDERTAKER: J. Falcon — ADDRESS: Hennet

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

MAR 10 1921

33021

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Benewah

City of Wenner

Registration District No. 21

Primary Registration District No.

(No. ....., ... St.)

File No. 1

Registered No. 21

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Anthony Cherraplin

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: Indian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Boy

6. DATE OF BIRTH. Oct 13 (Month) (Day) 1913 (Year)

7. AGE: 7 Yrs. 3 Mos. 19 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Scholar

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Charles Cherraplin

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Mary

13. BIRTHPLACE OF MOTHER (State or Country): Washington

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles Cherraplin

(Address)

15. Filed Feb 14 1921

J. E. Bilsan
Local Registrar

SYMS - YORK CO., PTRS. & SDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 12 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,

that I last saw h..... alive on ..... 191...,

and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Tuberculosis Pulmonary

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Wenner

DATE OF BURIAL: Feb 14 1921

20. UNDERTAKER: J. Falcon

ADDRESS: Wenner

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

33022

CERTIFICATE OF DEATH.

MAR 10 19

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 21

Primary Registration District No.

File No. 1

Registered No. 29

1. PLACE OF DEATH.

County of Benewah

City of Clemnet

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Clarence Campbell

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M.	Indian	Infant

6. DATE OF BIRTH. Jan. (Month) 7 (Day) 1921 (Year)

7. AGE ..... Yrs. 1 Mos. ..... ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Infant
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Clemnet

10. NAME OF FATHER Nicholas Campbell

11. BIRTHPLACE OF FATHER (State or Country) Clemnet Idaho

12. MAIDEN NAME OF MOTHER Esther Kennedy

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Teresa Campbell
(Address) .....

15. Filed Feb-10 1921 J. E. Bihan Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. (Month) 7 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
No physician attended

..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration ..... yrs. ..... mos. ..... ds.
(Signed) ..... M. D.
..... 19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Clemnet	Feb 10 1921
20. UNDERTAKER	**ADDRESS**
J. Falcon	Clemnet

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

6Y168 - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-12 M. 6-15-17.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

MAR 10 1921

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33023
Registered No. 1

Registration District No. 46
Primary Registration District No. 2123

1. PLACE OF DEATH
County of Benewah
City of Plummer
If death occurs away from usual residence, give facts called for under special information.

(No. ....., ... St.)
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mrs. Caroline Harris

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH. March 24 (Month) 1. (Day) 1856 (Year)

7. AGE: 64 Yrs. 10 Mos. 17 ds.
IF LESS than 1 day how many .... hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Cook
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: Allen Leeper

11. BIRTHPLACE OF FATHER (State or Country): Ind.

12. MAIDEN NAME OF MOTHER: Amanda Black

13. BIRTHPLACE OF MOTHER (State or Country): Ind.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): John Haggard
(Address): Fernwood Idaho

15. Filed 3/2 1921
H. G. Jaques
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 11 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..... to ..... 191...
that I last saw her alive on Feb. 1 1921
and that death occurred on the date stated above, at ....., ...M.

The CAUSE OF DEATH* was as follows:
Hypostatic Congestion of
Chronic Nephritis Mitral
insufficiency Loss of Comp.
(Duration) 1 Yrs. ..... mos. ..... ds.
Contributory (Secondary) Tonsilitis
(Duration) ..... Yrs. ..... mos. ..... ds.
(Signed) Chas B Clegg M. D.
3/1 1921 (Address) Fernwood

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 10 yrs. ..... mos. ..... days. In the State 10 yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? yes
Former or usual residence Plummer Idaho

19. PLACE OF BURIAL OR REMOVAL: Plummer, Ida. DATE OF BURIAL: Feb. 14. 1921.

20. UNDERTAKER: H. G. Jaques ADDRESS: Plummer

FORM V. S. No. 5-25 M. 1-16-13

MAR 16 1927

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 116
Primary Registration District No. 2185
(No. ..... St.)

File No. 33024
Registered No. .....

1. PLACE OF DEATH.
County of Bingham
City of Aberdeen
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elva Helena Wheeler

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH. (Month) Jan (Day) 30 (Year) 1921
7. AGE ..... Yrs. ..... Mos. ..... ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....
9. BIRTHPLACE (State or Country) Idaho
10. NAME OF FATHER Edgar Andrew Wheeler
11. BIRTHPLACE OF FATHER (State or Country) Idaho
12. MAIDEN NAME OF MOTHER Edith Helena Parrish
13. BIRTHPLACE OF MOTHER (State or Country) Idaho
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) E. A. Wheeler
(Address) Aberdeen Ida
15. Filed 1-31 1927 H. McCausland
Local Registrar

SVMS - YORK CO., PTRS. & BOBS. 24853

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (Month) Jan (Day) 30 1921 (Year)
17. I HEREBY CERTIFY, That I attended deceased from 1-30 1927, to 1-30 1927, that I last saw h[er] alive on 1-30 1927, and that death occured on the date stated above, at 1:30 A.M.
The CAUSE OF DEATH* was as follows:
Premature birth - 28th week of gestation
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) H McCausland M. D.
1-30 1927 (Address) Aberdeen Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Jerma Ida — DATE OF BURIAL: 2-1 1927
20. UNDERTAKER: Friend — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33025
Registered No. 43

1. PLACE OF DEATH.
County of Bingham
City of Sterling
(No. ....., ... St.)
Registration District No. 116
Primary Registration District No. 2155

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Glen Satterfield

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH. Jan 8 1921 (Month) (Day) (Year)
7. AGE: — Yrs. — Mos. 6 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer): —
9. BIRTHPLACE (State or Country): Idaho
10. NAME OF FATHER: Luther Satterfield
11. BIRTHPLACE OF FATHER (State or Country): Alabama
12. MAIDEN NAME OF MOTHER: Lanna Rice
13. BIRTHPLACE OF MOTHER (State or Country): Nevada
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) O S Rice
(Address) Sterling Ida
15. Filed 1-16 21 Mcmanamin Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 1-14 21 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from 1-8 1921, to 1-14 1921, that I last saw h.. alive on 1-13 1921 and that death occured on the date stated above, at 9P M.
The CAUSE OF DEATH* was as follows: 1 Premature birth 7½ month
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) Mcmanamin M. D.
1-16 1921 (Address) Sterling Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Portillo Ida — DATE OF BURIAL: 1-16 1921
20. UNDERTAKER: Friends — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOBS. 24853

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

33026

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bingham
City of Aberdeen
(No. ....., ... St.)

Registration District No. 116
Primary Registration District No. 2195
File No. 3
Registered No. 44

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Virginia Ross

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. June 22 1920
(Month) (Day) (Year)

7. AGE: 6 Yrs. 21 Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Oregon

10. NAME OF FATHER: Henry P Ross

11. BIRTHPLACE OF FATHER (State or Country): Russia

12. MAIDEN NAME OF MOTHER: Carolina Schneider

13. BIRTHPLACE OF MOTHER (State or Country): Russia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) H P Ross.
(Address) Aberdeen Ida

15. Filed 1-13 21 191 ..... Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan 12 191 21
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 12 191 21, to Jan 12 191 21, that I last saw her alive on Jan 12 191 21 and that death occured on the date stated above, at 11 P M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... Yrs. ..... mos. 3 ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) M Cunningham M. D.
1-13 1921 (Address) Aberdeen Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL, OR REMOVAL: Mennonite Cemetery Aberdeen Ida
DATE OF BURIAL: 1-14 1921
UNDERTAKER: Friends
ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOBS. 24658

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

MAR 10 1921

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 121

Primary Registration District No. 2194

File No. 33027

County of Bingham

City of Moreland (No. ....., ... St.)

Registered No. 1

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jesse Wilson Ellis

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH: Sept (Month) 21 (Day) 1 (Year)

7. AGE: 60 Yrs. 3 Mos. 11 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Carpenter
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): South Africa

10. NAME OF FATHER: George Ellis

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Jemima Wiggle

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Augusta Ellis
(Address) Moreland Idaho

15. Filed Jan 5 1921 Mrs Helen E. Paine Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: January 4 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 20 1920, to Jan 4 1920 that I last saw h.. alive on Dec 20 1920 and that death occurred on the date stated above, at 4 30 P M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(Duration) 2 Yrs. — mos. — ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W W Beck M. D.

1/5 1920 (Address) Blackfoot, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Moreland Cemetery

DATE OF BURIAL: Jan 6 1921

20. UNDERTAKER: Ed L Egli

ADDRESS: Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

MAR 10 1921

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33028

Registered No. 2

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No. 121

Primary Registration District No. 2194

County of Bingham

City of Blackfoot

(No. Idaho Insane Asylum St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Fred Keller

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH.

December (Month) 4 (Day) 1872 (Year)

7. AGE

48 Yrs. 1 Mos. 2 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION

(a) Trade, profession or particular kind of work... Real Estate Agent

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Nebraska

10. NAME OF FATHER Dont Know

11. BIRTHPLACE OF FATHER (State or Country) Dont Know

12. MAIDEN NAME OF MOTHER Dont Know

13. BIRTHPLACE OF MOTHER (State or Country) Dont Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Records of Idaho Insane Asylum Dr. C. A. Howe, Superintendent

(Address) Blackfoot Idaho

15.

Filed Jan 8 1921 W. Mo Valen E. Pabst Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

January (Month) 6th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 14 1920, to Jan 6th 1921, that I last saw him alive on January 5 1921, and that death occured on the date stated above, at 5 A M.

The CAUSE OF DEATH* was as follows:

Eclampsia

(Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary) Paresis

(Duration) 3 yrs. 4 mos. ..... ds.

(Signed) [illegible] M. D.

Jan 8 1921 (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs. 4 mos. 22 days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? Dont Know

Former or usual residence Twin Falls Idaho

19. PLACE OF BURIAL OR REMOVAL Ogden Utah

DATE OF BURIAL 191

20. UNDERTAKER Ed Funk

ADDRESS Blackfoot Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

BYNUM - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 1007
File No. 33029
Registered No.

1. PLACE OF DEATH
County of Bingham
City of Blackfoot (No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ralph Heck
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH: Jan (Month) 7 (Day) 1883 (Year)

7. AGE: 37 Yrs. 11 Mos. 30 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Clerk
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: J. E. Heck

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Marguerite Lacke

13. BIRTHPLACE OF MOTHER (State or Country): Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. E. Heck
(Address) Twin Falls Idaho

15. Filed June 6 1921 Mrs Nellie E. Peters Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 6th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 2nd 1921, to Jan 6th 1921 that I last saw h— alive on Jan 5th 1921, and that death occurred on the date stated above, at 3:14 A.M.
The CAUSE OF DEATH* was as follows:
Carcinoma of Stomach & Intestines
(Duration) not known
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) J. A. Humphrey M. D.
1/6 1921 (Address) Blackfoot Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Idaho — DATE OF BURIAL ..... 19.....

20. UNDERTAKER: E. E. Peck — ADDRESS Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Bingham
City of Blackfoot
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 121
Primary Registration District No. 1007
(No. 409 E. alice St.)

File No. 33030
Registered No. 4
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary C. Dimock

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F.	W.	widow

6. DATE OF BIRTH: Jan. (Month) 20 (Day) 1839 (Year)

7. AGE: 81 Yrs. 11 Mos. 20 ds. IF LESS than 1 day how many ____ hrs. or ____ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Penn.

10. NAME OF FATHER: Wm O. Graham

11. BIRTHPLACE OF FATHER (State or Country): Penn

12. MAIDEN NAME OF MOTHER: Sarah Barger

13. BIRTHPLACE OF MOTHER (State or Country): Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs J. O. Morgan
(Address) Blackfoot. Ida

15. Filed Jan 10 1921 Mrs Nellie E. Fuller Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: January (Month) 10 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 20 1920, to Janu 10 1921 that I last saw her alive on Jan 8 - 1921, and that death occurred on the date stated above, at 8:30 A.M.

The CAUSE OF DEATH* was as follows:

Angina Pectoris -

(Duration) — Yrs. Several mos. — ds.

Contributory (Secondary) Atheroma

(Duration) Several yrs. mos. ds.

(Signed) R. H. Jackson M. D.

1/11 1921 (Address) Blackfoot

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Fern City cemetery	1-11 1921

20. UNDERTAKER E. Peck ADDRESS Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 2194
File No. 33031
Registered No. 5

1. PLACE OF DEATH
County of Bingham
City of Blackfoot
(No. ..... , ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Tokumatsu Yamada
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	Japanese	Single

6. DATE OF BIRTH: Sept. (Month) 12th (Day) 1877 (Year)

7. AGE: 44 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Japan

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country) Japan

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country) Japan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) The Japanese Baptist Association
(Address) Idaho Falls, Idaho

15. Filed Jan. 19 1921 Mrs Nellie E. Patrick
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: January (Month) 14 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 19th 1920, to January 14 1921, that I last saw h.. alive on January 14 1921, and that death occurred on the date stated above, at 9:30 A.M.
The CAUSE OF DEATH* was as follows:
Exhaustion
.....
.....
(Duration) ..... Yrs. ..... mos. 2 ds.
Contributory (Secondary) Auto Infection of Peychoard
Excited (Duration) ..... yrs. 1 mos. 25 ds.
(Signed) C. N. Howe M. D.
Jan 19 1921 (Address) Blackfoot Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. 7 mos. 25 days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? Don't Know
Former or usual residence Idaho Falls Idaho

19. PLACE OF BURIAL OR REMOVAL: Idaho Falls. Idaho | DATE OF BURIAL ..... 19.....

20. UNDERTAKER | ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

Registration District No. 121

Primary Registration District No. 2194

(No. ..... , ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33032

Registered No. 6

1. PLACE OF DEATH

County of Bingham

City of Moreland

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Grant Harding England

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH: Nov (Month) 2 (Day) 1921 (Year)

7. AGE: X Yrs. 2 Mos. 14 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Moreland, Ida.

10. NAME OF FATHER: Charles M. England

11. BIRTHPLACE OF FATHER (State or Country): Plain City Utah

12. MAIDEN NAME OF MOTHER: Susan H. Geddes

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C M England.

(Address) Moreland Ida

15. Filed Jan. 17 1921 Mrs Hales E. Pierce Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 16 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 14 1921, to Jan 16 1921 that I last saw h[illegible] alive on Jan 16 1921 and that death occurred on the date stated above, at 9P M.

The CAUSE OF DEATH* was as follows:

Pneumonia (Broncho)

(Duration) ..... Yrs. ..... mos. 7 ds.

Contributory (Secondary) Whooping cough

(Duration) ..... yrs. ..... mos. 21 ds.

(Signed) W W Beck M. D.

1/17 1921 (Address) Blackfoot, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Moreland Ida — DATE OF BURIAL: Jan 18 1921

20. UNDERTAKER: Ed L Egli — ADDRESS: Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 2194
File No. 33033
Registered No. 7

1. PLACE OF DEATH
County of Bingham
City of Blackfoot Ida.
(No. ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Peter Peterson
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widower (Write the word.)

6. DATE OF BIRTH: July (Month) 29 (Day) 1839 (Year)

7. AGE: 81 Yrs. 6 Mos. 18 ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER: Peter Jonson

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Dont Know

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Arthur Peterson
(Address) Blackfoot Idaho

15. Filed Jan 17 1921 Mrs Hadie E. Patrick Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. (Month) 17 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 17 1921, to Jan 17 1921
that I last saw h[illegible] alive on Jan 17 1921
and that death occurred on the date stated above, at 7 A M.
The CAUSE OF DEATH* was as follows:
Lobar pneumonia

(Duration) ... Yrs. ... mos. ... ds.
Contributory (Secondary): senile debility
(Duration) 5 yrs. ... mos. ... ds.

(Signed) H. J. Simmons M. D.
1/17 1921 (Address) Blackfoot Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lone Oak Cemetery — DATE OF BURIAL: 1-18 1921

20. UNDERTAKER: E. E. Peck — ADDRESS: Blackfoot

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 1987
File No. 33034
Registered No. 8

1. PLACE OF DEATH
County of Bingham
City of Blackfoot
If death occurs away from usual residence, give facts called for under special information.

(No. 241, Street Broadway)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Frank R. Thomas Britton

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widowed (Write the word.)

6. DATE OF BIRTH: Jan (Month) 19 (Day) 1860 (Year)

7. AGE: 60 Yrs. 7 Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Handwoman Nurse
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER: John Washington Britton

11. BIRTHPLACE OF FATHER (State or Country): Penn.

12. MAIDEN NAME OF MOTHER: Ann A. Rankin

13. BIRTHPLACE OF MOTHER (State or Country): Vermont

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Cornelia B. Wilson
(Address) 241 S. Broadway

15. Filed Jan 22 1921 Mrs Nalin E. Pabst Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 18 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased ~~from~~ Jan 15 1921, to 19..... that I last saw h- alive on Jan 15 1921 and that death occurred on the date stated above, at 1:01 A.M.

The CAUSE OF DEATH* was as follows:
Abdominal Aortic Aneurism

(Duration) Yrs. 6 mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. C. Hamilton M. D.
1/18 1921 (Address) Blackfoot Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Iron City Cemetery | DATE OF BURIAL: 1-25-1921

20. UNDERTAKER: E. J. Peck | ADDRESS: Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-A—25 M. 1-18.

CERTIFICATE OF DEATH

Registration District No. 121

Primary Registration District No. 2194

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33035

Registered No. 9

1. PLACE OF DEATH

County of Bingham

City of Moreland

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ruth Lilyenquist

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Female	White	Single (Write the word.)

6. DATE OF BIRTH: Jan (Month) 18 (Day) 1921 (Year)

7. AGE: ... Yrs. ... Mos. ... ds.

IF LESS than 1 day how many ... hrs. or 45 min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Eugene O. Lilyenquist

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Lillie May England

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Eugene O. Lilyenquist

(Address) Moreland Id

15. Filed Jan 15 1921 Mo Nellie E. Patrick Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 18 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 18 1921 to Jan 18 1921, that I last saw her alive on Jan 18 1921, and that death occurred on the date stated above, at 7:15 A.M.

The CAUSE OF DEATH* was as follows:

Premature Birth
5½ month
(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary)
(Duration) ... yrs. ... mos. ... ds.

(Signed) W W Beck M. D.

1/18 1921 (Address) Blackfoot, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Moreland Cemetery — DATE OF BURIAL: 1-19 1921

20. UNDERTAKER: Ed L Eyli — ADDRESS: Blackfoot

MAR 10 1921

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51067

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 2194
File No. 33036
Registered No. 10

1. PLACE OF DEATH
County of Bingham
City of Blackfoot (No. Route 5 St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Helen Myrtle Spencer
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: April 5 1920 (Month) (Day) (Year)

7. AGE: Yrs. 9 Mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Henry W Spencer

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Myrtle E. Thompson

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Henry W Spencer
(Address) Blackfoot Idaho

15. Filed Jan 26 1921 Mrs Mabel E. Paben Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan 25 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 20 1920 to Jan 25 1921 that I last saw her alive on Jan 21 1921 and that death occurred on the date stated above, at 9 a M.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) ..... Yrs. ..... mos. 7 ds.

Contributory (Secondary) Whooping Cough

(Duration) ..... yrs. 1 mos. 10 ds.

(Signed) W W Beck M. D.

Jan 25 1921 (Address) Blackfoot Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Grove City Cemetery — DATE OF BURIAL: Jan 27 1921

20. UNDERTAKER: Ed L Eggli — ADDRESS: Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

MAR 10 1921

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 2194
File No. 33037
Registered No. 11

1. PLACE OF DEATH
County of Bingham
City of Blackfoot
(No. R F D 3 St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Eliza Angelina Hungate
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widowed

6. DATE OF BIRTH: Nov (Month) 18 (Day) 1847 (Year)

7. AGE: 73 Yrs. 2 Mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kentucky

10. NAME OF FATHER: Short

11. BIRTHPLACE OF FATHER (State or Country): Kentucky

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country): Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W A Hungate
(Address) Blackfoot Idaho

15. Filed Jan 28 1921 Nora Adelia E. Peterson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: January (Month) 26 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 17 1921, to Jan 26 1921, that I last saw he alive on Jan 23 1921, and that death occurred on the date stated above, at 9:30 P.M.
The CAUSE OF DEATH* was as follows:
Chronic diffuse Nephritis
(Duration) / Yrs. \ mos. \ ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) W W Beck M. D.
1/27 1921 (Address) Blackfoot Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lincoln Mont — DATE OF BURIAL: 1-27-1920

20. UNDERTAKER: E S Funk — ADDRESS: Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 2194
(No. ....., ... St.)

File No. 33038
Registered No. 12

MAR 10 1921

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Bingham
City of Blackfoot Ida

2. FULL NAME Cuthbert Cheeley

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. January (Month) 22 (Day) 1849 (Year)

7. AGE: 72 Yrs. ..... Mos. 6 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: —

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Records of Idaho Insane Asylum by Jolene Green, Clerk
(Address) Beadefoot Idaho

15. Filed Jan. 29th 1921 Mrs Walter E. Peters Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
January (Month) 28 (Day) 1921 ~~191~~ (Year)

17. I HEREBY CERTIFY, That I attended deceased from January 16 1921 ~~191~~, to January 28th 1921 ~~191~~, that I last saw him alive on January 27th 1921 ~~191~~, and that death occured on the date stated above, at 7A M.

The CAUSE OF DEATH* was as follows:
Exhaustion of Psychozes Excited

(Duration) ..... Yrs. ..... mos. 3 ds.
Contributory (Secondary) Sclerosis of Senility
(Duration ..... yrs. ..... mos. 12 ds.
(Signed) C. A. Lamm M. D.
1/29 1921 (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. 12 days. In the State 6 yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? Dont Know
Former or usual residence Star, Idaho

19. PLACE OF BURIAL OR REMOVAL: Star Ida
DATE OF BURIAL: On arrival 191

20. UNDERTAKER: Ed L Egli
ADDRESS: Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

BYNS - YORK CO., PTRS. & STRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 2194
(No. ..... St.)
File No. 33039
Registered No. 13

MAR 10 1921

1. **PLACE OF DEATH.**
County of Bingham
City of Blackfoot Ida
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. **FULL NAME** Papra Madris

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
male	Mexican	Single

6. **DATE OF BIRTH.**
..... (Month) ..... (Day) 1881 (Year)

7. **AGE**
40 Yrs. — Mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. **OCCUPATION**
(a) Trade, profession or particular kind of work... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. **BIRTHPLACE**
(State or Country) Mexico

10. **NAME OF FATHER**
Dont Know

11. **BIRTHPLACE OF FATHER**
(State or Country) Dont Know

12. **MAIDEN NAME OF MOTHER**
Dont Know

13. **BIRTHPLACE OF MOTHER**
(State or Country) Dont Know

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.**
(Informant) Records Idaho Insane asylum
(Address) Blackfoot Idaho By Julius L Greer clerk

15.
Filed Jan. 31 1921 Flora Hallie E. Patterson
Local Registrar

SVMS - YORK CO., PTRS & SONS. 24658

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH**
January (Month) 28 (Day) ~~191~~ 1921 (Year)

17. **I HEREBY CERTIFY,** That I attended deceased from December 15 ~~191~~ 1921, to January 28 ~~191~~ 1921, that I last saw h sm alive on January 28 ~~191~~ 1921, and that death occured on the date stated above, at 9 a. M.

The CAUSE OF DEATH* was as follows:
Exhaustion with Auto Infeation
(Duration) — Yrs. — mos. 6 ds.
Contributory (Secondary) Psychosis Depressed
(Duration) ..... Yrs. ..... mos. ..... ds.
(Signed) C. A. Greer M. D.
1/29 1921 (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death..... yrs. 1 mos. 13 days. In the State..... yrs..... mos. ..... days
Where was disease contracted if not at place of death? Dont Know
Former or usual residence Pocatello Idaho

19. **PLACE OF BURIAL OR REMOVAL** Asylum Cemetery
DATE OF BURIAL 191
20. **UNDERTAKER** C. E. Wright
ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 121

Primary Registration District No. 1171

(No. ....., ... St.)

FEB 10 1921

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33040

Registered No. 17

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. **PLACE OF DEATH.**

County of Bingham

City of Blackfoot

If death occurs away from usual residence, give facts called for under special information.

2. **FULL NAME** William M. Saulls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. **SEX**: male

4. **COLOR OR RACE**: White

5. **SINGLE, MARRIED, WIDOWED OR DIVORCED.** (Write the word.): Single

6. **DATE OF BIRTH.** May (Month) 8 (Day) 1897 (Year)

7. **AGE**: 23 Yrs. 8 Mos. 25 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. **OCCUPATION**

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer):

9. **BIRTHPLACE**

(State or Country) Tennessee

10. **NAME OF FATHER** [illegible]

11. **BIRTHPLACE OF FATHER**

(State or Country)

12. **MAIDEN NAME OF MOTHER**

13. **BIRTHPLACE OF MOTHER**

(State or Country)

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.**

(Informant) Record Idaho Insane Asylum By Martha E. Hyde Clerk

(Address) Blackfoot Idaho

15.

Filed Jan 31 1921 Valeria E. Patterson Local Registrar

SYMS - YORK CO., PTRS. & BOOKS. 24658

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH**

Jan. (Month) 29 (Day) 1921 (Year)

17. **I HEREBY CERTIFY,** That I attended deceased from Sept 4 1919, to Jan 29 1921, that I last saw him alive on Jan 29 1921, and that death occured on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

Status Epilepticus

(Duration) ..... Yrs. ..... mos. 4 ds.

Contributory (Secondary) Chronic Epilepsy

Duration 4 yrs. ..... mos. ..... ds.

(Signed) C. H. Wright M. D.

1-31 1921 (Address) Blackfoot, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 1 yrs. 4 mos. 25 days. In the State 4 yrs. — mos. — days

Where was disease contracted if not at place of death? Don't know

Former or usual residence Grays Lake Idaho

19. **PLACE OF BURIAL OR REMOVAL**: Caryhurst

DATE OF BURIAL 191

20. **UNDERTAKER**: C. H. Wright

ADDRESS: Blackfoot

FORM V. S. No. 5-21 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Bingham
City of Blackfoot (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 121
Primary Registration District No. 1007

File No. 33041
Registered No. 75

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Martha Tennessee Call

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Dec (Month) 2 (Day) 1859 (Year)

7. AGE: 64 Yrs. 1 Mos. 27 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mo.

10. NAME OF FATHER: Wm. A Downing

11. BIRTHPLACE OF FATHER (State or Country): Tenn.

12. MAIDEN NAME OF MOTHER: Susan Bouchus

13. BIRTHPLACE OF MOTHER (State or Country): Kent Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. D. Downing
(Address) Montpelier Idaho

15. Filed Jan. 31 1921 Mrs Nadine E. Patterson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. (Month) 29 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 26 1921, to Jan 29 1921
that I last saw her alive on Jan 26 1921
and that death occurred on the date stated above, at 2:50 P.M.
The CAUSE OF DEATH* was as follows:

Cardiac insufficiency
(Duration) ..... Yrs. ..... mos. 4 ds.
Contributory (Secondary) Asphyxia Pyrosago
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) M W Beck M. D.
Jan 31 1921 (Address) Blackfoot, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lyons City Cemetery — DATE OF BURIAL: 1-31 1921

20. UNDERTAKER: E. F. Funk — ADDRESS: Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back o

State of Ida
BOARD OF HE
Bureau of Vital

File No. 33

Registered No.

City of Blackfoot (No. 69 No Eleventh St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurr
pital, institutio
give its NAM
street and num

2. FULL NAME Henry Rose

PERSONAL AND STATISTICAL PARTICULA

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARR
OWED OR DIV
Mar
(Write the

6. DATE OF BIRTH: Mar 2 (Month) (Day)

7. AGE: 42 Yrs. 10 Mos. 27 ds.

IF
how
or

8. OCCUPATION
(a) Trade, profession or particular kind of work: Day Labore
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): North Ogd
Utah

10. NAME OF FATHER: Hyrum Rose

11. BIRTHPLACE OF FATHER (State or Country): Tennessee

12. MAIDEN NAME OF MOTHER: Martha E. Sh

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY
(Informant) Mrs Constance
(Address) Blackfoot Ida

15. Filed Jan. 30 19 21 Mrs Hale
Lo

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan 29 (Month) (Day)

17. I HEREBY CERTIFY, That I attended dec
Jan 7 19 21 to Jan 29
that I last saw h alive on Jan 29
and that death occurred on the date stated above, at
The CAUSE OF DEATH* was as follows:
Typhoid Fever

(Duration) Yrs. mos.
Contributory (Secondary): Pneumonia
(Duration) yrs. mos.

(Signed) W. E. Patrick
1/30 19 21 (Address) Blackfoot

*State the Disease Causing Death; or in deaths from Violent
(1) Means of Injury; and (2) whether Accidental, Suicidal or H

18. LENGTH OF RESIDENCE (For Hospitals, I
Transients or Recent Residents.)
At place of death yrs. mos. 5 days. In the State yrs. mo
Where was disease contracted if not at place of death? 64 No Eleventh St
Former or usual residence Blackfoot Idaho

19. PLACE OF BURIAL OR REMOVAL: Weston Ida
DATE OF BURIAL: on arrival 19

20. UNDERTAKER: Ed L Egli
ADDRESS: Blackfoot

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 1007
File No. 33044
Registered No. 18

1. PLACE OF DEATH
County of Bingham
City of Blackfoot
(No. 76 N. Main St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Howard Ray Beam

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single. (Write the word.)

6. DATE OF BIRTH: Dec. (Month) 10 (Day) 1920 (Year)

7. AGE: Yrs. 1 Mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Nampa Idaho

10. NAME OF FATHER Howard B. Beam

11. BIRTHPLACE OF FATHER (State or Country) Oklahoma

12. MAIDEN NAME OF MOTHER Maude Isabel Driver

13. BIRTHPLACE OF MOTHER (State or Country) Texas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Howard B. Beam
(Address) Jerome Idaho

15. Filed Jan. 31 1921 Mrs Hallie E. Fabris Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: January (Month) 31 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 25 1921 to Jan. 31 1921 that I last saw h[illegible] alive on Jan. 31 1921 and that death occurred on the date stated above, at 9-15 P.M.

The CAUSE OF DEATH* was as follows:
Broncho-Pneumonia
(Duration) ..... Yrs. ..... mos. 7 ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. E. Fabris M. D.
1/31/1921 (Address) Blackfoot Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Groveland Cem. Blackfoot | DATE OF BURIAL: Jan. 19

20. UNDERTAKER Acting U. Howard B. Beam | ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 121

Primary Registration District No. 2194

(No. Idaho Insane Asylum St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33045

Registered No. 19

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Bingham

City of Blackfoot

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME T F Mack

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.) Single

6. DATE OF BIRTH. (Month) (Day) 1880 (Year)

7. AGE 40 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work. Hotel Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) New York

10. NAME OF FATHER Dont Know

11. BIRTHPLACE OF FATHER (State or Country) Dont Know

12. MAIDEN NAME OF MOTHER Dont Know

13. BIRTHPLACE OF MOTHER (State or Country) Dont Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Records of Idaho Insane asylum Blackfoot Idaho

(Address) By Julius L Greer. clerk

15. Filed Feb. 1st 1921 Mrs Nellie E. Patrick Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January (Month) 31st (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from December 15th 1920, to January 31st 1921, that I last saw h sm alive on January 31st 1921, and that death occured on the date stated above, at 6.50 P.M.

The CAUSE OF DEATH* was as follows:

Paresis

(Duration) Yrs. mos. ds.

Contributory (Secondary) Exhaustion due to Asylum

Excited (Duration) 1 yrs. 1 mos. 16 ds.

(Signed) C. T. Jones M. D.

2/1 1921 (Address) Blackfoot, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 1 yrs. 1 mos. 16 days. In the State yrs. mos. days

Where was disease contracted if not at place of death? Dont Know

Former or usual residence Salt Lake City, Utah

19. PLACE OF BURIAL OR REMOVAL Middleton Ny. **DATE OF BURIAL** 191

20. UNDERTAKER E J Peck ADDRESS Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 85 MAR 10 1921

Primary Registration District No. 2185

File No. 1 33046

Registered No. 23

County of Bonner

City of Priest River, Ida (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME ~~Mrs~~ Clamatis Rock

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Single

6. DATE OF BIRTH: Feb (Month) 13 (Day) 1921 (Year)

7. AGE: ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many 2 hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: ~~Mrxxxxxxx~~ Walter Rock

11. BIRTHPLACE OF FATHER (State or Country): Wis.

12. MAIDEN NAME OF MOTHER: Nora Seymour

13. BIRTHPLACE OF MOTHER (State or Country): Minn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Walter J Rock

(Address) Priest River, Ida

15. Filed Mch 1 1921 C. P. Gehlhoff Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 13 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 13 1921 to Feb 13 1921, that I last saw her alive on Feb 13 1921, and that death occurred on the date stated above, at 11.30 A.M.

The CAUSE OF DEATH* was as follows:

Respiratory failure

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. P. Gehlhoff M. D.

Feb 13 1921 (Address) Priest River Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR ~~REMOVAL~~	DATE OF BURIAL
Priest River	Feb 14 1921

20. ~~UNDERTAKER~~	ADDRESS
Neighbor Elmer Stone	Priest River Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bonners

City of Priest River (No. ....., ... St.)

Registration District No. 85

Primary Registration District No. 2185

MAR 10 1921

File No. 33047

Registered No. 32

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Margurite Wray Reynolds

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): widdowe

6. DATE OF BIRTH: January (Month) 24 (Day) 1837 (Year)

7. AGE: 44 Yrs. — Mos. 25 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.? —

8. OCCUPATION

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Gallia Co Ohio

10. NAME OF FATHER William Miller

11. BIRTHPLACE OF FATHER (State or Country) Ohio

12. MAIDEN NAME OF MOTHER Margret M Miller

13. BIRTHPLACE OF MOTHER (State or Country) Gallia Co Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) Priest River Ida

15. Filed March 1 1921 C. F. Getzloff Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 18 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 16 1921, to Feb 18 1921, that I last saw her alive on Feb 16 1921, and that death occurred on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) — Yrs. — mos. 5 ds.

Contributory (Secondary) .....

(Duration) — yrs. — mos. — ds.

(Signed) C. F. Getzloff M. D.

Feb 19 1921 (Address) Priest River, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Priest River — DATE OF BURIAL: Feb 20 1921

20. UNDERTAKER: John Merrick — ADDRESS: Priest River

Merrick

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

MAR 10 1921

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 23 — File No. 33049

Primary Registration District No. 21 J-0 — Registered No. 2

1. PLACE OF DEATH

County of Bannock

City of Ida Falls (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Teddie B Saterfield

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Infant

6. DATE OF BIRTH: Dec (Month) 10 (Day) 1919 (Year)

7. AGE: 1 Yrs. 1 Mos. 4 ds. — IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Teddie F Saterfield

11. BIRTHPLACE OF FATHER (State or Country) Texas

12. MAIDEN NAME OF MOTHER Edith Butler

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Butler
(Address) City

15. Filed 1/17 1921 — Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jany (Month) 14 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 20 1920 to Jan 14 1921 that I last saw h.. alive on Jan 14 1921, and that death occurred on the date stated above, at 4a M.

The CAUSE OF DEATH* was as follows:

Enterocolitis

(Duration) ..... Yrs. ..... mos. 30 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. B. Spencer M. D.

1/17 1921 (Address) Ida Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Pocatello	1-16 1921

20. UNDERTAKER	ADDRESS
E E Dinwoodey	Ida Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

MAR 10 1921

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 21 J-0
File No. 33050
Registered No. 1

1. PLACE OF DEATH
County of Bonneville
City of Lincoln
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Frank Earl Hogan

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Jan (Month) 2 (Day) 1921 (Year)

7. AGE: ..... Yrs. ..... Mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Lincoln Idaho.

10. NAME OF FATHER: Chas. Frank Hogan

11. BIRTHPLACE OF FATHER (State or Country): Louisiana

12. MAIDEN NAME OF MOTHER: Hannah Dodge.

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Walter Dodge
(Address) Rigby R 2

15. Filed Jan 1 1921 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 5 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 2 1921, to Jan 6 1921
that I last saw him alive on Jan 4 1921
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Pneumonia

(Duration) ..... Yrs. ..... mos. 2 ds.
Contributory (Secondary) Jaundice
(Duration) ..... yrs. ..... mos. 2 ds.

(Signed) Geo. A. Tupperle M.D.
19 ..... (Address) Idaho Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. 3 days. In the State ..... yrs. ..... mos. 3 days
Where was disease contracted if not at place of death? Lincoln
Former or usual residence Lincoln

19. PLACE OF BURIAL OR REMOVAL: Rigby Ida — DATE OF BURIAL: Jan 6 1921

20. UNDERTAKER: [illegible] — ADDRESS: Rigby

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51038

FORM V. S. No. 5-25 M. 1-19.

MAR 10 19

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 59
Primary Registration District No. 2129
File No. 33051
Registered No.

1. PLACE OF DEATH
County of Butte
City of Arco
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Joseph Westley Winger
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: June (Month) 7 (Day) 1903 (Year)

7. AGE: 18 Yrs. 8 Mos. 19 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: A. H. Winger

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Ruth Cooper

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A. H. Winger
(Address) Arco Ida

15.
Filed ..... 19 .....
W. M. Cannon
Local Registrar
acting

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 25 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2-21-1921, to 2-25-1921 that I last saw him alive on 2-25-1921 and that death occurred on the date stated above, at 4 P.M.
The CAUSE OF DEATH* was as follows:
Lobar Pneumonia
(Duration) ..... Yrs. ..... mos. 5 ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) W. M. Cannon M.D.
2-26 1921 (Address) Arco Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR ~~REMOVAL~~: Arco — DATE OF BURIAL: 2/27 1921

20. UNDERTAKER: A. H. Winger — ADDRESS: Arco

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

amended 12/27/78

CERTIFICATE OF DEATH

MAR 10

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 59
Primary Registration District No. 2129
File No. 33052
Registered No.

1. PLACE OF DEATH
County of Butte
City of Arco
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Waite

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: 1 (Month) 27 (Day) 21 (Year)

7. AGE: ..... Yrs. ..... Mos. 16 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Arco, Idaho

10. NAME OF FATHER: Albert Waite

11. BIRTHPLACE OF FATHER (State or Country): Afton, Wyoming

12. MAIDEN NAME OF MOTHER: Olga May Nichols

13. BIRTHPLACE OF MOTHER (State or Country): Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Albert Waite
(Address) Arco, Idaho

15. Filed 2/13 19 21 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 2 (Month) 11 (Day) 19 21 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2/10 19 21 to 2/11 19 21
that I last saw h~~im~~ alive on 2/11 19 21
and that death occurred on the date stated above, at 29 M.
The CAUSE OF DEATH* was as follows:
Bronchial Pneumonia
(Duration) ..... Yrs. ..... mos. 3 ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) [illegible] M. D.
2/13 19 21 (Address) Arco, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Arco, Ida. DATE OF BURIAL: 2/14 19 21

20. UNDERTAKER: McHenry ADDRESS: Arco, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

IDAHO DEPARTMENT OF HEALTH AND WELFARE
Bureau of Vital Statistics

AFFIDAVIT TO CORRECT OR AMEND AN ORIGINAL CERTIFICATE

State of _____ } ss.
County of _____ }

Certificate No. 33052
Date Filed _____

The undersigned does solemnly swear that certain facts on the certificate of death for Unnamed male Waite (Name on Original Certificate) who died (Was Born, Died, etc.) on February 11, 1921 (Date of Event) in Arco, ID (Butte) (Place of Event) are erroneous or were omitted:

ITEMS TO BE CORRECTED	FROM	TO
mother's name	Alva Nicholes	Olga May Nichols

Subscribed and sworn to before me this 27th day of December, 1972.
Notary Public, Florence Curtright
Residing at Boise
My commission expires Lifetime
(Seal)

Reva N. Walker
Signature of Applicant
Box 32 Arco Idaho 83213
Street Address, City, State

SUPPORTING AFFIDAVIT OF A SECOND PERSON

State of _____ } ss.
County of _____ }

(Must be completed __)
(Is not necessary X)

The undersigned does solemnly swear that he has knowledge of the facts as set forth above and that they are true to the best of his knowledge.

Subscribed and sworn to before me this _____ day of _____, 19__.
Notary Public, _____
Residing at _____
My commission expires _____
(Seal)

_____
Supporting Signature

_____
Street Address, City, State

Sister's birth certificate, #98342, born February 3, 1922, in Moore, Idaho, named Reva Waite, lists mother as Olga May Nichols.
viewed by vs December 27, 1978

DEC 27 1978

Family record, dated January 25, 1972, lists name as Olga May Nichols.
viewed by vs December 27, 1978

FORM V. S. No. 5-25 M. 1-19.

MAR 10 1921

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 59
Primary Registration District No. 2320
File No. 33053
Registered No.

1. PLACE OF DEATH
County of Butte
City of Arco
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Albert Gardner
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word)

6. DATE OF BIRTH: Aug 28 1863 (Month) (Day) (Year)

7. AGE: 58 Yrs. 5 Mos. 22 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: James Gardner

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Elsie Gardner
(Address) Arco Ida

15. Filed 2/20/21 19.... J.M. Cannon Local Registrar acting

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb 19 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 16, 1921 to Feb 19 1921 that I last saw ~~him~~ alive on Feb 19 1921 and that death occurred on the date stated above, at 8 A.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ..... Yrs. ..... mos. 6 ds.

Contributory (Secondary) Valvular Heart disease

(Duration) 2 yrs. ..... mos. ..... ds.

(Signed) J.M. Cannon M.D.

2/21 1921 (Address) Arco

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Paton Ida
DATE OF BURIAL: 2/22 1921

20. UNDERTAKER: W.T. Peck
ADDRESS: Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

MAR 1 0 1921

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 59
Primary Registration District No. 2129
File No. 33054
Registered No.

1. PLACE OF DEATH
County of Butte
City of Arco
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Louis Farnell Andreason

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single
6. DATE OF BIRTH: April (Month) 19 (Day) 1909 (Year)
7. AGE: 11 Yrs. 11 Mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Eureka, Utah
10. NAME OF FATHER: Lewis Andreason
11. BIRTHPLACE OF FATHER (State or Country): Ephraim Utah
12. MAIDEN NAME OF MOTHER: Lenora Allred
13. BIRTHPLACE OF MOTHER (State or Country): Springville, Utah
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Lewis Andreason
(Address) Arco, Idaho
15. Filed 1/31 1921 E. W. Fox Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan 29 (Month) (Day) 1921 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Jan 24 1921 to Jan 29 1921
that I last saw h[illegible] alive on Jan 29 1921
and that death occurred on the date stated above, at 4 9 M.
The CAUSE OF DEATH* was as follows:
Lobar Pneumonia
(Duration) ..... Yrs. ..... mos. 5 ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) E. W. Fox M. D.
1/30 1921 (Address) Arco, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Arco, Idaho
DATE OF BURIAL: 2/1 1921
20. UNDERTAKER: [illegible]
ADDRESS: Arco, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

MAR 10 1921

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 58th
Primary Registration District No. 2138
(No. ..... , ... St.)

File No. 33055
Registered No. .....

1. PLACE OF DEATH
County of Camas
City of Soldier
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sam Rowland
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widower

6. DATE OF BIRTH: Aug. (Month) 25th (Day) 1849 (Year)

7. AGE: 71 Yrs. 4 Mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: —

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Camas County Courier
(Address) Fairfield, Idaho

15. Filed Feb. 9 1921 — L Wilencheck, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: January (Month) 5 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 23 1920, to Jan 3 1921, that I last saw him alive on Jan 3 1921, and that death occurred on the date stated above, at 3:00 a M.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) 15 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) L Wilencheck M. D.

Feb 9 1921 (Address) Fairfield, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL ..... 19.....

20. UNDERTAKER | ADDRESS

FORM V. S. No. 5-A—25 M. 1-19.

MAR 1921

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 1006
File No. 33056
Registered No.

1. PLACE OF DEATH
County of Canyon
City of Nampa
(No. 315 - 12th Ave S St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lyndon J. Dell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	white	Married

6. DATE OF BIRTH
Feb (Month) 4 (Day) 1875 (Year)

7. AGE
46 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work R.R. Employee
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Iowa

10. NAME OF FATHER James Dell

11. BIRTHPLACE OF FATHER (State or Country) Canada

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER (State or Country) Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs L. G. Dell
(Address) Nampa Ida.

15.
Filed Jan. 25 1921 Pearle Dodds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Jan (Month) 19 (Day) 19 21 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred on the date stated above, at 7 a.m.
The CAUSE OF DEATH* was as follows:
Self inflicted gun shot wound —

(Duration) Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) Jas. L. Baird M. D.
19..... (Address) Caldwell Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Vale Oregon	1-21 1921

20. UNDERTAKER	ADDRESS
Fred Robinson	Nampa

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 1006
File No. 3357
Registered No.

1. PLACE OF DEATH
County of Canyon
City of Nampa
(No. 306 — 10th St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Infant of Mr. & Mrs. J. D. Simpson
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.):

6. DATE OF BIRTH: Jan (Month) 22 (Day) 21 (Year)

7. AGE: ....Yrs....Mos. 1 ds.
IF LESS than 1 day how many....hrs. or....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: J D Simpson

11. BIRTHPLACE OF FATHER (State or Country): Ontario

12. MAIDEN NAME OF MOTHER: Ellen Armstrong

13. BIRTHPLACE OF MOTHER (State or Country): Ontario

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J D Simpson
(Address) Nampa Ida

15. Filed Feb 10 1921 Pearle Dodds
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 23 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 22 1921, to Jan 23 1921, that I last saw her alive on Jan 23 1921, and that death occurred on the date stated above, at 4 P. M.
The CAUSE OF DEATH* was as follows:
Prematurity
....(Duration) ....Yrs....mos. 1 ds.
Contributory (Secondary)
....(Duration) ....yrs....mos....ds.
(Signed) Marion D. Jones M. D.
Feb 1921 (Address) Nampa Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Nampa Ida
DATE OF BURIAL: 1-24 1921

20. UNDERTAKER: None.
ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Canyon

City of Nampa

Registration District No. 7

Primary Registration District, No. 1006

(No. State Sanitarium St.)

File No. 33058

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Domingo Conayo

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. (Month) (Day) (Year): 1887

7. AGE: 34 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Sheep Herder
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Spain

10. NAME OF FATHER: Marcelo Conayo

11. BIRTHPLACE OF FATHER (State or Country): Spain

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Spain

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Dr. Coyner
(Address) Nampa Idaho

15. Filed Feb. 10 1921 Pearle Dodds Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (Month) January (Day) 16th 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 1 1920, to Jany 16 1921, that I last saw him alive on Jany 15 1921, and that death occured on the date stated above, at 6 A. M.

The CAUSE OF DEATH* was as follows:
Chronic Nephritis

(Duration) 2 Yrs. 4 mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Dr. Coyner M. D.

1/16 1921 (Address) Nampa

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. 8 mos. 16 days. In the State 14 yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? Beaverhead Co Idaho
Former or usual residence Mt. Home Idaho Co

19. PLACE OF BURIAL OR REMOVAL: Nampa Idaho — DATE OF BURIAL: 1-19 1921

20. UNDERTAKER: Fred K. Robinson — ADDRESS: Nampa Idaho

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33059.
Registered No.

Registration District No.
Primary Registration District No. 1056

1. PLACE OF DEATH
County of Canyon
City of Nampa
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Earl Emerson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: July (Month) 1 (Day) 1907 (Year)

7. AGE: 13 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: In school
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Eugene Emerson

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Bogue

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs E Emerson
(Address) Nampa Ida

15. Filed Feb 13 1921 Pearle Dodds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 3d (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 31, 1921, to Feb 3d 1921
that I last saw him alive on Feb 3d 1921
and that death occurred on the date stated above, at 8 P. M.
The CAUSE OF DEATH* was as follows:
Diptheria

(Duration) Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) Thos E. Mangum M. D.
Feb 3d 1921 (Address) Nampa Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Nampa Ida — DATE OF BURIAL: 2/5 1921

20. UNDERTAKER: Fred K. Robinson — ADDRESS: Nampa Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 1004
File No. 33060
Registered No.

1. PLACE OF DEATH
County of Canyon
City of Nampa
If death occurs away from usual residence, give facts called for under special information.

(No. Nurses Hospital St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Annie M. Berry

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Fem	White	Married

6. DATE OF BIRTH
Mar (Month) 4 (Day) 1890 (Year)

7. AGE
31 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Vancouver

10. NAME OF FATHER J. H. Walle

11. BIRTHPLACE OF FATHER (State or Country) Norway

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER (State or Country) Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. Berry
(Address) Nampa Ida

15. Filed Feb 10 1921 Pearle Dodds Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Febr. (Month) 3rd (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 26th, 1921, to Feb. 3rd 1921.
that I last saw her alive on Febr. 2nd 1921.
and that death occurred on the date stated above, at 1:30 P.M.
The CAUSE OF DEATH* was as follows:
Mitral insufficiency
(Duration) 12 Yrs. mos. ds.
Contributory (Secondary) Heart block and acute dilitation (Duration) 5 yrs. 0 mos. 16 ds.
(Signed) Geo. D. A. Kellogg M. D.
19 (Address) Nampa, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Nampa Idaho | DATE OF BURIAL 2-6 1921

20. UNDERTAKER Fred K. Robertson | ADDRESS Nampa

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

K

FORM V. S. No. 5-A—25 M. 1-19.

MAR 10

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7

Primary Registration District No. 1004

File No. 33061

Registered No.

1. PLACE OF DEATH

County of Canyon

City of Nampa

If death occurs away from usual residence, give facts called for under special information.

(No. 503 - 11th S St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Robert Jeriah

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.):

6. DATE OF BIRTH: Jan (Month) 20 (Day) 92 (Year)

7. AGE: ... Yrs. - Mos. 7 ds.

IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: V

(b) General nature of industry, business or establishment in which employed (or employer): 1

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country): Ill.

12. MAIDEN NAME OF MOTHER: Robinson

13. BIRTHPLACE OF MOTHER (State or Country): Colo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jas Prewett

(Address) Nampa Ida

15. Filed Feb. 10 1921 Pearle Dodds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 27 (Day) 21 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 26 1921, to Jan 27 1921, that I last saw him alive on Jan 26 1921, and that death occurred on the date stated above, at ... P.M.

The CAUSE OF DEATH* was as follows:

Prematurity

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary) Congenital

(Duration) ... yrs. ... mos. 4 ds.

(Signed) Geo R Proctor M. D.

Jan 27 1921 (Address) Nampa Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Nampa Ida — DATE OF BURIAL: 1/29 1921

20. UNDERTAKER: J K Robinson — ADDRESS: Nampa

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

P

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 1006
File No. 33062
Registered No.

1. PLACE OF DEATH
County of Canyon
City of Nampa
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James F. Waltman.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married.

6. DATE OF BIRTH
Oct (Month) 7 (Day) 1846 (Year)

7. AGE
74 Yrs. 3 Mos. 4 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Farmer retired.
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Ohio

10. NAME OF FATHER Philip Waltman

11. BIRTHPLACE OF FATHER (State or Country) Ohio

12. MAIDEN NAME OF MOTHER Katherine Finke

13. BIRTHPLACE OF MOTHER (State or Country) Ohio.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H. C. Waltman.
(Address) Nampa Ida.

15. Filed Feb. 10 1921 Pearle Dodds Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Jan (Month) 11 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 1 1920, to Jan 10 1921, that I last saw h.im alive on Jan 10 1921 and that death occurred on the date stated above, at 2 A M.
The CAUSE OF DEATH* was as follows:
Cardiac Insufficiency.
"Valvular"

(Duration) Yrs. 3 mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) H. V. Ross M. D.
Jan 11 1921 (Address) Nampa Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death, yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Rockdale	1/13 1921

20. UNDERTAKER	ADDRESS
Ford & Robinson	Nampa

Ross.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 2006
File No. 33064
Registered No.

1. PLACE OF DEATH

County of
City of
(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James C Barnard

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH: Nov (Month) 25 (Day) 1840 (Year)

7. AGE: 81 Yrs. 1 Mos. 25 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Prince Edward Isle B.C.

10. NAME OF FATHER: James C Barnard

11. BIRTHPLACE OF FATHER (State or Country): Prince Edward Isle B.C. ~~Scotland~~

12. MAIDEN NAME OF MOTHER: Jane McLeod

13. BIRTHPLACE OF MOTHER (State or Country): Prince Ed Isle B.C.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R. J. Gifford
(Address) Milton Ida

15. Filed Jan 25 1921 Pearle Dodds Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 19 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I ~~attended~~ knew of condition of deceased from Nov 23 1920, to Jan 19 1921, that I last saw h alive on 19, and that death occurred on the date stated above, at 9 P.M.

The CAUSE OF DEATH* was as follows:

Hemorrhage of lung following an attack of Pneumonia

(Duration) Yrs. 2 mos. ds.

Contributory (Secondary) Age + Chronic bronchitis

(Duration) 5 yrs. mos. ds.

(Signed) J H Murray M. D.

1/25 1921 (Address) Nampa Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Reynolds Cem	1-21 1921

20. UNDERTAKER	ADDRESS
Fred H Robinson	Nampa

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 2006
File No. 95065
Registered No.

1. PLACE OF DEATH
County of Canyon
City of Nampa
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME E. G. Rose

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.):

6. DATE OF BIRTH: Dec (Month) 13 (Day) 1835 (Year)

7. AGE: 85 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer): (Retired)

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Daniel Rose

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: Russell

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H. S. Neal
(Address) Nampa Idaho

15. Filed Jan. 25 1921 Pearle Dodds Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) – 19 (Day) – 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 19 1921, to Jan 19 1921, that I last saw h— alive on Jan 19 1921, and that death occurred on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

Apoplexy

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary): Mitral insufficiency

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Thos. E. Mangum M. D.

Jan 19 1921 (Address) Nampa, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Yakima Wash — DATE OF BURIAL: 1 – 1921

20. UNDERTAKER — ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

M

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 2006
File No. 33066
Registered No.

1. PLACE OF DEATH
County of Canyon
City of Melba
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Aline Ellen Walker
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: 1 (Month) — 21 (Day) 1921 (Year)

7. AGE: ....Yrs....Mos....ds.
IF LESS than 1 day how many 7 hrs. or 30 min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: ✓
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Melba, Canyon Co, Ida.

10. NAME OF FATHER: John Robert Walker

11. BIRTHPLACE OF FATHER (State or Country): Colorado

12. MAIDEN NAME OF MOTHER: Martha Elizabeth Moore

13. BIRTHPLACE OF MOTHER (State or Country): Wyoming

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Robert Walker.
(Address) Melba. Ida.

15. Filed Jan. 25 1921 Pearle Dodds Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 1 (Month) — 21 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1-21 1921, to 1-21 1921, that I last saw her alive on 1-21-1921, and that death occurred on the date stated above, at 7:45 A.M.

The CAUSE OF DEATH* was as follows:
Prematurity — utero gestation seven months
½ hrs.
(Duration) ....Yrs....mos....ds.

Contributory (Secondary)
(Duration) ....yrs....mos....ds.

(Signed) Samuel A Swayne M. D.
1-21-1921 (Address) Melba, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Melba	1-22 1921
20. UNDERTAKER	ADDRESS
—	—

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

MAR 10 1921

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 2004
File No. 3367
Registered No.

1. PLACE OF DEATH
County of Canyon
City of Melba
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Gladys Cummins
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Nov. (Month) 7 (Day) 1913 (Year)

7. AGE: 17 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Invalid.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Okla

10. NAME OF FATHER: H. H Cummins

11. BIRTHPLACE OF FATHER (State or Country): Ind.

12. MAIDEN NAME OF MOTHER: Katherine Mathews

13. BIRTHPLACE OF MOTHER (State or Country): Wales

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H. H. Cummins
(Address) Melba Ida

15. Filed Feb 10 1921 Pearle Dodds
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 12 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 9 1921, to Jan 9 1921
that I last saw her alive on Jan 9th 1921
and that death occurred on the date stated above, at —— M.
The CAUSE OF DEATH* was as follows:
Insufficient secretion of the pituitary gland
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Lobar pneumonia
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Thos R Morgan M. D.
Jan 13 1921 (Address) Nampa Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Melba Cemet. DATE OF BURIAL: 1/14 1921
20. UNDERTAKER: Fred H Robinson ADDRESS: Nampa

Swond + Morgan

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

MAR 10 1921

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33069

Registered No. .....

Registration District No. 7

Primary Registration District No. 2006

1. PLACE OF DEATH.

County of Canyon

City of Nampa

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Huber

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. ~~Feb~~ (Month) ..... (Day) 1873 (Year)

7. AGE: 48 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Unknown

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) O'Connor Coyner

(Address) Nampa Idaho

15. Filed Feb 10 1921 Pearle Dodds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feby (Month) 4 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mch 1920, to Feby 4 1921, that I last saw her alive on Feby 4 1921, and that death occured on the date stated above, at 8 A.M.

The CAUSE OF DEATH* was as follows:

Diabetes Mel.

..... (Duration) 6 Yrs. ..... mos. ..... ds.

Contributory (Secondary) Broken Arm

..... (Duration ..... yrs. ..... mos. 1 ds.

(Signed) O'Connor Coyner M. D.

2/4 1921 (Address) Nampa Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs 11 mos. 2 days. In the State ..... yrs ..... mos ..... days

Where was disease contracted if not at place of death? Blackfoot Idaho

Former or usual residence Boise Idaho

19. PLACE OF BURIAL OR REMOVAL: Boise Ida. | DATE OF BURIAL: 2-5-1921

20. UNDERTAKER: Fred H Robinson | ADDRESS: Nampa

SYMS - YORK CO., PTRS. & BOOKS. 24658

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 2004
(No. ..... St.)

File No. 33070
Registered No. .....

1. PLACE OF DEATH
County of Canyon
City of Nampa
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Nellie Davis
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word.): Married

6. DATE OF BIRTH: Nov (Month) 8 (Day) 1871 (Year)

7. AGE: 49 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Calif

10. NAME OF FATHER: Alfred Pogan

11. BIRTHPLACE OF FATHER (State or Country): Mo

12. MAIDEN NAME OF MOTHER: Rodergoss

13. BIRTHPLACE OF MOTHER (State or Country): .....

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) M. L. Davis
(Address) Nampa Ida

15. Filed Feb. 10 1921 Pearle Dodds
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. (Month) 9 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9-20 1920, to 1-9 1921 that I last saw h.. alive on 1-8 1921, and that death occurred on the date stated above, at 6 A.M.

The CAUSE OF DEATH* was as follows:
Chronic Nephritis

..... (Duration) ..... Yrs. 11 mos. ..... ds.
Contributory (Secondary) Influenza
..... (Duration) ..... yrs. 2 mos. ..... ds.

(Signed) H. E. Robinson M. D.
1-11 1921 (Address) Nampa Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Nampa Ida
DATE OF BURIAL: 1-12 1921

20. UNDERTAKER: H. E. Robinson
ADDRESS: Nampa

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-12 M. 6-15-17.

MAR 10

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3971
Registered No. 478
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Cassia

City of Burley

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 117

Primary Registration District No. 2196

(No. [redacted] N. Main St.)

2. FULL NAME Hattie Waples Ridd

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female

4. COLOR OR RACE White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.) Married

6. DATE OF BIRTH. June 6, 1889
(Month) (Day) (Year)

7. AGE 32 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many .... hrs. or .....min.?'

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): formerly School Teacher

9. BIRTHPLACE
(State or Country) Salt Lake City Utah.

10. NAME OF FATHER Wm. Waples

11. BIRTHPLACE OF FATHER
(State or Country) Penn.

12. MAIDEN NAME OF MOTHER Leone Chambers

13. BIRTHPLACE OF MOTHER
(State or Country) Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A. M. Solomon
(Address) Solomon Davidson, Burley

15.
Filed Jan 26 1921. Ida Dr. J. C. Patterson
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan 26 - 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 26 1921 to Jan 26 1921
that I last saw h.. alive on Jan 26 1921
and that death occurred on the date stated above, at 10:25 P.M.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of Heart

.....(Duration) ..... Yrs..... mos. ..... ds.

Contributory (Secondary) .....

.....(Duration) ..... Yrs..... mos. ..... ds.

(Signed) F. H. Cowley M. D.

.....19.... (Address) Burley

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Salt Lake City Utah.

DATE OF BURIAL Jan 29. 1921

20. UNDERTAKER L. B. Talbot

ADDRESS Burley Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

Registration District No. 11

Primary Registration District No. 2196

(No. ....., ... St.)

Burley.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33072
Registered No. 2 .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Cassia.
City of Burley.
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Alvira Smith.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH. May (Month) 1st (Day) 1854 (Year)

7. AGE: 66 Yrs. 8 Mos. 12 ds.
IF LESS than 1 day how many .... hrs. or .....min.?'

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Utah.

10. NAME OF FATHER Johnithon Partridge.

11. BIRTHPLACE OF FATHER (State or Country) New York.

12. MAIDEN NAME OF MOTHER Mary A. Whittaker.

13. BIRTHPLACE OF MOTHER (State or Country) Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Silas Smith.
(Address) Burley Ida. Box 457.

15. Filed Feb 5-21 1921. Dr. J. C. Patterson Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan. (Month) 12 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 12 1921 to Jan. 12 1921 that I last saw her alive on Jan. 12 1921 and that death occurred on the date stated above, at 9:30 P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia Croupous Nephritis

(Duration) ..... Yrs. 3 mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) W. C. Burley M. D.

1/26 1921 (Address) Burley, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs.....mos....days. In the ,State....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Burley Ida. DATE OF BURIAL: Jan. 14, 1921.

20. UNDERTAKER: L. B. Bellegy. ADDRESS: Burley Ida.

of OCCUPATION is very important. See instructions on back of certificate. Exact statement

FORM V. S. No. 5-12 M. 6-15-17.

MAR 10 1921

Cullen.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33073
Registered No. 708

Registration District No. 11
Primary Registration District No. 2196

1. PLACE OF DEATH
County of Cassia
City of Burley
If death occurs away from usual residence, give facts called for under special information.
(No. 332 So Hanson St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Jack Jones.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. March (Month) 20 (Day) 1920 (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many .... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home.
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Salt Lake City Utah.

10. NAME OF FATHER: Edward Jones.

11. BIRTHPLACE OF FATHER (State or Country): Utah.

12. MAIDEN NAME OF MOTHER: Isabelle Brimhall.

13. BIRTHPLACE OF MOTHER (State or Country): Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A. L. Jones 332 So Hanson
(Address) Burley Ida.

15. Filed Jan 29 1921 Dwight Pattison Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH ..... Jan. (Month) 25 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 24 1921 to Jan 24 1921 that I last saw h.. alive on Jan 25 1921 and that death occurred on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

..... Pneumonia .....

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) L. K. Corbett M. D.

..... 19.... (Address) Burley Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs....mos....days. In the State....yrs....mos....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Burley Ida. DATE OF BURIAL: Jan 27 1921

20. UNDERTAKER: L. B. Tillotson ADDRESS: Burley Ida.

FORM V. S. No. 5-25 M. 1-16-18

CERTIFICATE OF DEATH.

MAR 10 1921

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33074

Registered No. .....

1. PLACE OF DEATH.

County of Cassia

City of Rubleit

Registration District No. 119

Primary Registration District No. .....

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Orin Madison Olson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. August 29 1920
(Month) (Day) (Year)

7. AGE: ..... Yrs. 5 Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Infant
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Rubleit Idaho

10. NAME OF FATHER Arnold Olson

11. BIRTHPLACE OF FATHER (State or Country) Snowville Utah

12. MAIDEN NAME OF MOTHER Edvira Horn

13. BIRTHPLACE OF MOTHER (State or Country) Rubleit Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Daniel Horn
(Address) .....

15. Filed Feb 7 1921 C. I. Slater Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January 29 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from January 20 1921, to January 30 1921, that I last saw him alive on January 28 1921, and that death occured on the date stated above, at 10 P M.

The CAUSE OF DEATH* was as follows:
Bronchial Pneumonia

(Duration) — Yrs. — mos. 10 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. I. Slater M. D.
2/7 1921 (Address) Malta Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death..... yrs. 5 mos. ..... days In the State..... yrs. 5 mos. ..... days

Where was disease contracted if not at place of death? At place of death

Former or usual residence Same

19. PLACE OF BURIAL OR REMOVAL: Rubleit Idaho — DATE OF BURIAL: Feb 1 1921

20. UNDERTAKER — ADDRESS —

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STNRS. 24858

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

MAR 10 1921

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 90
Primary Registration District No. 2168
File No. 33075
Registered No. ✓

1. PLACE OF DEATH.
County of Clearwater
City of Orofino (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME W. H. Terry

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH
About (Month) 1 (Day) 1853 (Year)

7. AGE
About 68 yrs. ✓ mos. ✓ ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Farming
(b) General nature of industry business, or dstablishment in which employed (or employer) Agriculturing & Stock Raising

9. BIRTHPLACE (State or Country) Illinois

10. NAME OF FATHER ?

11. BIRTHPLACE OF FATHER (State or Country) ?

12. MAIDEN NAME OF MOTHER ?

13. BIRTHPLACE OF MOTHER (State or Country) ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. W. Atteberry
(Address) Orofino, Idaho

15. Filed Feby 12 1921 J. M. Fain Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
January (Month) 15th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 19th 1913, to January 15th 1921, that I last saw h. m. alive on January 15th 1921 and that death occurred on the date stated above, at 4:30 P.M.

The CAUSE OF DEATH* was as follows:
Cancer of Lip and Nose
?
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Insanity
(Duration) ? yrs. ..... mos. ..... ds.
(Signed) J. Shawen Williams M. D.
1/18 1921 (Address) Orofino Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 7 yrs. 6 mos. 28 days. In the State about 7 yrs. 7 mos. 5 days.
Where was disease contracted if not at place of death? Unknown & Marshall, Texas
Former or usual residence Alberta Canada

19. PLACE OF BURIAL OR REMOVAL: Grave #11 Row #4 New Sec. The North Lawn Cemetery
DATE OF BURIAL: Jan. 18 1921

20. UNDERTAKER: P. M. Johnson
ADDRESS: Orofino, Idaho

SYMS - YORK CO., PTRS. & BDRS. 19760

MAR 10 1921

Form V. S. No. 5 20M.1-10-[illegible]

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Clearwater
City of Orofino
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 90
Primary Registration District No. 2168
(No. ....., ... St.)

File No. 33076
Registered No. 3
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME H. T. Crowder

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH
..... (Month) ..... (Day) 1839 (Year)

7. AGE
About 82 yrs. ✓ mos. ✓ ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry business, or establishment in which employed (or employer): None

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. W. Atteberry
(Address) Orofino Idaho

15. Filed Feb 5 1921 J. M. Faile Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
February (Month) 4th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 11, 1919 ~~191~~, to February 4, 1921 ~~191~~, that I last saw h[illegible] alive on February 3rd ~~191~~ 1921 and that death occurred on the date stated above, at 8:15 A.M.

The CAUSE OF DEATH* was as follows:
Arteria Sclerosis
Unknown
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Insanity
(Duration) Unknown yrs. / mos. ..... ds.
(Signed) John O'Rivers M. D.
(Address) Orofino, Idaho
Mar. 1 1921

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 1 yrs. 2 mos. 14 days. In the State 4 yrs. mos. days.
Several Years
Where was disease contracted if not at place of death? Unknown
Former or usual residence Lewiston, Idaho.

19. PLACE OF BURIAL OR REMOVAL: Grave 12 Row 4 New Addn Th N.L. Sanitarium Cemetery
DATE OF BURIAL: Feb. 7 1921

20. UNDERTAKER: P. M. Johnson
ADDRESS: Orofino Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

BYNS - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

MAR 10 19[illegible]

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33077

Registered No. 6

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No. 40

Primary Registration District No. 2168

County of Clearwater

City of Orofino (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James Roden

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: 1 (Month) (Day) 832 (Year)

7. AGE: 89 yrs. ✓ mos. ✓ ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher
(b) General nature of industry business, or establishment in which employed (or employer): Stock Raising & Farming

9. BIRTHPLACE (State or Country): Tennessee

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. W. Atteberry
(Address) Orofino Idaho

15. Filed Feb 9 1921 J. M. Faile Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: February (Month) Eighth (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 21st 1917 to Feb. 8th 1921, that I last saw him alive on Feb. 8th 1921 and that death occurred on the date stated above, at 10:31 P.M.

The CAUSE OF DEATH* was as follows:

Epilepsy

Unknown

(Duration) Unknown yrs. mos. ds.

Contributory (Secondary) Insanity

(Duration) Unknown yrs. mos. ds.

(Signed) John Summers M. D.

Feb. 10 1921 (Address) Orofino, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 3 yrs. 4 mos. 19 days. In the State Many Years yrs. mos. days.
Where was disease contracted if not at place of death? Unknown
Former or usual residence Clark Fork, Idaho

19. PLACE OF BURIAL OR REMOVAL: Grave #13 Row 4 New Add. Ft. Northern Idaho Veritaries
DATE OF BURIAL: Feb. 10 1921

20. UNDERTAKER: P. M. Johnson
ADDRESS: Orofino, Idaho

SYMS - YORK CO., PTRS. & BDRS. 19780

FORM V. S. No. 5-25 M. 1-19.

MAR 10 1921

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 90
Primary Registration District No. 2168
File No. 33078
Registered No.

1. PLACE OF DEATH
County of Clearwater
City of Orofino
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Daniel Raymond

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Indian
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: April 8 (Month) (Day) 901 (Year)

7. AGE: 19 Yrs. 10 Mos. 5 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Govt School
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: William Raymond

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Em Edwards

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E H Townsend
(Address) Asotin Idaho

15. Filed Feb 13 1921 J W Fairley Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 12 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 15 1921 to Feb 12 1921 that I last saw h[illegible] alive on Feb 12 1921 and that death occurred on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:
Recurrent Pneumonia + tuberculosis of lung.
(Duration) Yrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) Earle M Worswick M. D.
2/17 1921 (Address) Orofino Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Asotin Idaho
DATE OF BURIAL: Dec 14 1921

20. UNDERTAKER: E H Townsend
ADDRESS: Asotin Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

MAR 10 1921

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33079
Registered No. 8

1. PLACE OF DEATH.
County of Clearwater
City of Orofino,
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 96
Primary Registration District No. 2162
(No. ....., ... St.)
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Fanny Kelly

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: About X (Month) (Day) 1897 (Year)

7. AGE: 24 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Formerly School Girl
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Conby, Oregon

10. NAME OF FATHER:

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. W. Ottebery
(Address) Orofino, Idaho.

15. Filed Feb 26 1921 J. M. Faris Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: February Twenty-fifth 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 25th 1912 to Feb. 25 1921, that I last saw her alive on Feb. 24 1921 and that death occurred on the date stated above, at 5:10 A.M.

The CAUSE OF DEATH* was as follows:
Epilepsy
Since Birth
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Insanity
(Duration) Unknown yrs. 1 mos. ..... ds.
(Signed) R. Rawlings M. D.
19 1 (Address) Orofino Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 9 yrs. 1 mos. 1 days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? Since Birth
Former or usual residence Wardner, Idaho

19. PLACE OF BURIAL OR REMOVAL: Grave #17 Row #4 New add The Northern Idaho Penitentiary Cemetery
DATE OF BURIAL: Feb. 28 1921

20. UNDERTAKER: P. M. Johnson
ADDRESS: Orofino Idaho

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Clearwater

City of Orofino

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 96

Primary Registration District No. 2168

(No. ..... St.)

File No. 33081

Registered No. 10

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Benjamin Hines

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Indian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): married

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1 (Year)

7. AGE: ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: James Hines

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: .....

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) James Hines

(Address) Ahsahka Idaho

15. Filed Feb 28 19 21

J. M. Faires
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 28 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feby 19, 1921, to Feby 28 1921, that I last saw h... alive on Feby 28 1921, and that death occurred on the date stated above, at 4 00 P.M.

The CAUSE OF DEATH* was as follows:

Brights Disease

(Duration) 6 Yrs. — mos. — ds.

Contributory (Secondary) Arteriosclerosis

(Duration) ? yrs. ..... mos. ..... ds.

(Signed) J. M. Faires M. D.

2/28 1921 (Address) Orofino Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Ahsahka Idaho

DATE OF BURIAL: Mar 2 1921

20. UNDERTAKER: Bell and Son

ADDRESS: Orofino

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

Registration District No. 76 MAR 10 1921

Primary Registration District No. 2153

(No. ..... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33082

Registered No. .....

1. PLACE OF DEATH

County of Custer

City of Mackay.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Dale Young Knepp.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Infant.

6. DATE OF BIRTH: August (Month) 4 (Day) 1920 (Year)

7. AGE: ..... Yrs. 5 Mos. 25 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Infant.

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Utah.

10. NAME OF FATHER: Geo F Knepp.

11. BIRTHPLACE OF FATHER (State or Country): Neb.

12. MAIDEN NAME OF MOTHER: Emily Young.

13. BIRTHPLACE OF MOTHER (State or Country): Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Geo. F Knepp.

(Address) Mackay Ida.

15. Filed 3/9 1921 Rose Nowacka Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. (Month) 29 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Not in attendance 19.....

that I last saw h..... alive on ..... 19.....,

and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Marasmus.

(Duration) Since birth. ds.

Contributory (Secondary) Bronchitis

(Duration) ..... yrs. ..... mos. 7 ds.

(Signed) W. H. Farrell M. D.

1/29 1921 (Address) Mackay Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: To Salt Lake City Utah | DATE OF BURIAL ..... 19.....

20. UNDERTAKER: W. D. Parker | ADDRESS Twin Falls Ida

FORM V. S. No. 5-25 M. 1-19.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

MAR 10 1921

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 34
Primary Registration District No. 2020
File No. 33083
Registered No. 1

1. PLACE OF DEATH

County of Elmore
City of Mtn Home
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Frank E Austin

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH July (Month) 12 (Day) 1874 (Year)

7. AGE 36 Yrs. 5 Mos. 27 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Banking

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Kansas

10. NAME OF FATHER Herbert Austin

11. BIRTHPLACE OF FATHER (State or Country) Canada

12. MAIDEN NAME OF MOTHER Florence Washburg

13. BIRTHPLACE OF MOTHER (State or Country) Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Elvira Austin

(Address) Mtn Home Ida

15.

Filed 1921

J E Evans
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January (Month) 9th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 9th 1921, to Jan 9th 1921, that I last saw h[illegible] alive on Jan 9th 1921, and that death occurred on the date stated above, at 8:40 P.M.

The CAUSE OF DEATH* was as follows:

Acute Gastritis

2 hrs (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. E. Evans M. D.

1-14-1921 (Address) Mtn Home Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Mtn Home Cemetery	1-13-1921

20. UNDERTAKER	ADDRESS
A W Conover	Mtn Home Ida

MAR 10 1921

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33084
Registered No.

1. PLACE OF DEATH.
County of Elmore
City of Glenns Ferry Ida (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 35
Primary Registration District No. 2021

2. FULL NAME Laura R Wilkins

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow
6. DATE OF BIRTH: Nov (Month) 27 (Day) 1835 (Year)
7. AGE: 86 yrs. 2 mos. 16 ds. IF LESS than 1 day how many ..... hrs. or ..... min.)
8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business or establishment in which employed (or employer) At Home
9. BIRTHPLACE (State or Country) Maine
10. NAME OF FATHER Samuel Smith
11. BIRTHPLACE OF FATHER (State or Country) New England
12. MAIDEN NAME OF MOTHER Elvine Savage
13. BIRTHPLACE OF MOTHER (State or Country) Maine
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Nelly C. Wilkins
(Address) Glenns Ferry Ida
15.
Filed Feb. 12th 1921 J. W. Davis Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Feb. 12th (Month) (Day) 1921 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Dec. 22nd 1920, to Feb. 12th 1921, that I last saw her alive on Feb. 11 1921, and that death occurred on the date stated above, at 1-30 A M.
The CAUSE OF DEATH* was as follows:
Senility
..... (Duration) ..... yrs. 2 mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) J. W. Davis M. D.
Feb. 12th 1921 (Address) Glenns Ferry Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and 2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mountain Home Idaho — DATE OF BURIAL: Feb. 13 1921
20. UNDERTAKER: J. W. Pinkham — ADDRESS: Glenns Ferry Ida

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MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

FORM V. S. No. 5-25 M. 1-19.

MAR 10 1921

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2119
Primary Registration District No. 27
File No. 33085
Registered No. 16

1. PLACE OF DEATH

County of Franklin
City of Dayton
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Evelyn Vilate Griffeth

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F

4. COLOR OR RACE W

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Single (Write the word.)

6. DATE OF BIRTH Feb. (Month) 18 (Day) 1901 (Year)

7. AGE 18 Yrs. 11 Mos. 26 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Fairview Idoh

10. NAME OF FATHER Geo. A. Griffeth

11. BIRTHPLACE OF FATHER (State or Country) Hyde Park Utah

12. MAIDEN NAME OF MOTHER Evelyn Vilate Pratt

13. BIRTHPLACE OF MOTHER (State or Country) Meadowill Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Geo. A. Griffeth

(Address) Preston Idaho

15. Filed Mar 3 1921 D. A. Cutler Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 2 (Month) 15 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1920 to 2-15 1921 that I last saw h.er alive on 2-13 1921, and that death occurred on the date stated above, at 6 A.M.

The CAUSE OF DEATH* was as follows:

Chronic endocarditis valvular Disease

..... (Duration) 5 Yrs. ..... mos. ..... ds.

Contributory (Secondary) Acute rheumatic fever

..... (Duration) ..... yrs. 2 mos. 15 ds.

(Signed) L. R. Budge M. D.

..... 19..... (Address) Preston Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Dayton — **DATE OF BURIAL** Feb 17 1921

20. UNDERTAKER W. A. Skidmore — **ADDRESS** Preston Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

MAR 10 1921

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2119
Primary Registration District No. 27
File No. 33087
Registered No. 19

1. PLACE OF DEATH
County of Franklin
City of Preston
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Paul Bell Perkins

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): ✓

6. DATE OF BIRTH: January 31 (Month) (Day) 1921 (Year)

7. AGE: ..... Yrs. 16 Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Franklin Co. Idaho

10. NAME OF FATHER: Joseph M. Perkins

11. BIRTHPLACE OF FATHER (State or Country): Kaysville Utah

12. MAIDEN NAME OF MOTHER: Nellie Bell

13. BIRTHPLACE OF MOTHER (State or Country): Weston Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Joseph M. Perkins
(Address) Preston Idaho

15. Filed Mar 3 1921
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb 16 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Probably Pneumonia Lobar
Statement of midwife
Who officiated the Gr
and father & mother
(Duration) ..... Yrs. ..... mos. ..... ds.
No doctor in attendance
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Dr A R Reed M. D.
Feb 18 1921 (Address) Preston

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Weston Ida — DATE OF BURIAL: Feb. 18 1921

20. UNDERTAKER: None — ADDRESS:

18. Operation

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

MAR 10 1921

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33089

Registered No. 14

1. PLACE OF DEATH

County of Franklin

City of Preston

Registration District No. 2119

Primary Registration District No. 27

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Laura D Fuhrmann

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): married

6. DATE OF BIRTH: Aug (Month) 31 (Day) 1885 (Year)

7. AGE: 35 Yrs. 5 Mos. 3 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: wife

(b) General nature of industry, business or establishment in which employed (or employer): Housework

9. BIRTHPLACE (State or Country): Georgia

10. NAME OF FATHER: Henry Allison

11. BIRTHPLACE OF FATHER (State or Country): Georgia

12. MAIDEN NAME OF MOTHER: M C Maycock

13. BIRTHPLACE OF MOTHER (State or Country): Dont know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Miles A. Fuhrmann

(Address) Preston Idaho

15. Filed Feb. 7 1921

Dr A Cutler
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 3 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 15 1920, to Feb 3 1921 that I last saw h.. alive on Feb 3 1921, and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Chronic Cardio valvular disease

(Duration) 3 Yrs. ..... mos. ..... ds.

Contributory (Secondary) Cause Pneumonia Fever

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A. P. Cutler M. D.

2-7 1921 (Address) Preston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Conasoga Penn. DATE OF BURIAL: Feb. 5 1921

20. UNDERTAKER: W. A. Skidmore ADDRESS: Preston Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 102
Primary Registration District No. 6
File No. 33091 1921
Registered No.

1. PLACE OF DEATH
County of Fremont
City of
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ernie Schuttler
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Oct (Month) 2 (Day) 1882 (Year)

7. AGE: 39 Yrs. 3 Mos. 27 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer): Farm Laborer

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: Dont Know

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Dont Know

13. BIRTHPLACE OF MOTHER (State or Country): Gemany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chris Harrigfeldt
(Address) Sgarrie Idaho

15. Filed 1-30 1921
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 29 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec date 19 , to Dec date 19 , that I last saw h alive on Jan 29 1921, and that death occurred on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:
Fell from straw stack
Back instant

(Duration) Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.
Jan 31 1921 (Address) Athol Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Sgarrie Idaho — DATE OF BURIAL: 1-31 1921

20. UNDERTAKER: Jones Risser — ADDRESS: Athol Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33092

Registration District No. 102
Primary Registration District No. 6

1. PLACE OF DEATH
County of Fremont
City of Ashton (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Albert Lundquist

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

Registered No. .....

MAR 19 1921

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Feb (Month) 2 (Day) 1875 (Year)

7. AGE: 46 Yrs. ..... Mos. 1 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: John Lundquist

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Augusta Reed

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Lucetta Lundquist
(Address) Marysville Idaho

15. Filed 2/4 1921 [signature] Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 3 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 15 1921, to Feb 3 1921, that I last saw h[illegible] alive on Feb 3 1921, and that death occurred on the date stated above, at 2:30 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia

..... (Duration) ..... Yrs. ..... mos. 21 ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E. L. Stanger M. D.

Feb 3 1921 (Address) Ashton Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL ..... 19.....

20. UNDERTAKER David R Young | ADDRESS Teton, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MAR 10

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33093
Registered No.

1. PLACE OF DEATH
County of Fremont
City of Ashton Idaho
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 1
Primary Registration District No. 6

2. FULL NAME Mary Virginia Nedrow

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.):

6. DATE OF BIRTH: Oct (Month) 6 (Day) 1920 (Year)

7. AGE: 1 Yrs. 3 Mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Ashton Idaho

10. NAME OF FATHER: Geo Nedrow

11. BIRTHPLACE OF FATHER (State or Country): Ashton Idaho

12. MAIDEN NAME OF MOTHER: Leda C Vaughn

13. BIRTHPLACE OF MOTHER (State or Country): Colorado

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Geo. Nedrow
(Address) Ashton Idaho

15. Filed 2/4/1921 C E Meacham Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 2 - 2 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Did not to see deceased that I last saw h... alive on ... 1921, and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Heart Disease (Probably Strangulation)

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) C. P.
(Duration) — yrs. — mos. — ds.

(Signed) C E Meacham M. D.
2/4 1921 (Address) Ashton, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Ashton Idaho
DATE OF BURIAL: 2/5 1921
20. UNDERTAKER: Lemon Risser
ADDRESS: Ashton Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

MAR 10 1921

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 115
Primary Registration District No. 6
File No. 33094
Registered No.

1. PLACE OF DEATH
County of Fremont
City of Ashton
(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Herbert Green

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH December 1 1886
(Month) (Day) (Year)

7. AGE 35 Yrs. 3 Mos. 4 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Farm Laborer
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Preston Idaho

10. NAME OF FATHER Silas Green

11. BIRTHPLACE OF FATHER (State or Country) Ohio

12. MAIDEN NAME OF MOTHER Laura Gibbons

13. BIRTHPLACE OF MOTHER (State or Country) Wales

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Stephen Dames
(Address) Ashton Idaho

15. Filed 3/5/ 1921 — Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 3 (Month) — 4 (Day) — 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3/2 1921, to 3/4 1921
that I last saw h~~im~~ alive on 3/4 1921,
and that death occurred on the date stated above, at 6 P.M.
The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis

(Duration) Sev't Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) A. M. Richardson M. D.
3/5 1921 (Address) Ashton, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Ashton Idaho — DATE OF BURIAL 3/6 1921

20. UNDERTAKER Jones Bros — ADDRESS Ashton Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MAR 10 1921

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 102
Primary Registration District No. 6
File No. 33096
Registered No.

1. PLACE OF DEATH
County of Fremont
City of Ashton
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs Mary Nieland

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Oct. (Month) 8 (Day) 1863 (Year)

7. AGE: 58 Yrs. 3 Mos. 22 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer): Housewife

9. BIRTHPLACE (State or Country): Iowa Co Iowa

10. NAME OF FATHER: Christopher C. Kallman

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Vrina Carnegie

13. BIRTHPLACE OF MOTHER (State or Country): Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. F. Nieland
(Address) Ashton Idaho

15. Filed 1-31-1921 [signature] Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 1- (Month) 30 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1-1-1921, to 1-30-1921, that I last saw h~~er~~ alive on 1-30-1921 and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:
Cancer Uterus
.....
.....
.....(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) H.K.
.....(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [signature] M. D.
1-31 1921 (Address) Ashton, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Wayne Neb
DATE OF BURIAL ..... 19.....

20. UNDERTAKER
ADDRESS

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

MAR 10 1921

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 106
Primary Registration District No. 6
File No. 2-010097
Registered No. 6.

1. PLACE OF DEATH
County of Fremont
City of Ashton
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charles William Brown
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: S (Write the word.)

6. DATE OF BIRTH: 3 (Month) 2 (Day) 1921 (Year)

7. AGE: ..... Yrs. ..... Mos. 9 hrs. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Ashton, Fremont Co, Ida.

10. NAME OF FATHER: William Brown

11. BIRTHPLACE OF FATHER (State or Country): Wisconsin Idaho

12. MAIDEN NAME OF MOTHER: May Atkinson Brown

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Wm Brown
(Address) Ashton, Ida.

15. Filed 3/3 1921 A M Meacham
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 3 (Month) 2 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3/2 1921 to ——— 19....
that I last saw h— alive on 3/2 1921
and that death occurred on the date stated above, at 7.30 P.M.
The CAUSE OF DEATH* was as follows:
Premature —
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) ———
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) A M Meacham M. D.
3/3 1921 (Address) Ashton Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL 19....

20. UNDERTAKER | ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

MAR 10 '21

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Gem. co Ida

City of Montour

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 6

Primary Registration District No.

(No. , St.)

File No. 33098

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Milton Hamilton James

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Boy

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH: October 25 (Month) 1920 (Year) 16 (Day)

7. AGE: ....Yrs. ....Mos. ....ds.

IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Ida. Boise, Ada Co

10. NAME OF FATHER John Hamilton James

11. BIRTHPLACE OF FATHER (State or Country) Tenn. Putnam Co

12. MAIDEN NAME OF MOTHER Allie Smith

13. BIRTHPLACE OF MOTHER (State or Country) Ark. Boone Co

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John H. James Montour Ida

(Address)

15. Filed Feb 1 1921 J. L. Reynolds Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. (Month) 11 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from .... 19.... to .... 19....

that I last saw h.... alive on .... 19....

and that death occurred on the date stated above, at .... M.

The CAUSE OF DEATH* was as follows:

No Physician

Whooping Cough

(Duration) .... Yrs. .... mos. .... ds.

Contributory (Secondary)

(Duration) .... yrs. .... mos. .... ds.

(Signed) J. L. Reynolds M. D.

19.... (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .... yrs. .... mos. .... days. In the State .... yrs. .... mos. .... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Montour

DATE OF BURIAL: Jan 13 1921

20. UNDERTAKER: Folk in Neighborhood

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

MAR 1 1921

Registration District No. 6
Primary Registration District No.
File No. 33099
Registered No.

1. PLACE OF DEATH
County of Gem
City of Emmett
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Louise D. Schoenhuth
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widow (Write the word.)

6. DATE OF BIRTH: Aug (Month) 5 (Day) 1833 (Year)

7. AGE: 87 Yrs. 5 Mos. 3 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Schonberg. Germany

10. NAME OF FATHER: Not Known

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H E Schoenhuth
(Address) Emmett Ida

15. Filed 2/12 1921 J L Reynolds Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 8 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 5 1921 to Feb 8 1921, that I last saw h-s alive on Feb 8 1921, and that death occurred on the date stated above, at 4 00 M.

The CAUSE OF DEATH* was as follows:
Bronco Pneumonia
(Duration) Yrs. mos. ½ ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) J. L. Reynolds M. D.
2/12 1921 (Address) J L Reynolds

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Emmett Idaho
DATE OF BURIAL: 2/10 1921

20. UNDERTAKER: C Bucknum
ADDRESS: Emmett Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

MAR 10 192

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 6
Primary Registration District No.
(No. ..... St.)

File No. 33100
Registered No.

1. PLACE OF DEATH

County of Gem
City of Emmett
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jonathan A. Hiatt

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH: February (Month) 5th (Day) 1851 (Year)

7. AGE: 70 Yrs. — Mos. 17 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer): Farming

9. BIRTHPLACE (State or Country): Grant Co Indiana

10. NAME OF FATHER: Not Known

11. BIRTHPLACE OF FATHER (State or Country): ✓

12. MAIDEN NAME OF MOTHER: ✓

13. BIRTHPLACE OF MOTHER (State or Country): ✓

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R D Shaw
(Address) Emmett Ida

15. Filed Feb 24 19 21 J. L. Reynolds Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 22 (Day) 19 21 (Year)

17. I HEREBY CERTIFY, That I attended deceased from not at all 19..., to ..... 19...., that I last saw h..... alive on ..... 19...., and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Was called on Feb 22 but patient was dead when I got there. Myocarditis following influenza
(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. L. Reynolds M. D.
19..... (Address) Emmett

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Emmett Idaho	2/25 19 21
20. UNDERTAKER: C. D. Buckner	ADDRESS: Emmett Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 6

Primary Registration District No.

File No. 33101

Registered No.

1. PLACE OF DEATH

County of Gem

City of Ola

(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Paul Lenard Vaughan

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH: June (Month) 1 (Day) 1919 (Year)

7. AGE: 1 Yrs. 8 Mos. 22 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER M G Vaughan

11. BIRTHPLACE OF FATHER (State or Country) Oregon

12. MAIDEN NAME OF MOTHER Teenia Whitlock

13. BIRTHPLACE OF MOTHER (State or Country) Calif

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) M. G. Vaughan

(Address) Ola Idaho

15. Filed 3/31 1921 J. L. Reynolds Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: February 22th 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....

that I last saw h..... alive on ..... 19.....

and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Possibly Pneumonia,
no Doctor in attendance

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

19..... (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 1 yrs. 8 mos. 22 days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? at Home

Former or usual residence usual Residence

19. PLACE OF BURIAL OR REMOVAL: Ola cemetary

DATE OF BURIAL: Feb 24 1921

20. UNDERTAKER: no

ADDRESS

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33102
Registered No.

1. PLACE OF DEATH
County of Gem
City of Emmett
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No.
(No. , St.)

2. FULL NAME Alice Mildred Woods

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem
4. COLOR OR RACE: whr
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Infant (Write the word.)

6. DATE OF BIRTH: [redacted] 1 (Day) 1921 (Year)

7. AGE: ___ Yrs. ___ Mos. 12 ds.
IF LESS than 1 day how many ___ hrs. or ___ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Enos G. Woods

11. BIRTHPLACE OF FATHER (State or Country): Kansas

12. MAIDEN NAME OF MOTHER: Mildred B. Brandon

13. BIRTHPLACE OF MOTHER (State or Country): Arkansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Enos G. Woods
(Address) Emmett Idaho

15. Filed 3/5 1921 J. L. Reynolds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 13 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Febey 12 1921 to Febey 13 1921 that I last saw her alive on Febey 12 1921, and that death occurred on the date stated above, at ___ M.

The CAUSE OF DEATH* was as follows:
Epidemic influenza
(Duration) ___ Yrs. ___ mos. 3 ds.
Contributory (Secondary)
(Duration) ___ yrs. ___ mos. ___ ds.

(Signed) P N Cummings M. D.
2/14 1921 (Address) Emmett Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ___ yrs. ___ mos. ___ days. In the State ___ yrs. ___ mos. ___ days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Sweet Idaho	2/14 1921
20. UNDERTAKER: C. D. Buckmun	ADDRESS: Emmett Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 24

Primary Registration District No. .....

(No. ....., ... St.)

MAR 10 1921

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33103

Registered No. .....

1. PLACE OF DEATH.

County of Gooding

City of Gooding

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Alice M Eastman ~~Evans~~

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. May (Month) 5 (Day) 1919 (Year)

7. AGE: 1 Yrs. 9 Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Baby
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Gooding, Idaho

10. NAME OF FATHER Ernest Eastman

11. BIRTHPLACE OF FATHER (State or Country) Washington

12. MAIDEN NAME OF MOTHER Evans

13. BIRTHPLACE OF MOTHER (State or Country) Minn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) E.R. Evans
(Address) Gooding, Ida.

15. Filed 2-10-1924 F. J. Carymyer Local Registrar

SYMS - YORK CO., PTRS. & BOOK. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 3 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 31 1921, to Feb 3rd 1921, that I last saw h-11 alive on Feb 4th 1921, and that death occured on the date stated above, at 1-30 P.M.

The CAUSE OF DEATH* was as follows:

Cerebro Spinal Meningitis

(Duration) ..... Yrs. ..... mos. 1 ds.

Contributory (Secondary) Broncho Pneumonia

(Duration ..... yrs. ..... mos. 5 ds.

(Signed) H. C. Fegan M. D.

2/4 1921 (Address) Gooding Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Hagerman - Ida. | DATE OF BURIAL 2/6 1921

20. UNDERTAKER A E Thompson - | ADDRESS Gooding, Ida -

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

MAR 10 1921

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 24
Primary Registration District No.
File No. 33104
Registered No.

1. PLACE OF DEATH
County of Gooding
City of Gooding
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Thomas Benton Pilgrim
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	White	Married

6. DATE OF BIRTH: Oct (Month) 9th (Day) 1897 (Year)

7. AGE: 23 Yrs. 8 Mos. 30 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farming
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: Geo N Pilgrim

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Iulela Fraher

13. BIRTHPLACE OF MOTHER (State or Country): Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Geo N Pilgrim
(Address) Gooding Ida

15. Filed 2-10-1921 F. F. Camp M.D. Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 8 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 3 1921, to Feb 8 1921, that I last saw h[illegible] alive on Feb 5 1921, and that death occurred on the date stated above, at 1 P. M.
The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis
(Duration) Yrs. 6 mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) J. H. Cromwell M. D.
2/9 1921 (Address) Gooding Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Gooding Cemetery | DATE OF BURIAL: 2/9 1921

20. UNDERTAKER: A Thompson | ADDRESS: Gooding

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 106
Primary Registration District No. 2184
File No. 33105
Registered No. 1921

1. PLACE OF DEATH.
County of Idaho
City of Kooskia
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Henry Harrison

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Indian
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Feb (Month) 28 (Day) 1918 (Year)

7. AGE: 2 Yrs. 10 Mos. 21 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER: Benjamin Harrison

11. BIRTHPLACE OF FATHER (State or Country): Washington

12. MAIDEN NAME OF MOTHER: Dorcas Miller

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Benjamin Harrison
(Address) Kooskia - Idaho

15. Filed Jan 20 1921 J. M. Verbeck Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Jan (Month) 19 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 13 1921, to Jan 19 1921, that I last saw him alive on Jan 18 1921, and that death occured on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:
Broncho pneumonia

..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Verbeck M. D.
Jan 20 1921 (Address) Kooskia - Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mt. Miller Ranch near Kooskia — DATE OF BURIAL: Jan 20 1921

20. UNDERTAKER: Geo Tenney — ADDRESS: Kooskia - Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

MAR 10 1921

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 105
Primary Registration District No. 2183
File No. 5 33106
Registered No.

1. PLACE OF DEATH
County of Idaho
City of Kenterville
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Beusching
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: married (Write the word.)

6. DATE OF BIRTH: Feby 23rd (Month) 23 (Day) 1901 (Year)

7. AGE: 19 Yrs. 11 Mos. 12 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: William Entrup

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Mary Herzog

13. BIRTHPLACE OF MOTHER (State or Country): Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Elvin Henry Beusching
(Address) Kenterville Ida

15. Filed Feby 11 1921 H W Blake Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feby (Month) 11 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feby 7th 1921, to Feby 11 1921, that I last saw her alive on Feby 11 1921 and that death occurred on the date stated above, at 12¼ a M.

The CAUSE OF DEATH* was as follows:
Puerperal Convulsions —
Albuminuria —
(Duration) Yrs. mos. 5 ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) H W Blake M. D.
2/14 1921 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Kenterville Ida
DATE OF BURIAL: 2-12 1921

20. UNDERTAKER: A H Nau
ADDRESS: Ola Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Idaho — Registration District No. 103 — 10 1921 — File No. 33108

City of Grangeville — Primary Registration District No. 2181 — Registered No. 4

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Margret K Holbrook

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.)
F	W	widow

6. DATE OF BIRTH — Dec (Month) 16 (Day) 1838 (Year)

7. AGE — 82 Yrs. ..... Mos. ..... ds. — IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Iowa.

10. NAME OF FATHER: James Rice

11. BIRTHPLACE OF FATHER (State or Country): Canada

12. MAIDEN NAME OF MOTHER: Nancy Bear

13. BIRTHPLACE OF MOTHER (State or Country): U.S.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Eugene Holbrook
(Address) Grangeville Idaho

15. Filed March 1 1921 — G. B. Stockton, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH — Feb (Month) 21 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1 1921, to Feb 21 1921, that I last saw h.er alive on Feb 1 1921, and that death occurred on the date stated above, at 6 A. M.

The CAUSE OF DEATH* was as follows:

Senile decay

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Intra Capsular fracture of right femur

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G B Stockton M. D.

2/22 1921 (Address) Grangeville Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Fair View	2/22 1921

20. UNDERTAKER	ADDRESS
A J Mangg	Grangeville

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

MAR 10 1921

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Idaho

City of Grangeville

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 103

Primary Registration District No. 1001

(No. ..... St.)

File No. 3309

Registered No. 6

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Emily Jane Sly.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widow (Write the word.)

6. DATE OF BIRTH: Oct. 18 1842 (Month) (Day) (Year)

7. AGE: 78 Yrs. 3 Mos. 27 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ontario Canada

10. NAME OF FATHER: Lorenzo Keith

11. BIRTHPLACE OF FATHER (State or Country): Canada

12. MAIDEN NAME OF MOTHER: ?

13. BIRTHPLACE OF MOTHER (State or Country): Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Rose Wood

(Address) Grangeville

15. Filed March 1 1921 G B Stockton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 15 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 1 1921, to Feb 15 1921 that I last saw h[illegible] alive on Feb 15 1921 and that death occurred on the date stated above, at 9:50 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

(Duration) 1 Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) B. Stephenson M. D.

2/16 1921 (Address) Grangeville Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Minneapolis Minn. DATE OF BURIAL: Feb. 17 1921

20. UNDERTAKER: A. J. Maugg ADDRESS: City

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

MAR 10 1921

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 103
Primary Registration District No. 21 811
File No. 33110
Registered No. 8

1. PLACE OF DEATH

County of .....
City of ..... (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Rose Hayes.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX:

4. COLOR OR RACE:

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: married (Write the word.)

6. DATE OF BIRTH: July (Month) 21 (Day) 1887 (Year)

7. AGE: 34 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Washington

10. NAME OF FATHER: John Skelton

11. BIRTHPLACE OF FATHER (State or Country): Ill

12. MAIDEN NAME OF MOTHER: Bell Bishop.

13. BIRTHPLACE OF MOTHER (State or Country): Neb.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Skelton
(Address) Mt Idaho Idaho

15. Filed Mch 1 1921 G B Stockton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 24 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 17 1921 to Feb 24 1921 that I last saw her alive on Feb 24 1921 and that death occurred on the date stated above, at 9-30 P. M.
The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G B Stockton M. D.
2/26 1921 (Address) Grangeville Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mt Idaho — DATE OF BURIAL: Mch 2 1921

20. UNDERTAKER: A J Maugg — ADDRESS: Grangeville

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MAR 10 1921

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 30
Primary Registration District No. 1057
File No. 33111
Registered No. 891

1. PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene (No. 615 Sherman Ave St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Thomas Platt Morrow
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: April (Month) 30 (Day) 1915 (Year)

7. AGE: 5 Yrs. 9 Mos. 28 ds.
IF LESS than 1 day how many.....hrs. or.....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Platt Morrow

11. BIRTHPLACE OF FATHER (State or Country): Washington

12. MAIDEN NAME OF MOTHER: Bernaide Ward

13. BIRTHPLACE OF MOTHER (State or Country): Washington

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Platt Morrow
(Address) Coeur d Alene Ida

15. Filed Mch 4 1921 D D Drenna Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 28 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 17 1921, to Feb 28 1921, that I last saw h[im] alive on Feb 28 1921, and that death occurred on the date stated above, at 11 A.M.
The CAUSE OF DEATH* was as follows:

Acute Endocarditis,
(Duration) Yrs. mos. 12 ds.
Contributory (Secondary) Inflammation, Rheumatism
(Duration) yrs. mos. 12 ds.

(Signed) [illegible] M. D.
Mch 19 21 (Address) Coeur d Alene Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: M J Kroon Cemetery — DATE OF BURIAL: Mch 2 1921

20. UNDERTAKER: R B Mooney — ADDRESS: Coeur d'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

MAR 1 1921

File No. 33112

Registered No. 890

Registration District No. 30

Primary Registration District No. 1051

1. PLACE OF DEATH

County of Kootenai

City of Coeur d'Alene (No. 423 (C D'A Ave St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Wallace S. Kincaid

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH: Dec (Month) 29 (Day) 1847 (Year)

7. AGE: 73 Yrs. 1 Mos. 27 ds.

IF LESS than 1 day: how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Alabama

10. NAME OF FATHER: Andrew J Kincaid

11. BIRTHPLACE OF FATHER (State or Country): Ky

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Wallace Kincaid

(Address) Coeur d'Alene, Ida

15. Filed Mch 4 1921 D D Brennan Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 26 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 15 1921, to Feb 26 1921, that I last saw h/im alive on Feb 25 1921, and that death occurred on the date stated above, at 8:45 P.M.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary): Chronic Interstitial Nephritis

(Duration) 2 yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

2/28 1921 (Address) Coeur d'Alene Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State 11 yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetery — DATE OF BURIAL: Feb 28 1921

20. UNDERTAKER: [signature] — ADDRESS: Coeur d'Alene, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

MAR 10 19

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 30
Primary Registration District No. 105-1
File No. 33113
Registered No. 889

1. PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene
(No. 813, Bancroft St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Harold Lundstrom

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): single

6. DATE OF BIRTH: Sept 5 1914 (Month) (Day) (Year)

7. AGE: 6 Yrs. 5 Mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: scholar
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Minn

10. NAME OF FATHER: Carl Lundstrom

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Anna Sundquist

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Carl B Lundstrom
(Address):

15. Filed Mch 4 1921 — D D Drennan, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feby 18 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 1 1921, to Feb 18 1921, that I last saw h.m alive on Feb 18 1921, and that death occurred on the date stated above, at 4 P. M.
The CAUSE OF DEATH* was as follows:

Scarlet fever

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D O Brown M. D.
Feb 19 21 (Address) Coeur d Alene Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Forest-Cem. | DATE OF BURIAL: 2-19 1921

20. UNDERTAKER: J. Cassedy. Ino Nelson | ADDRESS: C D Alene.

FORM V. S. No. 5-25 M. 1-19.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

MAR 10 1921

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 30
Primary Registration District No. 1057
File No. 3514
Registered No. 888

1. PLACE OF DEATH

County of Kootenai
City of Coeur d'Alene (No. 813 Bancroft St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Geo. Walter Lundstrom

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: single (Write the word.)

6. DATE OF BIRTH: Dec. (Month) 6 (Day) 1919 (Year)

7. AGE: 2 Yrs. 2 Mos. 2 ds.

IF LESS than 1 day: how many ... hrs. or ... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work:

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Minn

10. NAME OF FATHER: Carl Lundstrom

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Hannah Sundgren

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant): Carl Lundstrom

(Address):

15. Filed Mch. 4 1921 — D D Drennan, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 8 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 7, 1921, to Feb 8 1921 that I last saw h[im] alive on Feb 8 1921, and that death occurred on the date stated above, at 4A M.

The CAUSE OF DEATH* was as follows:

Scarlet fever

(Duration) ... Yrs. ... mos. 2 ds.

Contributory (Secondary)

(Duration) ... yrs. ... mos. ... ds.

2/9 1921 (Signed) J C Davis M. D.

(Address) Coeur d'Alene Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Forest-Cem. C D'Alene	2-9 1921

20. UNDERTAKER	ADDRESS
C. Cossedy	C D'Alene

Gus Nelson.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

MAR 10 1921

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 30
Primary Registration District No. 1007
File No. 3315
Registered No. 887

1. PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene
(No. 725 Military St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Gus F Fellman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. Follow instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: July (Month) 24 (Day) 1877 (Year)

7. AGE: 43 Yrs. 6 Mos. 12 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Millworker
(b) General nature of industry, business or establishment in which employed (or employer): Lumber Co.

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER: Carl Fellman

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Katherine Erickson

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs G. F. Fellman
(Address) Coeur d'Alene Ida.

15. Filed Mch 4 1921 D D Brennan Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 6 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 6 1921, to Feb. 6 1921
that I last saw h.* alive on ..... 19..,
and that death occurred on the date stated above, at 10 P. M.
The CAUSE OF DEATH* was as follows:
Hemorrhage,

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Gastric ulcer.
(Duration) ..... yrs. ? mos. ..... ds.

(Signed) John O Wood M. D.
Feb. 8 1921 (Address) Coeur d'Alene Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State 1 yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Glen Brook Mine — DATE OF BURIAL: Feb 10 1921

20. UNDERTAKER: P J Mooney — ADDRESS: Coeur d'Alene Ida

FORM V. S. No. 5-25 M. 1-19.

MAR 10

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 30
Primary Registration District No. 1037
File No. 33116
Registered No. 886

1. PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene (No. 705 Indiana St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Robert H. Blount

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: single (Write the word.)

6. DATE OF BIRTH: Feb. (Month) 2 (Day) 1921 (Year)

7. AGE: 0 Yrs. 0 Mos. 1 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Hanson Blount

11. BIRTHPLACE OF FATHER (State or Country): Ken.

12. MAIDEN NAME OF MOTHER: Ivey Allen

13. BIRTHPLACE OF MOTHER (State or Country): Wash.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Hanson H. Blount
(Address)

15. Filed Mch 4 1921 D D Drennan Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb 3 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 1 1921, to Feb 3 1921, that I last saw h[illegible] alive on Feb 2 1921, and that death occurred on the date stated above, at 8:30 A. M.

The CAUSE OF DEATH* was as follows:
Pneumonia Lobar -

(Duration) — Yrs. — mos. — ds.
Contributory (Secondary)
(Duration) — yrs. — mos. — ds.

(Signed) D H Drennan M. D.
3/3 1921 (Address) Coeur d Alene Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Forest Cem. C D A. | DATE OF BURIAL: 2-4 1921

20. UNDERTAKER: C. Carney | ADDRESS: C D Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

MAR 10

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3317
Registered No. 885

Registration District No. 30
Primary Registration District No. 185-1

1. PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene
(No. 814, Front St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Harry Sparshatt

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Nov. (Month) 17 (Day) 1853 (Year)

7. AGE: 67 Yrs. 2 Mos. 17 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Book Keeper
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: James Sparshott

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): England.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs H Sparshott
(Address) Coeur d Alene Idg

15. Filed Mch 4 1921 D L Drenna Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 14 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to Feb 16 1921
that I last saw h.. alive on Feb 14 1921,
and that death occurred on the date stated above, at 8 40 P.M.
The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) Not known Yrs. mos. ds.
Contributory (Secondary) Arteria Sclerosis
(Duration) yrs. mos. ds.

(Signed) J C Owen M. D.
2/16 1921 (Address) Coeur d Alene Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Forest-Cem. C'D'A. | DATE OF BURIAL: 2-16 1921

20. UNDERTAKER: C. Casseedy | ADDRESS: C'D'Alene.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

MAR 10 1921

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 64
Primary Registration District No. 2144
File No. 33118
Registered No. ....

1. PLACE OF DEATH.
County of Latah
City of Troy
(No. ...., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ebey Miller

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. Apr (Month) 5 (Day) 1842 (Year)

7. AGE: 78 Yrs. 10 Mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): ....

9. BIRTHPLACE (State or Country): Ohio U S

10. NAME OF FATHER: John Sorrer

11. BIRTHPLACE OF FATHER (State or Country): U S

12. MAIDEN NAME OF MOTHER: Dont Know

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) adam miller
(Address) Troy Idaho

15. Filed Feb 16 1921 J E Packard Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 15 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 14 1921, to Feb. 15 1921, that I last saw her alive on Feb. 14 1921 and that death occured on the date stated above, at 6 P M.

The CAUSE OF DEATH* was as follows:
Acute Nephritis
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) L B Stockslager M. D.
2/16 1921 (Address) Troy, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Bucmanon Com — DATE OF BURIAL: 17 1921

20. UNDERTAKER: J E Packard — ADDRESS: Troy

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

MAR 10 1921

33119

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2147
Primary Registration District No. 67
File No. 2
Registered No. 32

1. PLACE OF DEATH
County of Latah
City of Avon P.O. (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charles Richard Waller
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M.	W.	single

6. DATE OF BIRTH Feb. 22 1921
(Month) (Day) (Year)

7. AGE 0 0 0
Yrs. Mos. ds.
IF LESS than 1 day how many 0 hrs. or 2 min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Infant
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Arnold H. Waller

11. BIRTHPLACE OF FATHER (State or Country) Minn.

12. MAIDEN NAME OF MOTHER Bertha Osterberg

13. BIRTHPLACE OF MOTHER (State or Country) Minn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) P. C. Janet
(Address) Deary

15. Filed 2-23 1921 P. C. Janet
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb 22 1921
(Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 0 19..., to 0 19...
that I last saw h.im alive on never 19...
and that death occurred on the date stated above, at 5 P.M.
The CAUSE OF DEATH* was as follows: Premature Birth.

(Duration) Yrs. mos. ds.
Contributory (Secondary) unknown
(Duration) yrs. mos. ds.
(Signed) P. C. Janet M. D.
2/23 1921 (Address) P. C. Janet

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Dry Ridge Cem.	2-23 1921
20. UNDERTAKER Moore	ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 68 — MAR 10 1921 — File No. 33120

Primary Registration District No. ____

1. PLACE OF DEATH
County of Latah
City or (No. ____ St.) Juliaetta
If death occurs away from usual residence, give facts called for under special information.

Registered No. ____
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ernest E Fleiger.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	White	Single

6. DATE OF BIRTH: Feb (Month) 23 (Day) 1902 ~~1918~~ (Year)

7. AGE: 18 Yrs. 11 Mos. 5 ds. — IF LESS than 1 day how many ____ hrs. or ____ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farm Laborer
(b) General nature of industry, business or establishment in which employed (or employer): Student

9. BIRTHPLACE (State or Country): Maine

10. NAME OF FATHER: Ernest Fleiger

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Martha Dobenschutz

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ernest Fleiger
(Address) Juliaetta

15. Filed Jan 29 1921 — R. F. Pepple, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 27 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ____ 19____ to ____ 19____ that I last saw h____ alive on ____ 19____ and that death occurred on the date stated above, at 10 P M.

The CAUSE OF DEATH* was as follows:
Gun Shot Wound in Forehead (Revolver)
Suicide
(Duration) ____ Yrs. ____ mos. ____ ds.
Contributory (Secondary) No Inquest
(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) Glen Ives, Coroner
1/28 1921 (Address) Moscow

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients or Recent Residents.)
At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days
Where was disease contracted if not at place of death? ____
Former or usual residence ____

19. PLACE OF BURIAL OR REMOVAL: Juliaetto Ida — DATE OF BURIAL: Jan 30 1921

20. UNDERTAKER: J C Croucher — ADDRESS: Juliaetta Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

MAR 10 1921

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 68

Primary Registration District No.

File No. 33121

Registered No.

1. PLACE OF DEATH.

County of Latah

City of Juliaetta

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William Ord Hart

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. July (Month) 5 (Day) 1834 (Year)

7. AGE: 87 Yrs. ..... Mos. 6 ds. 13

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: George Hart

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Mary Ord

13. BIRTHPLACE OF MOTHER (State or Country): Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs R. E. Maynard

(Address) Juliaetta

15. Filed 1/18/21 191.....

R. F. Peppler
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 18 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Decemb 191 to ..... 191 ..... that I last saw him alive on Jan 9th 1921, and that death occured on the date stated above, at 3 A. M.

The CAUSE OF DEATH* was as follows:

Tuberculosis of the lungs 6

(Duration) 5 Yrs. ..... mos. ..... ds.

Contributory (Secondary) Not ascertained

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. W. Stevenson M. D.

1/18 1921 (Address) Moscow Id.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Juliaetta — DATE OF BURIAL: 1/19/21 191

20. UNDERTAKER: Echovela — ADDRESS: Juliaetta

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SORS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

MAR 10 1921

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33122

Registered No. .....

1. PLACE OF DEATH.

County of Latah

City of Juliaetta

Registration District No. 68

Primary Registration District No. .....

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George Brown

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Infant

6. DATE OF BIRTH. Sept (Month) 6 (Day) 1920 (Year)

7. AGE: ..... Yrs. 4 Mos. 4 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: George Brown

11. BIRTHPLACE OF FATHER (State or Country): N. C.

12. MAIDEN NAME OF MOTHER: Pearl Steward

13. BIRTHPLACE OF MOTHER (State or Country): N. C.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George Brown

(Address) Juliaetta Ida

15. Filed Jan 13 1921

R. F. Pepple
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 10 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 9th 1921, to Jan 10 1921, that I last saw him alive on Jan 10 1921, and that death occured on the date stated above, at 9 P M.

The CAUSE OF DEATH* was as follows:

Acute Indigestion

(Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. A. Rothwell M. D.

Jan 10 1921 (Address) Kendrick Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Juliaetta Cem — DATE OF BURIAL: 1-13 1921

20. UNDERTAKER: J. E. Crowder — ADDRESS: Juliaetta Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24658

MAR 10 1921

Deliver This Certificate to Your Local Registrar. Not to the State Board of Health.

PLACE OF DEATH

~~Washington~~ State Board of Health

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Record No. 33123

Registered No. 6

County of Latah

City or Town of Garfield Mn R F D

Registration Dist. No. 61 (No. ..... St.; 2141 Ward)

[If death occurs away from USUAL RESIDENCE give facts called for under Item 18.]

FULL NAME Ida Thorp

[If death occurred in a Hospital or Institution give its NAME instead of street and number.]

Personal and Statistical Particulars

3 Sex: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced (Write the word): Married

6 Date of Birth: March (Month) 3 (Day) 1866 (Year)

7 Age: 54 yrs. 11 mos. 12 ds. If LESS than 1 day, ... hrs. or ..... min?

8 Occupation
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer): Home

9 Birthplace (State or country): Missouri

PARENTS

10 Name of Father: T. G. Lewis

11 Birthplace of Father (State or country): Mo

12 Maiden name of Mother: Artemina Thorp

13 Birthplace of Mother (State or country): Illinois

14 The above is true to the best of my knowledge

(Informant) J. H. Thorp

(Address) Garfield Wash

15 Filed Feb 28, 1921 W H Carothers Registrar.

Medical Certificate of Death

16 Date of Death: Feb (Month) 15 (Day) 1921 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Nov 19, 1919 to Feb 15, 1921, that I last saw h[er] alive on February 13, 1921, and that death occurred, on the date above, at 10.30 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of liver

(Duration) 4 yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) P. E. Wiest M. D.

Feb 16, 1921 (Address) Garfield Wash

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 Length of Residence (For Hospitals, Institutions, Transients, or Recent Residents)

At Place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 Place of Burial or Removal: Pierce Idaho — Date of Burial: Feb 17, 1921

20 Undertaker: L L Bruning — Address: Garfield Wash

I HEREBY CERTIFY, That I have been unable to secure answers to Questions ..... (Insert numbers of unanswered questions)

(Signature of Undertaker)

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

Registration District No. MAR 10 1921

Primary Registration District No. 1011

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33124
Registered No. 4

1. PLACE OF DEATH
County of Latah
City of Moscow
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Emanuel M. Hites

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
M	White	Married

6. DATE OF BIRTH: June (Month) 10 (Day) 1861 (Year)

7. AGE: 59 Yrs. 8 Mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Johnathan Hites

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Catherine Hatfield

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF ~~MY~~ KNOWLEDGE
(Informant): Esther Hites
(Address): Moscow

15. Filed Feb 15 1921 W. H. Carruthers Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 14 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from January 28 1921, to February 18 1921 that I last saw h[illegible] alive on February 18 1921 and that death occurred on the date stated above, at 7:30 P.M.

The CAUSE OF DEATH* was as follows:
~~Pneumonia and Kidneys~~
Paralysis of Kidneys
(Duration) ..... Yrs. 1 mos. ..... ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Dr J P Brown M.D.
2/15 1921 (Address) Moscow Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence Moscow Idaho

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Moscow	2/16 1921
20. UNDERTAKER	ADDRESS
Neil Rice	Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

MAR 10 1921

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 61
Primary Registration District No. 1011
(No. ..... , ... St.)

File No. 33125
Registered No. 25

1. PLACE OF DEATH
County of Latah
City of Moscow
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Leonard James Snow
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	White	Single

6. DATE OF BIRTH: July (Month) 28 (Day) 1910 (Year)

7. AGE: 10 Yrs. 6 Mos. 18 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: at Home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Isaac Edgar Snow

11. BIRTHPLACE OF FATHER (State or Country): Idaho.

12. MAIDEN NAME OF MOTHER: Etta May Berry

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. E. Snow
(Address) Moscow

15. Filed Feb 16 1921 W. H. Carithers Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 15 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 1918, to Feb 15 - 1921, that I last saw him alive on Feb 15 - 1921, and that death occurred on the date stated above, at 8 a.m. M,
The CAUSE OF DEATH* was as follows:
Coma

(Duration) ..... Yrs. ..... mos. 3 ds.
Contributory (Secondary) Diabetes mellitus
(Duration) 2 yrs. 3 mos. 15 ds.
(Signed) Chas. L. Pettibone M. D.
2/16 1921 (Address) Moscow, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Moscow — DATE OF BURIAL: 2/18 1921

20. UNDERTAKER: Miller Bros. — ADDRESS: Moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 61 MAR 10 1924 File No. 33126

Primary Registration District No. 1011 Registered No. 3

1. PLACE OF DEATH

County of Latah

City of Moscow (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Amos H. Biddison

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	White	Married

6. DATE OF BIRTH Sept 18 1852 (Month) (Day) (Year)

7. AGE 68 Yrs. 4 Mos. 21 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Retired Farmer
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Ohio.

10. NAME OF FATHER — Biddison

11. BIRTHPLACE OF FATHER (State or Country) Ohio.

12. MAIDEN NAME OF MOTHER Nancy Martin

13. BIRTHPLACE OF MOTHER (State or Country) Ohio.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. F. Biddison
(Address) Juliaetta Ida.

15. Filed Feb 9 1924 W. H. Carithers Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb 8 1924 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....
and that death occurred on the date stated above, at 5 P.M.
The CAUSE OF DEATH* was as follows:

Probably Heart Failure
No Inquest Held
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Allen Bros. Coroner
2/9 1924 (Address) Moscow Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Moscow DATE OF BURIAL Feb 10 1924

20. UNDERTAKER Allen Bros ADDRESS Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

MAR 10 1921

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 41
Primary Registration District No. 2116
File No. 33127
Registered No. ____

1. PLACE OF DEATH.
County of Lemhi
City of Salmon
(No. ____, ____ St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Daniel Young

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Sept 29 th (Month) (Day) 1844 (Year)

7. AGE: 76 Yrs. 5 Mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: ....
(b) General nature of industry, business, or establishment in which employed (or employer): Farmer

9. BIRTHPLACE (State or Country): Pennsylvania

10. NAME OF FATHER: Fredrick

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Cathren Straus

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Ed Young 765 Main St
(Address) Salem Ore

15. Filed 3/10 1921 M. D. Greene Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: January 8th 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 29th 1921, to Jany 8 1921, that I last saw him alive on Jany 8 1921, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Valvular Heart Disease
(Duration) Several yrs. ... mos. ... ds.
Contributory (Secondary) ....
(Duration) ... yrs. ... mos. ... ds.

1/14/21 (Signed) C. V. Hamilton M. D.
(Address) Salmon Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs ... mos ... days. In the State ... yrs ... mos ... days
Where was disease contracted if not at place of death? ....
Former or usual residence ....

19. PLACE OF BURIAL OR REMOVAL: Salmon Cemetery — DATE OF BURIAL: 1-20" 1921

20. UNDERTAKER: W C Doebler — ADDRESS: Salmon Ida

SYMS - YORK CO., PTRS. & BDRS. 24858

FORM V. S. No. 5-A—25 M. 1-19.

MAR 10 1921

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 41
Primary Registration District No. A-116
File No. 33128
Registered No.

1. PLACE OF DEATH
County of Lemhi
City of Tendoy
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lester Wilmer Carlson
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M		

6. DATE OF BIRTH
Oct 25 (Month) (Day) 1920 (Year)

7. AGE
Yrs. Mos. 3 ds. 21
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Tendoy Lemhi Co Idaho

10. NAME OF FATHER
Charles A Carlson

11. BIRTHPLACE OF FATHER
(State or Country) Sweden

12. MAIDEN NAME OF MOTHER
Eliza Selway

13. BIRTHPLACE OF MOTHER
(State or Country) Dillon Beaverhead Co Mont

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Charles A Carlson
(Address) Tendoy Idaho

15.
Filed 3—10 1921 M. D. Greene
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
2 - 20th (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from
19..... to 19.....
that I last saw h..... alive on 19.....,
and that death occurred on the date stated above, at M.
The CAUSE OF DEATH* was as follows:
Left Lobar Pneumonia

(Duration) Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) W. C. Doelle Coroner
2-20 1921 (Address) Salmon Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Tendoy Cemetery — DATE OF BURIAL: 2-23 1921

20. UNDERTAKER: W C Doelle — ADDRESS: Salmon Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

MAR 10 1921

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 41
Primary Registration District No. 2-116
File No. 33129
Registered No.

1. PLACE OF DEATH
County of Lemhi
City of Salmon
(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Peter Amonson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: married (Write the word.)

6. DATE OF BIRTH: December (Month) 6th (Day) 1839 (Year)

7. AGE: 81 Yrs. 1 Mos. 22 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired (20 yrs)
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Bergen Norway

10. NAME OF FATHER: Amon Amonson

11. BIRTHPLACE OF FATHER (State or Country): Norway

12. MAIDEN NAME OF MOTHER: Not known

13. BIRTHPLACE OF MOTHER (State or Country): Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. E. Amonson
(Address) Salmon Idaho

15.
Filed 2/10 1921 M. D. Greene
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: January (Month) 28th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jany 12 1921, to Jany 28 1921, that I last saw him alive on Jany 27 1921, and that death occurred on the date stated above, at 4 A M.
The CAUSE OF DEATH* was as follows:

Old age

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary): Infected Bladder
(Duration) X yrs. mos. 25 ds.

(Signed) P J Wright M. D.
2/7 1921 (Address) Salmon

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Salmon Cemetery
DATE OF BURIAL: 1-28 1921

20. UNDERTAKER: W C Jacobs
ADDRESS: Salmon Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

MAR 10 1921

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 41
Primary Registration District No. 2116
(No. ....., ... St.)

File No. 33130
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Lemhi
City of Salmon
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Stephen Gardner Manfull

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH. August 8 (Month) (Day) 1839 (Year)

7. AGE: 81 Yrs. 5 Mos. 11 ds.
IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ohio.

10. NAME OF FATHER: Charles Manfull.

11. BIRTHPLACE OF FATHER (State or Country): England.

12. MAIDEN NAME OF MOTHER: Ann Gardner

13. BIRTHPLACE OF MOTHER (State or Country): England.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Olive Swift.
(Address) Salmon, Idaho.

15.
Filed 2/10 1921 M. D. Greene
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January 19" (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jany 1st 1921 to Jany 19th 1921
that I last saw him alive on Jany 17 1921
and that death occurred on the date stated above, at 3 a M.

The CAUSE OF DEATH* was as follows:

old age

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) .... Yrs. ..... mos. ..... ds.

(Signed) F. S. Wright M. D.

2/7 1921 (Address) Salmon

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs....mos....days. In the State....yrs....mos....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Salmon Cemetery — DATE OF BURIAL: 1-20" 1921

20. UNDERTAKER: W C Hoeble — ADDRESS: Salmon

MAR 10 1921

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 41
Primary Registration District No. 2116
File No. 33132
Registered No.

1. PLACE OF DEATH
County of Lemhi
City of May
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME. Sullivan James Knight

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
male	white	Single

6. DATE OF BIRTH: January (Month) 10 (Day) 1878 (Year)

7. AGE: 43 Yrs. ..... Mos. 18 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: James C. Knight

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Sunderger

13. BIRTHPLACE OF MOTHER (State or Country): New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) M. W. Knight
(Address) May Idaho

15. Filed 2/10 1921 W. D. Greene Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: January (Month) 25th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Suicidal intent by shooting in head.
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) W. C. Dubbles Coroner M. D.
1-28 1921 (Address) Salmon Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: May Cemetery
DATE OF BURIAL: 1-30th 1921

20. UNDERTAKER: W. C. Dubbles
ADDRESS: Salmon Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33134 MAR 1921

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No. 62

Primary Registration District No. 2129

County of Lewis

City of Craigmont (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sanford Ringle

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): widowed

6. DATE OF BIRTH. March (Month) 13 (Day) 1861 (Year)

7. AGE 69 Yrs. 10 Mos. 26 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION

(a) Trade, profession or particular kind of work... Farmer

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Ohio

10. NAME OF FATHER S. Ringle

11. BIRTHPLACE OF FATHER (State or Country) Ohio.

12. MAIDEN NAME OF MOTHER not known

13. BIRTHPLACE OF MOTHER (State or Country) Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. J. Fassnacht

(Address) Craigmont Idaho

15. Filed 7/13 1921 P E Dunbar Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 11 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 13 1920, to Feb 11 19[illegible], that I last saw h[illegible] alive on Feb 11 191[illegible], and that death occured on the date stated above, at 8:30 P.M.

The CAUSE OF DEATH* was as follows:

Pul. embolus

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Chronic endocarditis

Hypertrophy

..... (Duration) [illegible] yrs. ..... mos. ..... ds.

(Signed) P E Dunbar M. D.

7/13 1921 (Address) Craigmont

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Nez Perce Mich | DATE OF BURIAL ..... 191.....

20. UNDERTAKER Stoddard | ADDRESS Lapwai

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 100
Primary Registration District No. 2178

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3314 20
Registered No. 16

1. PLACE OF DEATH.
County of Madison
City of Rexburg
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Reed Stoddard

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Feby (Month) 13 (Day) 1921 (Year)

7. AGE: ....Yrs. ....Mos. 15 ds.
IF LESS than 1 day how many ....hrs. or ....min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Rexburg, Idaho.

10. NAME OF FATHER: T. J. Stoddard

11. BIRTHPLACE OF FATHER (State or Country): Idaho.

12. MAIDEN NAME OF MOTHER: Eunice Mae Beattie

13. BIRTHPLACE OF MOTHER (State or Country): Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) T. J. Stoddard
(Address) Rexburg Ida.

15. Filed 3/1 1921
G. G. Espe
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feby (Month) 28 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 25 1921, to Feb 28 1921, that I last saw him alive on Feb 27 1921, and that death occured on the date stated above, at 12.30 A.M.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

(Duration) ....Yrs. ....mos. ....ds.

Contributory (Secondary)

(Duration ....Yrs. ....mos. ....ds.

(Signed) G. G. Espe M. D.

19.... (Address) ....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death....yrs....mos....days In the State....yrs....mos....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Burton, Idaho. DATE OF BURIAL: 3-1 1921

20. UNDERTAKER: John McRichards ADDRESS: Rexburg, Ida.

EVANS - YORK CO., PTRS. & BDRS. 24654

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

MAR 10 1921

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 100
Primary Registration District No. 2178
File No. 3345
Registered No. 15

1. PLACE OF DEATH

County of Madison
City of Sugar City
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elizabeth Dredge Roberts

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: March (Month) 5th (Day) 1861 (Year)

7. AGE: 59 Yrs. 11 Mos. 22 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wales

10. NAME OF FATHER: Jesse P. Dredge

11. BIRTHPLACE OF FATHER (State or Country): Wales

12. MAIDEN NAME OF MOTHER: Ellen Rheese

13. BIRTHPLACE OF MOTHER (State or Country): Wales

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Addie R. West

(Address) Sugar City, Ida.

15. Filed 3/27 21

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: February (Month) 24th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 17 1921 to Feb. 26 1921 that I last saw h.. alive on Feb. 3rd 1921 and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Pancreas

(Duration) about 6 yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) H. B. Evans M. D.

2-28 1921 (Address) Sugar City

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rexburg, Idaho

DATE OF BURIAL: Mar. 2 1921

20. UNDERTAKER: David Young

ADDRESS: Rexburg

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 100

County of Madison

Primary Registration District No. 2178

City of Sugar (No. ....., ... St.)

File No. 33145

Registered No. 13

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jacob Ira Naef.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)
Male	White	Widower

6. DATE OF BIRTH: November (Month) 1 (Day) 1836 (Year)

7. AGE: 84 yrs. 3 mos. 12 ds.

IF LESS than 1 day how many ..... *hrs.* or ..... *mins.*?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Switzerland

10. NAME OF FATHER: John Naef

11. BIRTHPLACE OF FATHER (State or Country): Switzerland

12. MAIDEN NAME OF MOTHER: Elizabeth Schutzer

13. BIRTHPLACE OF MOTHER (State or Country): Switzerland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Robert Naef
(Address) Sugar City

15. Filed 2/13 1921 G. G. Eske Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: February (Month) 12th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from December 27 1920 to February 12th 1921 that I last saw h. alive on February 12th 1921 and that death occurred on the date stated above, at 10:30 P. M.

The CAUSE OF DEATH* was as follows:
(Senility) - Pathology Unknown

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. B. Evans M. D.

2-13-1921 (Address) Sugar City, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Logan, Utah | DATE OF BURIAL ..... 191...

20. UNDERTAKER: John Phillips | ADDRESS: Rexburg, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 100
Primary Registration District No. 2178
File No. 33146
Registered No. 12

1. PLACE OF DEATH

County of Madison
City of Rexburg
(No. ..... , ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Laurence Romney

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Male	White	Single (Write the word.)

6. DATE OF BIRTH: August 21 (Month) 1909 (Year)

7. AGE: 11 Yrs. 5 Mos. 22 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: School Student
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Gaskell Romney

11. BIRTHPLACE OF FATHER (State or Country): Utah.

12. MAIDEN NAME OF MOTHER: Anna Pratt

13. BIRTHPLACE OF MOTHER (State or Country): Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Anna Romney
(Address) Rexburg, Idaho

15. Filed 2/13 1921 G. L. Eastle Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 12 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 26 1920, to Feb 11 – 1921
that I last saw h. IM... alive on Feb 11 – 1921,
and that death occurred on the date stated above, at 9 A M.
The CAUSE OF DEATH* was as follows:

Mitral Insufficiency
(From Endocarditis)
(Duration) 1 Yrs. – mos. – ds.
Contributory (Secondary) Rheumatic Fever
(Duration) ..... yrs. 3 mos. – ds.

(Signed) Lorin F. Kiel M. D.
2.13.1924 (Address) Rexburg, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Sugar City
DATE OF BURIAL: 2-14 1921

20. UNDERTAKER: David R Young
ADDRESS: Rexburg

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

MAR 10 1921

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. **PLACE OF DEATH**

County of Madison

City of Rexburg

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 100

Primary Registration District No. 2178

(No. ..... St.)

File No. 33147

Registered No. 9

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Alma Roylance

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH

May (Month) 29 (Day) 1845 (Year)

7. AGE

75 Yrs. 8 Mos. 3 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Utah

10. NAME OF FATHER John Roylance

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER Mary Ann Oaks

13. BIRTHPLACE OF MOTHER (State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wallace Roylance

(Address) Rexburg, Ida.

15. Filed 2/3 1921

G. H. Espe
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

2 (Month) 1 (Day) 21 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 20 1921, to Feb 1 1921, that I last saw h[illegible] alive on Feb 1 1921, and that death occurred on the date stated above, at 1:30 A.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ..... Yrs. ..... mos. 3 ds.

Contributory (Secondary) Chronic Myocarditis

(Duration) years yrs. ..... mos. ..... ds.

(Signed) Jos Walker M. D.

2-2 1921 (Address) Rexburg

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Sugar City, Ida.	2-6 1921
20. UNDERTAKER David R. Young	ADDRESS Rexburg.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

MAR 10 1921

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 100

Primary Registration District No. 2178

File No. 33148

County of Madison

City of Rexburg (No. ....., ... St.)

Registered No. 10

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME .....

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
Female	White	Single (~~White~~ the word.)

6. DATE OF BIRTH: Feb (Month) 12 (Day) 1921 (Year)

7. AGE: 0 yrs. 0 mos. 0 ds.

IF LESS than 1 day how many ... 0 ... hrs. or ... 0 ... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Sugar Idaho

10. NAME OF FATHER: Harry D. Camphouse

11. BIRTHPLACE OF FATHER (State or Country): Holland

12. MAIDEN NAME OF MOTHER: Mary Baggeson

13. BIRTHPLACE OF MOTHER (State or Country): Colo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Harry D. Camphouse
(Address) Sugar City Idaho

15. Filed 2/13 1921 G. G. Espe Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb (Month) 12 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 12 1921, to Feb 12 1921
~~that I last saw h~~ alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Still Born & Premature

(Duration) 0 yrs. 0 mos. 0 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Parley Nelson M. D.
2-12 1921 (Address) Rexburg Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL 191...

20. UNDERTAKER	ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

MAR 10 1921

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 100
Primary Registration District No. 2178
(No. ....., ... St.)

File No. 33149
Registered No. 11

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Madison
City of Sunnydell

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ada Leona Wilcox

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH.
May (Month) 8 (Day) 1920 (Year)

7. AGE
..... Yrs. 8 Mos. 29 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE
(State or Country) Sunnydell Idaho.

10. NAME OF FATHER
Adrain Boyd Wilcox

11. BIRTHPLACE OF FATHER
(State or Country) Sunnydell Idaho.

12. MAIDEN NAME OF MOTHER
May Allen

13. BIRTHPLACE OF MOTHER
(State or Country) Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Adrain Boyd Wilcox
(Address) Sunnydell Idaho

15.
Filed 2/8 1921
G G Tasse
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
February (Month) 7 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at 2:15 P. M.
The CAUSE OF DEATH* was as follows:
Broncho Pneumonia

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) G G Tasse M. D.
19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Archer. DATE OF BURIAL: Feby. 8 1921

20. UNDERTAKER: John McEachern ADDRESS: Rexburg, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24854

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 100 — 1921
Primary Registration District No. 2178
File No. 3350
Registered No. ....

1. PLACE OF DEATH,
County of Madison
City of Rexburg
If death occurs away from usual residence, give facts called for under special information.

(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mrs. Suka Kawakami

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: Jap.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Oct. (Month) 27 (Day) 1899 (Year)

7. AGE: 21 Yrs. 2 Mos. 5 ds. — IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Japan

10. NAME OF FATHER: Sanhichi

11. BIRTHPLACE OF FATHER (State or Country): Japan

12. MAIDEN NAME OF MOTHER: Miyo

13. BIRTHPLACE OF MOTHER (State or Country): Japan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) ~~Joe Kawakami~~ Joe Kawakami
(Address) Joe Rexburg

15. Filed 1/28 1921 — G. Gleason, Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. (Month) 27 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 27 1921 to Jan 27 1921 that I last saw him alive on Jan 27 1921 and that death occurred on the date stated above, at 2:10 P.M.

The CAUSE OF DEATH* was as follows:
Fracture of Skull-Accidental
Tree fell & crushed
nose & Forehead
(Duration) ..... Yrs. ..... mos. 1 hr 40 min ds.

Contributory (Secondary) .....
(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) Parley Nelson M. D.
1-28 1921 (Address) Rexburg Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rexburg — DATE OF BURIAL: 1/29 1921

20. UNDERTAKER: J Rexburg — ADDRESS: Rexburg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

MAR 10 1921

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 150
Primary Registration District No. 2178
(No. ....., ... St.)

File No. 3315
Registered No. 7

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Madison
City of Rexburg
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elizabeth Grace Casper

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. October (Month) 2 (Day) 1919 (Year)

7. AGE: 1 Yrs. 3 Mos. 24 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Reuben W. Casper

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Sarah E. Allen

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Edwin A. Tuttle
(Address) Rexburg Idaho

15. Filed 1/27 1921 G. H. Estes Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: January (Month) 26 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 25 1921, to Jan 25 1921, that I last saw her alive on Jan 25 1921, and that death occured on the date stated above, at 10.15 A.M.

The CAUSE OF DEATH* was as follows:
Malnutrition
(Duration) 1 Yrs. 4 mos. ds.
Contributory (Secondary) acute Coriza
(Duration yrs. mos. 10 ds.
(Signed) Carlly Nelson M. D.
1-27 1921 (Address) Rexburg Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewisville, Idaho — DATE OF BURIAL: 1-28 1921

20. UNDERTAKER: John M. Richards — ADDRESS: Rexburg, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24654

FORM V. S. No. 5-12 M. 6-15-17.

MAR 10 1921

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 100
Primary Registration District No. 2178
(No. ....., ... St.)

File No. 3515
Registered No. 2
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Madison
City of Thorton
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John J. Simmons

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	W	Married

6. DATE OF BIRTH. June (Month) 12 (Day) 1891 (Year)

7. AGE 29 Yrs. 7 Mos. 13 ds. — IF LESS than 1 day how many .... hrs. or .....min.?'

8. OCCUPATION
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Utah

10. NAME OF FATHER Andrew J. Simmons

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Agnes Bellows

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. A. J. Simmons
(Address) Rexburg

15. Filed 1/27 1921 — G. H. Cope, Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 24 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 22 1921 to Jan 25 1921
that I last saw him alive on Jan 25 1921
and that death occurred on the date stated above, at 6:30 P.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ..... Yrs..... mos. Eight ds.

Contributory (Secondary) .....

(Duration) ..... Yrs..... mos..... ds.

(Signed) A. O. Martin M. D.
Jan 27 1921 (Address) Rexburg Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs.....mos....days. In the ,State....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Burton — **DATE OF BURIAL** 1/28 1921

20. UNDERTAKER J. Cyrus Fox & Son — **ADDRESS** Rexburg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 100
Primary Registration District No. 2178
File No. 33155
Registered No. 5

1. PLACE OF DEATH
County of Madison
City of Rexburg
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Male	White	Single (Write the word.)

6. DATE OF BIRTH
Jan 3 (Month) ..... (Day) 1921 (Year)

7. AGE
..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many 9 hrs. or — min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: home
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE
(State or Country) Idaho

10. NAME OF FATHER
Alfred H Paul

11. BIRTHPLACE OF FATHER
(State or Country) Idaho

12. MAIDEN NAME OF MOTHER
Jennie Jensen

13. BIRTHPLACE OF MOTHER
(State or Country) Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Alfred Paul
(Address) .....

15. Filed 1/4 1921
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
January (Month) 8 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 3 1921, to Jan 3 - 1921
that I last saw h. IM alive on Jan 3 - 1921,
and that death occurred on the date stated above, at 10-A M.
The CAUSE OF DEATH* was as follows:
Cyanosis

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Patulous foramen Ovale
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Lorin F. Rich M. D.
1/4 1920 (Address) Rexburg Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL 19
20. UNDERTAKER	ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 100 — 1019
Primary Registration District No. 2178
File No. 33156
(No. ..... St.)
Registered No. 2

1. PLACE OF DEATH
County of Madison
City of Rexburg
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lila Beatrice Hinckley

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Single

6. DATE OF BIRTH: Oct (Month) 13 (Day) 1913 (Year)

7. AGE: 8 Yrs. 2 Mos. 20 ds. — IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Arthur S Hinckley

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Clara Mason

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Clara Hinckley
(Address) Rexburg Ida

15. Filed 1/5 1921 — Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: January (Month) 3 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 15 1920, to Jan 3 1921, that I last saw her alive on Jan 2 1921, and that death occurred on the date stated above, at 10:30 M.

The CAUSE OF DEATH* was as follows:
Mitral Regurgitation

(Duration) 3 Yrs. ..... mos. ..... ds.
Contributory (Secondary) Acute Poly arthritis
(Duration) ..... yrs. ..... mos. 21 ds.

(Signed) Parley Nelson M. D.
1-5 1921 (Address) Rexburg Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rexburg Ida — DATE OF BURIAL: Jan 19 21

20. UNDERTAKER: Rexburg Furn. Co. — John Phillips — ADDRESS: Rexburg Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

MAR 10 1921

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Madison

City of Rexburg

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 100

Primary Registration District No. 2178

(No. ..... St.)

File No. 33157

Registered No. 1

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Vilate Woodmansee

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widowed (Write the word.)

6. DATE OF BIRTH: Aug. (Month) 24 (Day) 1867 (Year)

7. AGE: 53 Yrs. 4 Mos. 7 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: John Pincock

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Isabella Douglas

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E. Beesley

(Address) Rexburg

15. Filed 1/5 1921

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. (Month) 1 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 3 1920, to Jan 1 1921 that I last saw her alive on Jan 1 1921, and that death occurred on the date stated above, at 5:25 A M.

The CAUSE OF DEATH* was as follows: Carcinoma of Spleen

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Lorin F. Rich M. D.

1/3 1921 (Address) Rexburg Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Ogden, Utah — DATE OF BURIAL: 1/4 1921

20. UNDERTAKER — ADDRESS

Be sure to be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in a manner to be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-25 M. 1-19.

MAR 10 19

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 19
Primary Registration District No. 2015
File No. 33163
Registered No. 6

1. PLACE OF DEATH
County of Minidoka
City of Rupert.
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Rosel Lee Hoyde

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH: Aug (Month) 8 (Day) 1920 (Year)

7. AGE: Yrs. 5 Mos. 12 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Rupert Idaho

10. NAME OF FATHER Rosel P. Hoyde.

11. BIRTHPLACE OF FATHER (State or Country) Ida.

12. MAIDEN NAME OF MOTHER Connie Allen

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Rosel Hoyde
(Address) Rupert

15. Filed Jan 20 1921 E. H. Elmore
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 20 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 19 1921, to Jan 20 1921
that I last saw h.. alive on Jan 19 1921
and that death occurred on the date stated above, at 24 M.
The CAUSE OF DEATH* was as follows:
Bronchial Pneumonia
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... mos. ..... ds.
(Signed) ..... M. D.
Jan 20 1921 (Address) Rupert Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL 19..
20. UNDERTAKER	ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Groom MAR 1921

File No. 33165

Registered No. 8

Registration District No. 19

Primary Registration District No. 2015

1. **PLACE OF DEATH**

County of Minidoka

City of Rupert

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. **FULL NAME** John L. Merrell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Male	White	Married

6. DATE OF BIRTH: Nov (Month) 17 (Day) 1868 (Year)

7. AGE: 52 Yrs. 1 Mos. 16 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Virgil L. Merrell

11. BIRTHPLACE OF FATHER (State or Country): ?

12. MAIDEN NAME OF MOTHER: Annie Lemmon

13. BIRTHPLACE OF MOTHER (State or Country): ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. J. L. Merrell
(Address) Rupert Idaho

15. Filed Jan. 17 1921 E. W. Elmore Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 8 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 16 1920 to Jan 8 1921 that I last saw h[illegible] alive on Jan 8 1921 and that death occurred on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Typhoid Fever.

Pneumonia.

(Duration) Hours ..... ds.

Contributory (Secondary) .....

(Duration) ..... mos. ..... ds.

(Signed) [signature] M. D.

1-21 1921 (Address) Rupert Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Rupert Cemetery	Jan 12 1920

20. UNDERTAKER: W. G. Goodman — ADDRESS: Rupert

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

Elmore MAR 8 1921

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33166

Registered No. 9

1. **PLACE OF DEATH**

County of Minidoka

City of Rupert

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 19

Primary Registration District No. 2015

2. **FULL NAME** Dis. H. Rognas

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. **SEX**: Mal

4. **COLOR OR RACE**: White

5. **SINGLE, MARRIED, WIDOWED OR DIVORCED** (Write the word.)

6. **DATE OF BIRTH**: Jan (Month) 11 (Day) 1921 (Year)

7. **AGE**: ..... Yrs. ..... Mos. 2 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. **OCCUPATION**

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. **BIRTHPLACE** (State or Country): Idaho

10. **NAME OF FATHER**: C. W. Rognas

11. **BIRTHPLACE OF FATHER** (State or Country): Minnesota

12. **MAIDEN NAME OF MOTHER**: Ruth H. Grundmann

13. **BIRTHPLACE OF MOTHER** (State or Country): Minnesota

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**

(Informant) C. W. Rognas

(Address) Rupert Idaho

15. Filed Jan. 14 1921 E. O. Elmore Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH**: Jan (Month) 13 (Day) 1921 (Year)

17. **I HEREBY CERTIFY**, That I attended deceased from Jan. 11 1921, to Jan 13 1921, that I last saw him alive on Jan 12 1921, and that death occurred on the date stated above, at 5 A.M.

The CAUSE OF DEATH* was as follows:

Premature Birth

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E. O. Elmore M. D.

1-14 1921 (Address) Rupert. Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. **PLACE OF BURIAL OR REMOVAL**: Rupert Cemetery

DATE OF BURIAL: Jan 13 1921

20. **UNDERTAKER**: A. A. Goodman

ADDRESS

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

MAR 10 1921

John Carman.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96

Primary Registration District No. 1009

File No. 33169

Registered No. 597

1. PLACE OF DEATH

County of Nez Perce

City of Lewiston

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William Henry Oglesby.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Widowed.

6. DATE OF BIRTH: Nov (Month) 26 (Day) 1874 (Year)

7. AGE: 46 Yrs. 2 Mos. 3 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Mechanic
(b) General nature of industry, business or establishment in which employed (or employer): ~~Auto~~ Auto.

9. BIRTHPLACE (State or Country): Mo.

10. NAME OF FATHER: Rodney Oglesby.

11. BIRTHPLACE OF FATHER (State or Country): Del.

12. MAIDEN NAME OF MOTHER: Katherine Chapman

13. BIRTHPLACE OF MOTHER (State or Country): Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J E Oglesby
(Address) Peck Ida.

15. Filed Feb 8 1921 Susan C Bruce Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 29 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 21, 1921, to Jan 29 1921, that I last saw h~~im~~... alive on Jan 24 1921, and that death occurred on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:
Ruptured appendix & general peritonitis.

(Duration) ..... Yrs. ..... mos. 8 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Paul D Johnson M. D.
1/31 1921 (Address) Lewiston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Peck Idaho.	1 19

20. UNDERTAKER: Lassar Undertaking Co. ADDRESS: Lewiston Ida

1:30 P.M.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

MAR 10 1921

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
(No. ..... St.)

File No. 33170
Registered No. 2-96

1. PLACE OF DEATH
County of Nez Perce
City of Lewiston
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Robert George Gaylord
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Sept (Month) 25 (Day) 1919 (Year)

7. AGE: 1 Yrs. 4 Mos. 1 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: F. M. Gaylord

11. BIRTHPLACE OF FATHER (State or Country): Wisconsin.

12. MAIDEN NAME OF MOTHER: Katherine Kerr

13. BIRTHPLACE OF MOTHER (State or Country): Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Gaylord
(Address) 814 12th St Clarkston Wn

15. Filed Feb 8 1921 Anna E Bruce Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 26 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 25 1921, to Jan 26 1921, that I last saw him alive on Jan 26 1921 and that death occurred on the date stated above, at 3:30 P.M.

The CAUSE OF DEATH* was as follows:
Status Lymphaticus

(Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E. L. White M. D.
Jan 26 1921 (Address) Lewiston Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Lewiston Ida	1/27 1921

20. UNDERTAKER: Vassar Undertaking Co. ADDRESS: Lewiston Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33171

Registered No. 595

1. **PLACE OF DEATH**

County of Nez Perce

City of Lewiston

(No. ..... , ... St.)

Registration District No. 96

Primary Registration District No. 1009

If death occurs away from usual residence, give facts called for under special information.

2. **FULL NAME** Frank Henry Whipple

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
male	White	Single

6. **DATE OF BIRTH** May (Month) 21 (Day) 1918 (Year)

7. **AGE** 2 Yrs. 8 Mos. 5 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. **OCCUPATION**

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business or establishment in which employed (or employer):

9. **BIRTHPLACE** (State or Country) Idaho

10. **NAME OF FATHER** C. C. Whipple

11. **BIRTHPLACE OF FATHER** (State or Country) Ill-

12. **MAIDEN NAME OF MOTHER** Ethel E. Snider

13. **BIRTHPLACE OF MOTHER** (State or Country) Ohio

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**

(Informant) C. C. Whipple

(Address) 801 7th Ave City

15. Filed Feb 8 19 21 Susan E Bruce Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH** Jan (Month) 26 (Day) 1921 (Year)

17. **I HEREBY CERTIFY**, That I attended deceased from Jan 23 19 21, to Jan 26 19 21 that I last saw h[illegible] alive on Jan 25 19 21 and that death occurred on the date stated above, at 7a M.

The **CAUSE OF DEATH*** was as follows:

Bronchio Pneumonia

(Duration) ..... Yrs. ..... mos. 4 ds.

Contributory (Secondary) Influenza

(Duration) ..... yrs. 1 mos. ..... ds.

(Signed) O. E. Spencer M. D.

19 ..... (Address) Lewiston Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Lewiston Ida	7/27 1921
20. UNDERTAKER	**ADDRESS**
Parsons Undt. Co.	Lewiston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE, IDA.

FORM V. S. No. 5-A—25 M. 1-19.

MAR 10 1921

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 33173
Registered No. 393

1. PLACE OF DEATH
County of Nez Perce
City of Lewiston
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Welch
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widow

6. DATE OF BIRTH: May (Month) 15 (Day) 1831 (Year)

7. AGE: 89 Yrs. 8 Mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Cork Ireland

10. NAME OF FATHER: Edward Draham

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Welch
(Address) 1835 7th ave

15. Filed Feb 5 1921 — Wm E Bruce, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 24th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 5 1917, to Jan 24th 1921, that I last saw her alive on about Jan 3 1921, and that death occurred on the date stated above, at — M.

The CAUSE OF DEATH* was as follows: Natural causes on old age

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J W Morris M. D.

19..... (Address) Genesee Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston-Ida — DATE OF BURIAL: 1/26 1921

20. UNDERTAKER: Vassar Bros Co. — ADDRESS: Lewiston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MAR 10 1921

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 33174
Registered No. 592

1. PLACE OF DEATH
County of Nez Perce
City of Lewiston, Idaho
(No. St. Josephs Hospital St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Martin Meuli
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH: Oct. (Month) 24 (Day) 1848 (Year)

7. AGE: 82 Yrs. 3 Mos. 27 ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Novia Scotia

10. NAME OF FATHER: Martin Beuli

11. BIRTHPLACE OF FATHER (State or Country): Novia Scotia

12. MAIDEN NAME OF MOTHER: Barbara ?

13. BIRTHPLACE OF MOTHER (State or Country): Novia Scotia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Martin Meuli
(Address) Clarkston, Wash.

15. Filed Feb 8 1921 Susan E Brun
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 21 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1 1921 to Jan 21 1921
that I last saw him alive on Jan 21 1921,
and that death occurred on the date stated above, at 4:30 P.M.
The CAUSE OF DEATH* was as follows:

Uremia

(Duration) ... Yrs. ... mos. 8 ds.
Contributory (Secondary) Had Operation for strangulated hernia.
(Duration) ... yrs. 1 mos. ... ds.

(Signed) Paul W Johnson M. D.
1/22 1921 (Address) Lewiston Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. 1 mos. ... days. In the State ... yrs. 1 mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence Clarkston Wash

19. PLACE OF BURIAL OR REMOVAL: Uniontown, Wash. DATE OF BURIAL: 1/23/21 1921

20. UNDERTAKER: H.R.Merchant ADDRESS: Clarkston, Wn.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51068

FORM V. S. No. 5-A—25 M. 1-19.

MAR 10 1921

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 33175
Registered No. 371

1. PLACE OF DEATH
County of Nez Perce
City of Lewiston
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charles Watson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married
6. DATE OF BIRTH: June (Month) 30 (Day) 1866 (Year)
7. AGE: 54 Yrs. 6 Mos. 20 Ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Iowa
10. NAME OF FATHER: David Watson
11. BIRTHPLACE OF FATHER (State or Country): U.S.
12. MAIDEN NAME OF MOTHER: Sarah Rosenberger
13. BIRTHPLACE OF MOTHER (State or Country): U.S.
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) M M Watson
(Address) 0201 7th Ave

15. Filed F-8 — 1921 Emma E Bruce Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 20 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....
and that death occurred on the date stated above, at 6.30 A.M.
The CAUSE OF DEATH* was as follows:
Probable Dead on Main St near 16th
probably apoplexy
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) W B Williamson Coroner M. D.
19..... (Address) Lewiston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston Ida — DATE OF BURIAL: 1/22 1921
20. UNDERTAKER: Vassar Undt. Co. — ADDRESS: Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

MAR 10 1921

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

CERTIFICATE OF DEATH

Registration District No. 96
Primary Registration District No. 1009
File No. 33176
Registered No. 390

1. PLACE OF DEATH
County of Nez Perce
City of Lewiston
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Dorothy Frances Lorang
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: single (Write the word.)

6. DATE OF BIRTH: 11 (Month) 27 (Day) 1919 (Year)

7. AGE: 1 Yrs. 1 Mos. 24 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Lewiston

10. NAME OF FATHER: Albert P Lorang

11. BIRTHPLACE OF FATHER (State or Country): Genesee Idaho

12. MAIDEN NAME OF MOTHER: Hazel B Misner

13. BIRTHPLACE OF MOTHER (State or Country): Mich.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A P Lorang
(Address) Lewiston, Idaho

15. Filed Feb 8 1921 Susan E Bruce, Local Registrar

BYRNE-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 18 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 16 1921, to Jan 18 1921
that I last saw her alive on Jan 18 1921
and that death occurred on the date stated above, at 6:30 A.M.
The CAUSE OF DEATH* was as follows:
Crushed occiput of skull and fracture of base - loss of brain substance
(Duration) Yrs. ..... mos. 2 ds.
Contributory (Secondary) Fall
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Edgar L. White M. D.
Jan 19 1921 (Address) Lewiston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Lewiston Ida — DATE OF BURIAL: 1-20 1921

20. UNDERTAKER: Lussar Mort Co — ADDRESS: Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

MAR 10

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 33178
Registered No. 588

1. PLACE OF DEATH
County of Nez Perce
City of Lewiston
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Katherine Lemley

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: January 14th 1921 (Month) (Day) (Year)

7. AGE: ....Yrs. ....Mos. 2 Ds.
IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho -

10. NAME OF FATHER: John F. Lemley

11. BIRTHPLACE OF FATHER (State or Country): Canada

12. MAIDEN NAME OF MOTHER: Nellie Carroll

13. BIRTHPLACE OF MOTHER (State or Country): Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) .....
(Address) .....

15. Filed Feb 8 1921 — Susan E Bruce, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: January 13th 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from January 11th 1921, to January 13th 1921, that I last saw her alive on January 13th 1921, and that death occured on the date stated above, at 5 P. M.
The CAUSE OF DEATH* was as follows:

Bronchitis
(Duration) ....Yrs. ....mos. 2 ds.
Contributory (Secondary)
(Duration ....yrs. ....mos. ....ds.
(Signed) D. C. Corran M. D.
1-15 1921 (Address) Lewiston, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Sticknpoo — DATE OF BURIAL: 1-16 1921

20. UNDERTAKER: Fathin & Child — ADDRESS: Sticknpoo

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRNS - YORK CO., PTGS. & ENGS. 24658

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

MAR 10 1922

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
(No. ..... St.)

File No. 33179
Registered No. 987

1. **PLACE OF DEATH**
County of Nez Perce
City of Lewiston
If death occurs away from usual residence, give facts called for under special information.

2. **FULL NAME** Mary Jane Brown

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widowed (Write the word.)

6. DATE OF BIRTH: Oct ..... 1 ..... (Month) (Day) (Year)

7. AGE: 95 Yrs. 7 Mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ill

10. NAME OF FATHER: Evan Lacus

11. BIRTHPLACE OF FATHER (State or Country): U.S.

12. MAIDEN NAME OF MOTHER: Mary Curtis

13. BIRTHPLACE OF MOTHER (State or Country): U.S.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Son Labor.
(Address): City

15. Filed Feb 8 1921 — Ann E Bruce, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. 14 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 11th 1921, to Jan 14th 1921
that I last saw h.e.r. alive on Jan 11th 1921.
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Paralysis Congestion of Lungs
Gradual Failure
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary): General Weakness
(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) J. O. Monroe M. D.
19..... (Address) Lewiston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Lewiston Ida	Mar 15 1921
20. UNDERTAKER	ADDRESS
Vassar Undertaking Co.	Lewiston

FORM V. S. No. 5-A—25 M. 1919.

Waters.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 33180
Registered No. 386

1. PLACE OF DEATH
County of Nez Perce
City of Lewiston,
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Abagail Bethsheba Hayden

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Jan (Month) 4 (Day) 1842 (Year)

7. AGE: 79 Yrs. — Mos. 10 ds.
IF LESS than 1 day, how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Her.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ill.

10. NAME OF FATHER: Ephriam Parker

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A A Hayden
(Address) 2122 Eighth Ave.

15. Filed Feb 8 1921 Susan E Bruce
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 14 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from January 10 1921, to Jan 14 1921, that I last saw h.e.r. alive on Jan 14 1921, and that death occurred on the date stated above, at 6 10 A.M.
The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) — Yrs. — mos. 6 ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Patterson A. Waters M. D.
1-15 1921 (Address) Lewiston, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston Ida — DATE OF BURIAL: 1/15 1921

20. UNDERTAKER: Vassar Und. Co. — ADDRESS: Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 33181
Registered No. 585

1. PLACE OF DEATH
County of Nez Perce
City of Lewiston
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Geo Rea.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH
..... (Month) ..... (Day) 1 (Year)

7. AGE: 72 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher
(b) General nature of industry, business or establishment in which employed (or employer): Gen Farming

9. BIRTHPLACE (State or Country): Canada

10. NAME OF FATHER: Rea.

11. BIRTHPLACE OF FATHER (State or Country): Canada.

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country): Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A. Branson
(Address) Rogers Falls Wash

15. Filed Feb 8 1921 Norman E Bruce
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Jan (Month) 17 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 11 1921, to Jan 12 1921
that I last saw him alive on Jan 12 1921
and that death occurred on the date stated above, at 4 A.M.
The CAUSE OF DEATH* was as follows:

Athenic Apoplexy

(Duration) ..... Yrs. ..... mos. 1 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) L F Drennan M. D.
19..... (Address) Lewiston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rogers Falls. Wash.
DATE OF BURIAL ..... 19.....

20. UNDERTAKER: Lassar Undertaking Co.
ADDRESS: Lewiston.
Em Brown

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

MAR 10 1921

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
(No. St. Joseph Hospital St.)

File No. 33182
Registered No. 584

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Nez Perce

City of Lewiston, Idaho

2. FULL NAME Luther John Mc Kee

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH: March (Month) 28 (Day) 1879 (Year)

7. AGE: 42 Yrs. 10 Mos. 12 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Book keeper

(b) General nature of industry, business or establishment in which employed (or employer): Camas Prairie Rr Co.

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: ?

11. BIRTHPLACE OF FATHER (State or Country): ?

12. MAIDEN NAME OF MOTHER: ?

13. BIRTHPLACE OF MOTHER (State or Country): ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
Mrs Mae McKee
(Informant)
Clarkston, Wash.
(Address)

15. Filed Feb 8 1921 — Susan E Bruce, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51068

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. (Month) 11 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 8. 1921, to Jan. 11. 1921 that I last saw him alive on Jan. 11. 1921 and that death occurred on the date stated above, at 11. A.M.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction.

(Duration) ..... Yrs. ..... mos. 11 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F.T.Harris, M. D.

1/13/1921 (Address) Lewiston, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston, Ida. DATE OF BURIAL: 1/13 1921

20. UNDERTAKER: H.R. Merchant ADDRESS: Clarkston, Wn.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M: 1-19.

MAR 1

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 95
Primary Registration District No. 1009
(No. ..... St.)

File No. 3318 3
Registered No. 583

1. **PLACE OF DEATH**
County of Nez Perce
City of Lewiston
If death occurs away from usual residence, give facts called for under special information.

2. **FULL NAME** Joseph August

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. **SEX**: M

4. **COLOR OR RACE**: White

5. **SINGLE, MARRIED, WIDOWED OR DIVORCED** (Write the word.): Married

6. **DATE OF BIRTH**: ..... (Month) ..... (Day) 1 (Year)

7. **AGE**: 45 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. **OCCUPATION**
(a) Trade, profession or particular kind of work: Farming
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. **BIRTHPLACE** (State or Country): Italy

10. **NAME OF FATHER**: John August

11. **BIRTHPLACE OF FATHER** (State or Country): Italy.

12. **MAIDEN NAME OF MOTHER**: Josephine Schmidli

13. **BIRTHPLACE OF MOTHER** (State or Country): Italy.

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**
(Informant) Pasco Spano
(Address) R#1 Lewiston

15. Filed Feb 8 1921 Roam E Bruce
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH**: Jan (Month) 11 (Day) 1921 (Year)

17. **I HEREBY CERTIFY, That I attended deceased from**
..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Injuries & Exposure due to Auto Accident,
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Edgar L Wheeler M. D.
..... 19..... (Address) Lewiston Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Lewiston Ida	1. 7. 1921
20. UNDERTAKER	ADDRESS
Vassar Undtg Co,	Lewiston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

BYRNS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

MAR 10 1921 Certificate

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 33184
Registered No. 582

1. PLACE OF DEATH
County of Nez Perce
City of Lewiston
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Virginia N. Wright

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Widowed

6. DATE OF BIRTH: Dec (Month) 2 (Day) 1865 (Year)

7. AGE: 55 Yrs. 1 Mos. 5 ds.
IF LESS than 1 day: how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Wife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Cal

10. NAME OF FATHER: Jno. J. Berry

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER: Mary ——

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Manuel N. Wright
(Address) Lewiston Idaho

15. Filed Feb 8 1921 — Susan E. Burne, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 7th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 15 1920 to Jan 7th 1921 that I last saw h.. alive on Jan 7th 1921, and that death occurred on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows:
Uraemia. Nephritis

(Duration) 2 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) L. J. Carnes M. D.
1/8 1921 (Address) Lewiston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston Idaho — DATE OF BURIAL: Jan 9th 1921

20. UNDERTAKER: Bassett Undertaking Co. — ADDRESS: Lewiston Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96 — Broadbent — 1921
Primary Registration District No. 1009
File No. 33185
Registered No. 551

1. PLACE OF DEATH
County of Nez Perce
City of Lewiston
(No. St. Jos Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Cora May Cox

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: March (Month) 22 (Day) 1900 (Year)

7. AGE: 20 Yrs. 2 Mos. 14 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Minn.

10. NAME OF FATHER: H. C. Pitt.

11. BIRTHPLACE OF FATHER (State or Country): — — —

12. MAIDEN NAME OF MOTHER: Mary E. Whipkey

13. BIRTHPLACE OF MOTHER (State or Country): Iowa.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Everett Cox
(Address) Lewiston Idaho

15. Filed Feb 8 1921 — Wm E Bruce, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 6 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 18 1920 to Jan 6 1921
that I last saw h.. alive on Jan 6 1921
and that death occurred on the date stated above, at 10:30 A.M.
The CAUSE OF DEATH* was as follows:

Typhoid fever

(Duration) ..... Yrs. ..... mos. 21 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Elmer G Broadbent M. D.
Jan 6 1921 (Address) Lewiston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston Ida — DATE OF BURIAL ..... 19.....

20. UNDERTAKER: Vassar & Co — ADDRESS: Lewiston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

W—

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96 MAR 10 1921

Primary Registration District No. 1009

File No. 3318

Registered No. 330

1. PLACE OF DEATH

County of Nez Perce

City of Lewiston

(No. White's Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Oliver Curtis Keller

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: ..... 1 (Month) (Day) (Year)

7. AGE: 44 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Osteopathic Doctor

(b) General nature of industry, business or establishment in which employed (or employer): ..... *

9. BIRTHPLACE (State or Country): Mo.

10. NAME OF FATHER: Geo L. D. Keller

11. BIRTHPLACE OF FATHER (State or Country): Va.

12. MAIDEN NAME OF MOTHER: Mary McCormack

13. BIRTHPLACE OF MOTHER (State or Country): Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Keller

(Address) Lewiston

15. Filed Feb 8 1921 Simon E Bruce Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 5 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 29 1920 to Jan 5 1921

that I last saw h. alive on Jan 5 1921

and that death occurred on the date stated above, at 11 45 A M.

The CAUSE OF DEATH* was as follows:

Gangrenous Appendicitis.

Paralytic Ileus.

(Duration) ..... Yrs. ..... mos. 10 ds.

Contributory (Secondary) ..... , /

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Edgar L. White M. D.

Jan 6 1921 (Address) Lewiston Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Lewiston Ida — DATE OF BURIAL: 1/7 1921

20. UNDERTAKER: Bassar Undertaking Co. — ADDRESS: Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WHITE'S LEGAL BLANKS, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33187
Registered No. 579

1. PLACE OF DEATH
County of Nez Perce
City of Lewiston
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 96
Primary Registration District No. 1609
(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Unnamed Hubbard.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Single

6. DATE OF BIRTH: Jan (Month) 4 (Day) 1921 (Year)

7. AGE: ....Yrs. ....Mos. 1 ds. IF LESS than 1 day how many ....hrs. or ....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: N. L. Hubbard.

11. BIRTHPLACE OF FATHER (State or Country): Wash.

12. MAIDEN NAME OF MOTHER: Docia May McDitruff

13. BIRTHPLACE OF MOTHER (State or Country): Tenn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) N. L. Hubbard
(Address) Lapwai, Idaho Route #1

15. Filed Feb 8 1921 Susan E. Bruce Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 5 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 4 1921, to Jan 5 1921, that I last saw h[illegible] alive on Jan 5 1921 and that death occurred on the date stated above, at 4 A.M.

The CAUSE OF DEATH* was as follows:
Premature Birth

(Duration) ....Yrs. ....mos. 1 ds.

Contributory (Secondary)
(Duration) ....yrs. ....mos. ....ds.

(Signed) John H Alley M. D.
19.... (Address) Lewiston Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs. ....mos. ....days. In the State ....yrs. ....mos. ....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston Ida — DATE OF BURIAL: 2/6 1921

20. UNDERTAKER: [illegible] — ADDRESS: Lewiston.

End

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

MAR 1 1921

Registration District No. 95
Primary Registration District No. 1009
File No. 33188
Registered No. 578

1. PLACE OF DEATH
County of Nez Perce
City of Lewiston
(No. Lapwai Road St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Miles Dent Smith
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Dec (Month) 21 (Day) 1845 (Year)

7. AGE: 75 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Penn.

10. NAME OF FATHER: Elisha Smith

11. BIRTHPLACE OF FATHER (State or Country): U. S. England

12. MAIDEN NAME OF MOTHER: — Dent.

13. BIRTHPLACE OF MOTHER (State or Country): U. S.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Roy A Parks.
(Address)

15. Filed Feb 8 1921 Kenn E Brun Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 9 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....
and that death occurred on the date stated above, at about noon M.
The CAUSE OF DEATH* was as follows:
Coroners Verdict as follows
Gun shot self inflicted

.....(Duration) .....Yrs.....mos.....ds.
Contributory (Secondary)
.....(Duration) .....yrs.....mos.....ds.
(Signed) W B Brockhampton Coroner N. D.
19..... (Address) Lewiston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston Ida
DATE OF BURIAL: 1/5 1921

20. UNDERTAKER
ADDRESS: Lewiston

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

MAR 1

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33189

Registered No. 577

1. PLACE OF DEATH

County of Nez Perce

City of Lewiston

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 96

Primary Registration District No. 1009

(No. St Joseph Hospital St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John J. Frahm

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widower (Strike out words not necessary.)

6. DATE OF BIRTH: Oct (Month) 3rd (Day) 1853 (Year)

7. AGE: 67 Yrs. 2 Mos. 29 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Machinist

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: W. J. Frahm

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Anna Kelling

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. F. Gilbert

(Address)

15. Filed Feb 8 1921 — Susan E. Bruce, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: January (Month) 1st (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 10 1920, to Jan 28 1921, that I last saw h[illegible] alive on Jan 1st 1921 and that death occurred on the date stated above, at 10 A.M.,

The CAUSE OF DEATH* was as follows:

Uremia

(Duration) ..... Yrs. 4 mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) L. J. Perkins M. D.

1/2 1921 (Address) Lewiston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston Idaho | DATE OF BURIAL: Jan 4 1921

20. UNDERTAKER: [illegible] UNDERTAKING CO. | ADDRESS: Lewiston Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

(White)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 3319
Registered No. 576

1. PLACE OF DEATH
County of Nez Perce
City of Lewiston
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lucy Dutcher
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Married

6. DATE OF BIRTH: Jan 1 1837 (Month) (Day) (Year)

7. AGE: 83 Yrs. 7 Mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: HW
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ill.

10. NAME OF FATHER: Harriman

11. BIRTHPLACE OF FATHER (State or Country): Penn

12. MAIDEN NAME OF MOTHER: Bonner

13. BIRTHPLACE OF MOTHER (State or Country): Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) M. Dutcher
(Address) States Ida.

15. Filed Jan 8 1921 Susan E Bruce Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan 2 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 29 1920 to Jan 2 1921 that I last saw h.. alive on Dec 29 1920, and that death occurred on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:
Arteria sclerosis
General Debility
Senility
(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration) 0 yrs. 2 mos. ..... ds.

(Signed) E. G. Wilde M. D.
Jan 2 1921 (Address) Lewiston Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
States Ida	19
20. UNDERTAKER	ADDRESS
Bus Bowers	Lewiston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

MAR 10 1921

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 97
Primary Registration District No. 2174
(No. ..... St.)

File No. 33191
Registered No. 1

1. PLACE OF DEATH.
County of Nez Perce
City of Lapwai

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Clarence Welch

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Indian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Sept. 22 (Month) (Day) 1900 (Year)

7. AGE: 20 Yrs. 4 Mos. 14 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Student in High School
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): N. Carolina

10. NAME OF FATHER: Jas B. Welch

11. BIRTHPLACE OF FATHER (State or Country): N. Carolina

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): N. Carolina

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) L. D. Riggs
(Address) Lapwai

15. Filed Feb 5th 1921 L. D. Riggs Local Registrar

SYMS - YORK CO., PTRS. & STNRS. 24858

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 3rd (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 11th 1920, to Feb 5th 1921, that I last saw him alive on Feb 4th 1921, and that death occured on the date stated above, at 9:35 A.M.

The CAUSE OF DEATH* was as follows: Tuberculosis of lungs

(Duration) 2 Yrs. 6 mos. 0 ds.

Contributory (Secondary): None

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) L. D. Riggs M. D.

2/5 1921 (Address) Lapwai, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 0 yrs. 5 mos. 0 days. In the State 0 yrs. 5 mos. 0 days
Where was disease contracted if not at place of death? Pennsylvania
Former or usual residence Bonner, Mont.

19. PLACE OF BURIAL OR REMOVAL: Lapwai Idaho — DATE OF BURIAL: Feb 7 1921

20. UNDERTAKER: L. B. Walker — ADDRESS: Lapwai

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-25 M. 1-19.

MAR 10 1921

CERTIFICATE OF DEATH

Registration District No. 26

Primary Registration District No. 2069

(No. ..... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33192

Registered No. 5

1. PLACE OF DEATH

County of Oneida

City of Malad

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Veda Ashton

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: June 7 1920
(Month) (Day) (Year)

7. AGE: 0 Yrs. 7 Mos. 28 ds.

IF LESS than 1 day: how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Malad Ida

10. NAME OF FATHER: James L Ashton

11. BIRTHPLACE OF FATHER (State or Country): Woodruff Ida

12. MAIDEN NAME OF MOTHER: Jane Thorpe

13. BIRTHPLACE OF MOTHER (State or Country): Samaria Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) James L Ashton

(Address) Malad Ida

15. Filed Mar 2 1921

R. T. Mauer M.D.
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb 3 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 28 1921, to Feb 4 1921, that I last saw h. on alive on Feb 4 1921, and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Bronchus - pneumonia

..... (Duration) ..... Yrs. ..... mos. 10 ds.

Contributory (Secondary) whooping cough

..... (Duration) ..... yrs. ..... mos. 21 ds.

(Signed) R. T. Mauer M. D.

..... 19..... (Address) Malad, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Malad Ida

DATE OF BURIAL: 2-8 1921

20. UNDERTAKER: W. E. Johnson

ADDRESS: Malad

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

MAR 1 0 1921

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Owyhee
City of Murtaugh
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2C
Primary Registration District No. 2069
(No. ..., ... St.)

File No. 33193
Registered No. 4
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Thomas H. Moser

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Feb (Month) 4 (Day) 1859 (Year)

7. AGE: 45 yrs. ... mos. 6 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) Farmer & Carpenter

9. BIRTHPLACE (State or Country) Salt Lake City Utah

10. NAME OF FATHER George Moser

11. BIRTHPLACE OF FATHER (State or Country) Germany.

12. MAIDEN NAME OF MOTHER Not Known

13. BIRTHPLACE OF MOTHER (State or Country) —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Eva K Wetzel
(Address) #1 Langton Pl. Salt Lake City

15.
Filed Feb 12 1921 R. T. Mauer M. D. Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb (Month) 10 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 8 1921, to Feb 9 1921, that I last saw h[illegible] alive on Feb 9 1921, and that death occurred on the date stated above, at 12 P. M.

The CAUSE OF DEATH* was as follows:
Myocarditis

(Duration) ... yrs. ... mos. ... ds.
Contributory (Secondary) unknown
(Duration) ... yrs. ... mos. ... ds.

(Signed) R. T. Mauer M. D.
19 (Address) Malad, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs ... mos ... days. In the State ... yrs ... mos ... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Removed to Salt Lake
DATE OF BURIAL: ... 191...

20. UNDERTAKER: Woodland Furn. Co
ADDRESS: Malad, Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

MAR 10 1921

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 26
Primary Registration District No. 2069
(No. ____ St.)
File No. 33194
Registered No. 7

1. PLACE OF DEATH
County of Oneida
City of Malad
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Thomas Jones

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single
6. DATE OF BIRTH: April (Month) 9 (Day) 1848 (Year)
7. AGE: 72 Yrs. 10 Mos. 2 ds.
IF LESS than 1 day how many ____ hrs. or ____ min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer.
(b) General nature of industry, business or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Wales.
10. NAME OF FATHER: Thomas Jones
11. BIRTHPLACE OF FATHER (State or Country): Wales.
12. MAIDEN NAME OF MOTHER: Elizabeth Jenkins
13. BIRTHPLACE OF MOTHER (State or Country): Wales.
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Thos Jones
(Address) Malad Idaho.
15.
Filed Mar 2 1921
R. T. Mauer M.D.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 11 (Day) 1921 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Jan 17 1921, to Feby 11 1921, that I last saw h.m. alive on Jan 31 1921, and that death occurred on the date stated above, at 8 01 M.
The CAUSE OF DEATH* was as follows:
Senile decay
(Duration) ____ Yrs. ____ mos. ____ ds.
Contributory (Secondary)
(Duration) ____ yrs. ____ mos. ____ ds.
(Signed) R. T. Mauer M. D.
2-12-21 (Address) Malad

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Malad Idaho — DATE OF BURIAL: 2-14 1921
20. UNDERTAKER: D. E. Johnson — ADDRESS: Malad

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MAR 10 1921

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33195

Registered No.

Registration District No. 130

Primary Registration District No. Homedale

1. PLACE OF DEATH

County of Owyhee

City of Homedale

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Donald Leroy Bay

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	W	Single

6. DATE OF BIRTH: Jan (Month) 7 (Day) 1921 (Year)

7. AGE: ..... Yrs. ..... Mos. 20 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Chas S Bay

11. BIRTHPLACE OF FATHER (State or Country) Iowa

12. MAIDEN NAME OF MOTHER Sarah Buffington

13. BIRTHPLACE OF MOTHER (State or Country) Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C S Bay

(Address) Homedale

15. Filed Feb 1 1921 S Hoffman Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 27 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 27 1921, to Jan 27 1921, that I last saw h.. alive on Jan 27 1921, and that death occurred on the date stated above, at 4 P M.

The CAUSE OF DEATH* was as follows:

Pneumonia

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Simeon Hoffman M. D.

19..... (Address) Homedale

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Wilder — DATE OF BURIAL: Jan 29 1921

20. UNDERTAKER: Peckham Furniture Co — ADDRESS: Caldwell

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19

MAR 10 192

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 130
Primary Registration District No. Homedale
(No. ..... St.)
File No. 3319?
Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Owyhee
City of Homedale
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Austin C Sexton Jr

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	W	single

6. DATE OF BIRTH Nov (Month) 27 (Day) 1920 (Year)

7. AGE ..... Yrs. ..... Mos. 5 6 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work nothing
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Austin C Sexton

11. BIRTHPLACE OF FATHER (State or Country) Mo

12. MAIDEN NAME OF MOTHER Bernice E Skagg

13. BIRTHPLACE OF MOTHER (State or Country) Texas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A C Sexton
(Address) .....

15. Filed Feb 1 1921 Simeon Hopper Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 22 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 16 1921 to Jan 22 1921 that I last saw h~~im~~ alive on Jan 22 1921 and that death occurred on the date stated above, at 2 30 M.

The CAUSE OF DEATH* was as follows:

Pneumonia

..... (Duration) ..... Yrs. ..... mos. 6 ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Simeon Hopper M. D.
1-22 1921 (Address) Homedale

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Wilder — **DATE OF BURIAL** Jan 23 1921

20. UNDERTAKER Peckham Furniture Co — **ADDRESS** Wilder Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

MAR 1 0 1921

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 130
Primary Registration District No. Homedale
File No. 33198
(No. ..... St.)
Registered No. .....

1. PLACE OF DEATH
County of Owyhee
City of Homedale
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Josefa Uberuaga

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F M	W	Single

6. DATE OF BIRTH: Aug (Month) 27 (Day) 1920 (Year)

7. AGE: Yrs. 4 Mos. 15 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Homedale Idaho

10. NAME OF FATHER Donato Uberuaga

11. BIRTHPLACE OF FATHER (State or Country) Spain

12. MAIDEN NAME OF MOTHER Engracia Yraolabeitia

13. BIRTHPLACE OF MOTHER (State or Country) Spain

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Donato Uberuaga
(Address) .....

15. Filed Feb 1 1921 J Hopper Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 12 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 12 1921, to Jan 12 1921, that I last saw h.er alive on Jan 12 1921, and that death occurred on the date stated above, at 7 45 P.M.
The CAUSE OF DEATH* was as follows:
Emaciation
(Duration) unknown Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Simeon Hopper M. D.
19..... (Address) Homedale Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Canyon Hill	1-17-1921
20. UNDERTAKER	**ADDRESS**
Cash Furniture Co	Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

Form V. S. No. 5. 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Payette
City of Payette
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 4
Primary Registration District No. 1008
(No. ....., ... St.)

File No. 33199
Registered No. 1
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Cratus T Barker

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	White	Widowed

6. DATE OF BIRTH: Jan (Month) 11 (Day) 1843 (Year)

7. AGE: 77 yrs. 11 mos. 24 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer Retired
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ill

10. NAME OF FATHER: Jesse Barker

11. BIRTHPLACE OF FATHER (State or Country): Not Known

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W B Barker
(Address) Payette

15.
Filed Jan 8 1931 191 J B Woodu
Local R

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan (Month) 6 (Day) 1931 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 19 30 191 , to Jan 6 1931
that I last saw h in alive on Jan 4 1931
and that death occurred on the date stated above, at 1 a. M.
The CAUSE OF DEATH* was as follows:

Senility

(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Senility
(Duration) 6 yrs. ..... mos. ..... ds.
(Signed) ..... M. D.
1/10 1931 (Address) Payette Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
mer or al residence

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Payette Ida	Jan 7 1931

UNDERTAKER: McLain ADDRESS: Payette Ida

SYMS - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. FRACTIONS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Payette

City of Payette

If death occurred away from usual residence, give facts called for under special information.

Registration District No. 4

Primary Registration District No. 1008

(No. ..... St.)

File No. 33200

Registered No. 2

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME J D Hill

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	~~Widowed~~

6. DATE OF BIRTH: Sept. (Month) 29 (Day) 1853 (Year)

7. AGE: 68 Yrs. 4 Mos. 12 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Don't Know

11. BIRTHPLACE OF FATHER (State or Country): Don't "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Anna E. Hollenbeck
(Address) Payette Ida

15. Filed Jan 12 1921. J. C. Woodward Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 10 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 6 1921, to Jan 10 1921, that I last saw him alive on Jan 9 1921, and that death occurred on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows:

Cancer of Stomach
(Duration) ? Yrs. ? mos. ? ds.

Contributory (Secondary) Senility
(Duration) ? yrs. ? mos. ? ds.

(Signed) L. McNeal M. D.
19..... (Address) Payette Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Payette Idaho	Jan 12 1921
20. UNDERTAKER	ADDRESS
Glenn C Landon	Payette Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SIMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

33201

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

CERTE[redacted] DEATH.

1. PLACE OF DEATH.

Registration District 25

County of Power

Primary Registration District No. 2072

City of American Falls (No. ..... St.)

File No. 3

Registered No. 112

If death occurs away from usual residence, give facts called for under special information. Idaho

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lou S. Kujawa

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Sept 26 (Month) 1889 (Day) (Year)

7. AGE: 31 Yrs. 3 Mos. 23 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... House wife

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Wash

10. NAME OF FATHER Scott Darling

11. BIRTHPLACE OF FATHER (State or Country) IOWA

12. MAIDEN NAME OF MOTHER Cora E. Sherwood

13. BIRTHPLACE OF MOTHER (State or Country) Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C. J. Kujawa

(Address) Rockland Ida

15. Filed 1/20 1921

R. E. Norkus
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 18 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 17 1921, to Jan 18 1921, that I last saw her alive on Jan 18 1921, and that death occured on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

General peritonitis

(Duration) Yrs. mos. 2 ds.

Contributory (Secondary) Ruptured appendix

(Duration yrs. mos. 3 ds.

(Signed) C J Kujawa M. D.

1/19 1921 (Address) American Falls Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rockland Idaho

DATE OF BURIAL: 1-22-21

20. UNDERTAKER: A W Davis

ADDRESS: American Falls Ida

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-12 M. 6-15-17.

33202

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 123
Primary Registration District No. 7701
(No. ....., ... St.)

File No. 7
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Shoshone
City of Wallace
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Selma E. Anderson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Oct (Month) 20 (Day) 1871 (Year)

7. AGE: 49 Yrs. 2 Mos. 24 ds.
IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER: J. Broberg

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Wang

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) L. H. Anderson
(Address) Wallace Idaho

15. Filed 1/20 1921. Jos. S. Lasher Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 14 (Day) Friday 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 8 1921 to Jan 13 1921
that I last saw he alive on Jan 13 1921
and that death occurred on the date stated above, at 12 P.M.

The CAUSE OF DEATH* was as follows:
Diabetes
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... Yrs. ..... mos. ..... ds.
(Signed) H. C. Lindsley M. D.
1/19 1921. (Address) Wallace Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Wallace Ida. — DATE OF BURIAL: Jan 18, 1921.

20. UNDERTAKER: Mr. Thornburg — ADDRESS: Wallace Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-12 M. 6-15-17.

33203

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 123
Primary Registration District No. 7201
File No. 6
Registered No.

1. PLACE OF DEATH
County of Shoshone
City of Kellogg
If death occurs away from usual residence, give facts called for under special information.

(No. ....., ... St.)
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Alice Virginia Beasley

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: April 8 1920
(Month) (Day) (Year)

7. AGE: ....Yrs. 9 Mos. 14 ds.
IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): California

10. NAME OF FATHER: Alfred F. Beasley

11. BIRTHPLACE OF FATHER (State or Country): Illinois

12. MAIDEN NAME OF MOTHER: Ruth Gray

13. BIRTHPLACE OF MOTHER (State or Country): Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) M. H. Sullivan
(Address) Kellogg, Ida.

15. Filed 1/26 1921 Geo. D. Lees
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan 22 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 7 1921 to Jan 22 1921
that I last saw h alive on Jan 22 1921
and that death occurred on the date stated above, at 6:30 P. M.

The CAUSE OF DEATH* was as follows:
La Grippe - Accidents
.....
.....
.....
.....(Duration) — Yrs. — mos. 17 ds.

Contributory (Secondary) .....
.....(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) Alex. D. McCrackin M. D.
Jan 23 1921 (Address) Kellogg Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Spokane
DATE OF BURIAL: Jan 24 1921

20. UNDERTAKER: McCrackin
ADDRESS: Kellogg Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-12 M. 6-15-17.

33205

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 125
Primary Registration District No. 7701
File No. 9
Registered No. .....

1. PLACE OF DEATH
County of Kootenai
City of Cataldo
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William Herbin

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: November 9 (Month) (Day) 1885 (Year)

7. AGE: 35 Yrs. 3 Mos. 8 ds.
IF LESS than 1 day how many .... hrs. or .....min.?'

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Finland

10. NAME OF FATHER: Herman Herbin

11. BIRTHPLACE OF FATHER (State or Country): Finland

12. MAIDEN NAME OF MOTHER: Mary Biopala

13. BIRTHPLACE OF MOTHER (State or Country): Finland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Ada Herbin
(Address) Cataldo, Ida.

15. Filed Apr 7 1921 Jno S Lester Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: February 17 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191.... to .....191...
that I last saw h.....alive on .....191....
and that death occurred on the date stated above, at .....M.
The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs and heart disease

(Duration) 2 Yrs. 8 mos. 15 ds.

Contributory (Secondary)
(Duration) ..... Yrs..... mos. ..... ds.

(Signed) ..... M. D.
.....19.... (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 9½ yrs. ....mos. ....days. In the State 9 yrs. 6 mos. ....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Kingston Ida — DATE OF BURIAL: 2/19/1921

20. UNDERTAKER: M.C. Thornbrue — ADDRESS: Kellogg, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

MAR 10 1921

33206

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 8
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

Registration District No. 1W3
Primary Registration District No. 7V01

1. PLACE OF DEATH
County of Shoshone
City of Wardner
If death occurs away from usual residence, give facts called for under special information.

(No. ....., ... St.)

2. FULL NAME Edward B. Shuck

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	White	Single

6. DATE OF BIRTH. Aug (Month) 27 (Day) 1854 (Year)

7. AGE 66 Yrs. 6 Mos. 12 ds. IF LESS than 1 day how many .... hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Miner
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) California

10. NAME OF FATHER Harvey Shuck

11. BIRTHPLACE OF FATHER (State or Country) Iowa

12. MAIDEN NAME OF MOTHER Francis Jane Morrison

13. BIRTHPLACE OF MOTHER (State or Country) Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. O. Shuck
(Address) Wardner, Idaho

15. Filed 3-9-21 1921 Geo S Lesher Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 9 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..... to .....191..
that I last saw h.....alive on .....191....
and that death occurred on the date stated above, at .....,....M.

The CAUSE OF DEATH* was as follows:
Cancer
No Physician
.....(Duration) 2 Yrs..... mos. ..... ds.
Contributory .....
(Secondary)
.....(Duration) ..... Yrs..... mos. ..... ds.

(Signed) Geo S Lesher M. D.
2-7 1921 (Address) Kellogg Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the ,State....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Kellogg, Idaho — DATE OF BURIAL Feb 11 1921

20. UNDERTAKER M. C. Thornhill — ADDRESS Kellogg Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE, should be stated EXACTLY, PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-12 M. 6-15-17.

Dr Mowry

CERTIFICATE OF DEATH

MAR 10 1921

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33207
Registered No. 2

1. PLACE OF DEATH
County of Shoshone
City of Black Bear
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 12
Primary Registration District No. 270
(No.) Canyon Creek Lower Black Bear St.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Oscar Otto Dittwe

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. Jan (Month) 12 (Day) 1855 (Year)

7. AGE: 66 Yrs. 0 Mos. 7 ds.
IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession, or particular kind of work: Miner
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: Otto Dittwe

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Atilie Polascey

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Kate Dittwe
(Address) Gem Idaho

15.
Filed 1/22 1921 M. E. Mowry Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 20 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from .... 191.... to .... 191...
that I last saw h.....alive on .... 191....
and that death occurred on the date stated above, at .....M.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(Duration) 10 Yrs. .... mos. .... ds.

Contributory (Secondary)
(Duration) Do Yrs. .... mos. .... ds.

(Signed) Dr Mowry M. D.
1/20 1921 (Address) City

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days, In the State....yrs....mos....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Wallace Ida — DATE OF BURIAL: Jany 23 1921

20. UNDERTAKER: B G Worstell — ADDRESS: Wallace

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

MAR 10 1921

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 12
Primary Registration District No. 2001
File No. 33208
Registered No. 1

1. PLACE OF DEATH.

County of Shoshone
City of Tamarack
(No. Residence Tamarack St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Annie Mary Leonard

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): widowed

6. DATE OF BIRTH. (Month) (Day) 1 (Year)

7. AGE: 70 Yrs. — Mos. — ds.

IF LESS than 1 day, how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: at home
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Mr. Bradford

11. BIRTHPLACE OF FATHER (State or Country): Virginia

12. MAIDEN NAME OF MOTHER: not given

13. BIRTHPLACE OF MOTHER (State or Country): Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Claude Leonard
(Address) Tamarack Mines

15. Filed 1/13 1921 H. O. Mowry Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 13 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....191...., to ....191....,
that I last saw h....alive on ....191....,
and that death occured on the date stated above, at ....M.

The CAUSE OF DEATH* was as follows:

Uremic Convulsions

(Duration 25 Yrs. ... mos. ... ds.

Contributory (Secondary)

(Duration ... yrs. ... mos. ... ds.

(Signed) Dr H. Mowry M. D.
1/13 1921 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence Tamarack Mines

19. PLACE OF BURIAL OR REMOVAL: Spokane Wash. DATE OF BURIAL: Jan 15th 1921

20. UNDERTAKER: Harry Thompson ADDRESS: Wallace 2da.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SVMS - YORK CO., PTRS. & SHRS. 24653

FORM V. S. No. 5-A—25 M. 1-19.

MAR 10 1921

CERTIFICATE OF DEATH

Banner.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37.

Primary Registration District No. 1085

File No. 33209

Registered No.

1. PLACE OF DEATH

County of Twin Falls

City of " "

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Cornealer G Mareus

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Aug 1 1920
(Month) (Day) (Year)

7. AGE: Yrs. 5 Mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Twin Falls Ida.

10. NAME OF FATHER: D. Mareus

11. BIRTHPLACE OF FATHER (State or Country): Holland.

12. MAIDEN NAME OF MOTHER: Geneta Mueder

13. BIRTHPLACE OF MOTHER (State or Country): Holland.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. D. Mareus
(Address) Twin Falls Ida.

15. Filed Jan. 7. 1921 J. J. Coughlin Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan 4 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 4 1920, to Jan 4 1920 that I last saw h[illegible] alive on Jan 4 1920 and that death occurred on the date stated above, at 12 o'clock M.

The CAUSE OF DEATH* was as follows:
Intestinal Intoxication

..... (Duration) ..... Yrs. ..... mos. 03 ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. L. Lauzer M. D.
1/6 1921 (Address) Twin Falls, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls — DATE OF BURIAL: 1-7 1921

20. UNDERTAKER: P. J. Grossman — ADDRESS: Twin Falls

2da

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE, IDAHO

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

MAR 12 1921

Alex

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 31
Primary Registration District No. 1685
File No. 33210
Registered No.

1. PLACE OF DEATH

County of Twin Falls

City of "

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Susan F. G. Fry.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widow (Write the word.)

6. DATE OF BIRTH: Dec (Month) 12 (Day) 846 (Year)

7. AGE: 74 Yrs. 0 Mos. 23 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Virginia

10. NAME OF FATHER: Don't Know

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) K.W. Fry.

(Address) Twin Falls, Ida.

15. Filed Jan 6. 1921

J. F. Coughlin
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec Jan 4 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5-1 1920, to 12-25 1920

that I last saw h. 24 alive on Dec 25 1920

and that death occurred on the date stated above, at Dec 25 3:30 P.M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis.

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D. L. Alexander M. D.

Jan 6 1921 (Address) Twin Falls, Ida. (per Dr. H. Bielu)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Earlham Iowa

DATE OF BURIAL ..... 19.....

20. UNDERTAKER: P. J. Grossman

ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

MAR 10 1921

CERTIFICATE OF DEATH

Registration District No. 37

Primary Registration District No. 1085

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33211

Registered No.

1. PLACE OF DEATH

County of Twin Falls

City of " "

If death occurs away from usual residence, give facts called for under special information.

(No. , St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Sarah Rebecca Secord

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Widowed

6. DATE OF BIRTH: February 10 1832
(Month) (Day) (Year)

7. AGE: 88 Yrs. 10 Mos. 23 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Canada.

10. NAME OF FATHER: James Buck

11. BIRTHPLACE OF FATHER (State or Country): Canada.

12. MAIDEN NAME OF MOTHER: Sarah Lampman

13. BIRTHPLACE OF MOTHER (State or Country): Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Wm V Secord
(Address): Twin Falls Idaho.

15.
Filed Jan 6 1921 J. F. Coughlin
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan 3rd 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 4 1920 to Jan. 3 1921
that I last saw her alive on Dec. 31 1920
and that death occurred on the date stated above, at M.
The CAUSE OF DEATH* was as follows:

Senility

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) C. D. Weaver M. D.

19 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls

DATE OF BURIAL: Jan 6 1921

20. UNDERTAKER: J. F. Grossman

ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

MAR 10 1921

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Twin Falls

City of .....

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 37

Primary Registration District No. 1085

(No. ..... St.)

File No. 33212

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Norma Green Salmon

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: (Write word.) married

6. DATE OF BIRTH: May 21 (Month) (Day) 1920 (Year)

7. AGE: Yrs. 7 Mos. 11 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Student

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Lawrence Salmon

11. BIRTHPLACE OF FATHER (State or Country): Ill

12. MAIDEN NAME OF MOTHER: Mary Burns

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15. Filed Jan 6 1921

J. F. Coughlin
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan 2 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 29 1920, to Jan 2 1921, that I last saw her alive on Jan 1 1921, and that death occurred on the date stated above, at 1:45 P.M.

The CAUSE OF DEATH* was as follows:

Marasmus

.....

.....

.....(Duration) ....Yrs. 5 mos. — ds.

Contributory (Secondary) .....

.....(Duration) ....yrs. ....mos. ....ds.

(Signed) H. W. Bartholomew M. D.

1/13 1921 (Address) Kimberly

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death....yrs....mos....days. In the State....yrs....mos....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Ida | DATE OF BURIAL: Jan 9 1920

20. UNDERTAKER: J E Wood | ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

MAR 10 1921

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. # 1085
File No. 33213
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of Twin Falls
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Chizuko Yasuda
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Female	Japanese	Single (Write the word.)

6. DATE OF BIRTH 1 — 8 — 1921 (Month) (Day) (Year)

7. AGE ..... Yrs. ..... Mos. 7 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Y Yasuda

11. BIRTHPLACE OF FATHER (State or Country) Japan

12. MAIDEN NAME OF MOTHER Koyoshi Muki

13. BIRTHPLACE OF MOTHER (State or Country) Japan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Y Yasuda
(Address) .....

15. Filed Jan. 15 1921 J. F. Coughlin Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 1 — 15 — 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 8 1921, to Jan 15 1921, that I last saw h.. alive on Jan 8 1921, and that death occurred on the date stated above, at 7 A. M.
The CAUSE OF DEATH* was as follows:

Pneumonia

..... (Duration) ..... Yrs. ..... mos. 1 ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. N. Leete M. D.
1/15 1921 (Address) Twin Falls Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Twin Falls Ida. DATE OF BURIAL 1-16 1921

20. UNDERTAKER L E Wood ADDRESS Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

MAR 10

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Twin Falls

City of [illegible]

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 39

Primary Registration District No. 1085

(No. Twin Falls County Hosp. St.)

File No. 33214

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Grieco

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	Italian	Married

6. DATE OF BIRTH: Don't know (Month) (Day) 1 (Year)

7. AGE: About 75 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Italy

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Twin Falls County Hosp

(Address)

15. Filed Jan. 17. 1921

J. F. Coughlin
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan 7 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1. 1920, to Jan 7, 1921 that I last saw him alive on Jan 6 1921 and that death occurred on the date stated above, at 3:30 P.M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(Duration) 5 Yrs. 0 mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.

1/17/1921 (Address) Twin Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Twin Falls	1/10 1921
20. UNDERTAKER	ADDRESS
[illegible]	Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

MAR 10 1921

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1085
File No. 33215
Registered No.

1. PLACE OF DEATH

County of Twin Falls, Idaho
City of Twin Falls
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George Washington Humphrey

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: [illegible]

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): married

6. DATE OF BIRTH: March (Month) 4 (Day) 1850 (Year)

7. AGE: 64 Yrs. 10 Mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer): Own

9. BIRTHPLACE (State or Country): Born the County Virginia

10. NAME OF FATHER: Lewis Humphreys

11. BIRTHPLACE OF FATHER (State or Country): Lynnth County Virginia

12. MAIDEN NAME OF MOTHER: Celina Higginbotham

13. BIRTHPLACE OF MOTHER (State or Country): Pascual Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Gov. Humphrey
(Address) Twin Falls

15. Filed Jan 21 1921 J. F. Coughenour Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: January (Month) 8 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw him alive on Jan 8 19 21,
and that death occurred on the date stated above, at 9:00 A.M.
The CAUSE OF DEATH* was as follows:
Acute Dilatation Stomach
(Post mortem finding)
..... (Duration) ..... Yrs. ..... mos. 1 ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) H. W. Allen M. D.
Jan 17 1921 (Address) Twin Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 64 yrs. 2 mos. 3 days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls — DATE OF BURIAL: 1/10 1921

20. UNDERTAKER: [illegible] Grossman — ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

MAR 10 Dr Boyd.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 38
Primary Registration District No. 1085
File No. 33216
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of "
(No. La. Merced Hospital St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Dallas Shutts

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write word.): ~~Married~~ Single

6. DATE OF BIRTH: Apr 19 1873 (Month) (Day) (Year)

7. AGE: 47 Yrs. 6 Mos. 1 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer): Owner

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Davis Shutts

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Francis Autrey.

13. BIRTHPLACE OF MOTHER (State or Country): Iowa.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs D. Shutts.
(Address) Route 1 Hansen

15. Filed Jan. 21 1921 J. F. Coughlin Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan 21" 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 12 1920 to Jan 21 1921 that I last saw h.im alive on Jan 21 1921 and that death occurred on the date stated above, at 9 A.M.
The CAUSE OF DEATH* was as follows:

Typhoid Fever

(Duration) 3 Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H H Boyd M. D.
Jan 21 1921 (Address) Twin Falls Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Sunset Cem. | DATE OF BURIAL: 1-24 1921

20. UNDERTAKER: C. E. Trautman | ADDRESS: Twin Falls Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

MAR 10

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1085
File No. 33217
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of Twin Falls
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Infant Potter
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: (Strike out two.) Single

6. DATE OF BIRTH: Jan 23 (Month) (Day) 1921 (Year)

7. AGE: 0 Yrs. 0 Mos. 0 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: W E Potter

11. BIRTHPLACE OF FATHER (State or Country): Kansas

12. MAIDEN NAME OF MOTHER: Cecil Goddard

13. BIRTHPLACE OF MOTHER (State or Country): Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. E. Potter
(Address) Twin Falls. Ida

15. Filed Jan. 25. 1921 J. T. Hughes Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan 23 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 23 1921, to 19..., that I last saw h[er] alive on 1/23/21 19..., and that death occurred on the date stated above, at 4 0 M.
The CAUSE OF DEATH* was as follows:
Premature.
(6 mos.)
(Duration) Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) C. O. Weaver, M. D.
19... (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Idah
DATE OF BURIAL: 1-26 1921

20. UNDERTAKER: L E Wendt
ADDRESS: Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

MAR 10 1921

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 31
Primary Registration District No. 1615
File No. 33218
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of " "
(No. County Hospital St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Harvey L. Smith
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Married

6. DATE OF BIRTH: Sept 19 1894 (Month) (Day) (Year)

7. AGE: 26 Yrs. 4 Mos. 7 ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Geo A Smith

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Zelnora E Glover

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Geo. L Smith
(Address): Twin Falls Ida.

15. Filed Jan 27 1921 J. F. Coughlin Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan 26 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 17 1921, to Jan. 26 1921 that I last saw h[im] alive on Jan. 26 1921, and that death occurred on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:
Peritonitis following ruptured appendix.
(Duration) ... Yrs. ... mos. 12 ds.
Contributory (Secondary)
(Duration) ... yrs. ... mos. ... ds.

(Signed) C. D. Glover M. D.
19 (Address) Twin Falls Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. 9 days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Robbins Ida
DATE OF BURIAL: ... 19 ...

20. UNDERTAKER: J. J. Grossman
ADDRESS: Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Twin Falls Registration District No. 37
Primary Registration District No. 1085
File No. 33219
City of " (No. ....., ... St.) Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George Henry McCollum

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Male	White	(Write word) Widower

6. DATE OF BIRTH: May (Month) 2 (Day) 1865 (Year)

7. AGE: 55 Yrs. 8 Mos. 20 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business or establishment in which employed (or employer): "

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Eunis McCollum

11. BIRTHPLACE OF FATHER (State or Country): Tenn.

12. MAIDEN NAME OF MOTHER: Don't Know

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Henry McCollum
(Address) Twin Falls

15. Filed Jan. 29. 1921 J. A. Coughlin Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 22 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....
and that death occurred on the date stated above, at 8:10 P. M.
The CAUSE OF DEATH* was as follows:

Revolver Wound in Chest.
Homicidal
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. J. Grossman Coroner
Jan 26 1921 (Address) Twin Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Twin Falls	Jan. 26 1921
20. UNDERTAKER	ADDRESS
J. J. Grossman	Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-A—25 M. 1-19.

MAR 1921

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1385
File No. 33220
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of
(No. County Hospital St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs Sophia Prosse

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widow (Write the word.)

6. DATE OF BIRTH: Nov (Month) 13 (Day) 1857 (Year)

7. AGE: 63 Yrs. 2 Mos. 22 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: Julius Splettstoser

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Don't Know

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Emma Gansbuster
(Address) Ogden, Utah

15. Filed Feb 7 1921 J. F. Coughlin Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 4 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5-15 1920, to 2-4 1921, that I last saw her alive on 2-4 1921, and that death occurred on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:
Peritonitis secondary to Colostomy for General Carcinoma Abdominal Cavity
(Duration) Yrs. 11 mos. 5 ds.
Contributory (Secondary) Recurrent Carcinoma Cervical
(Duration) yrs. 5 mos. ds.

(Signed) D. R. Strander M. D.
2/5 1921 (Address) Twin Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Denver, Colo
DATE OF BURIAL 19

20. UNDERTAKER: P. J. Grossman
ADDRESS: Twin Falls Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Twin Falls
City of " "
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 37
Primary Registration District No. 2085
(No. ..... , ... St.)

File No. 33221
Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Rodney N. Ruby.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	~~Single~~

6. DATE OF BIRTH: May (Month) 13 (Day) 1896 (Year)

7. AGE: 24 Yrs. 8 Mos. 6 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer): Stock Farm

9. BIRTHPLACE (State or Country): Calif.

10. NAME OF FATHER: W. N. Ruby.

11. BIRTHPLACE OF FATHER (State or Country): Ind.

12. MAIDEN NAME OF MOTHER: Pearl Hawskins

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. N. Ruby
(Address) San Diego, Calif.

15. Filed Feb 1 1921 J. F. Coughlin Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 25 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 22 1920 to Jan 14 1921 that I last saw h~~im~~ alive on Jan 24 1921 and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Uraemic Poisoning

..... (Duration) — Yrs. — mos. — ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Dr W.C. Brown D.C. Ph.C. M. D.
By Dr W. Clifford D.C. Ph.C.
3/1 1921 (Address) Twin Falls, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
San Diego Cal-	19 .....

20. UNDERTAKER: E. G. Grossman — ADDRESS: Twin Falls Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MAR 10 192 Dr. C.

FORM V. S. No. 5—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Twin Falls
City of .....
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 37
Primary Registration District No. 2085.
(No. ....., ... St.)

File No. 33222
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Robert E. Mathes

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Dec 6 (Month) (Day) 1920 (Year)

7. AGE: Yrs. 1 Mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Twin Falls

10. NAME OF FATHER: Ben Mathes

11. BIRTHPLACE OF FATHER (State or Country): Kan.

12. MAIDEN NAME OF MOTHER: Betty Peggy

13. BIRTHPLACE OF MOTHER (State or Country): Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ben Mathes
(Address) Twin Falls

15. Filed Jan. 20 1921 J. F. Coughenour Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan 18 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 18 - 1921, to Jan. 18 1921, that I last saw him alive on Jan. 18 1921, and that death occurred on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

Four days (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. F. Coughenour M. D.

Jan 21 1921 (Address) Twin Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: .....
DATE OF BURIAL: 1921

20. UNDERTAKER: P. J. Grossman
ADDRESS: Twin Falls Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 25
Primary Registration District No. 2086
File No. 3323

1. PLACE OF DEATH
County of Twin Falls
City of 11
(No. ..... St.)
Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Roy Buckman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Apr. (Month) 14 (Day) 1881 (Year)

7. AGE: 40 Yrs. 9 Mos. 24 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer): Farmer

9. BIRTHPLACE (State or Country): Penn

10. NAME OF FATHER: Jack Buckman

11. BIRTHPLACE OF FATHER (State or Country): Penn

12. MAIDEN NAME OF MOTHER: Anna Atkinson

13. BIRTHPLACE OF MOTHER (State or Country): Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H. W. Buckman
(Address) Harlem, Idaho

15.
Filed Jan 8 1921
Dr. A. A. Newberry
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. (Month) 8 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 1 1920, to Jan. 8 1921
that I last saw him alive on Jan. 8 1921,
and that death occurred on the date stated above, at 11.05 A.M.
The CAUSE OF DEATH* was as follows:

Cerebral Abcess
(Duration) 1 Yrs. ..... mos. ..... ds.
Contributory (Secondary) Encephalitis
(Duration) ..... yrs. ..... mos. 8 Hours.

(Signed) Frank A. Dwight M. D.
Jan. 8 1921 (Address) Twin Falls Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Filer Idaho
DATE OF BURIAL ..... 19.....

20. UNDERTAKER: J. P. Brennan
ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3F
Primary Registration District No. 2.0.5.6.0
(No. ....., ...)
File No. 33224
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Twin Falls
City of Filer
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Baby Neugent

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Jan. (Month) 14 (Day) 1921 (Year)

7. AGE: Still Born ....Yrs....Mos....ds.
IF LESS than 1 day how many .... hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Otis Neugent

11. BIRTHPLACE OF FATHER (State or Country) Okla

12. MAIDEN NAME OF MOTHER Fern Skinner

13. BIRTHPLACE OF MOTHER (State or Country) Okla

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E C Maceum
(Address) Filer

15. Filed Jan 15 1921 T. A. Newberry Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 7-30dM
Jan. (Month) 14 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I did not attend deceased from ..... 191... to ..... 191...
that I last saw h...alive on ..... 191....
and that death occurred on the date stated above, at 8 P.M.

The CAUSE OF DEATH* was as follows:
.....Premature.....
.....One of triplets.....
.....(Duration) .... Yrs.... mos.... ds.
Contributory (Secondary) .....
.....(Duration) .... Yrs.... mos.... ds.
(Signed) T. A. Dwight M. D.
Jan. 15. 1921. (Address) Filer Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Doof Cemetery — DATE OF BURIAL Jan 16 1921

20. UNDERTAKER H E Drake — ADDRESS Filer

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33225
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

Registration District No. 28
Primary Registration District No. 2086
(No. ..... St. 1921

1. PLACE OF DEATH
County of Twin Falls
City of Filer
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Kelley Welsan Delph

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. July (Month) 14 (Day) 1890 (Year)

7. AGE: 30 Yrs. 6 Mos. 4 ds.
IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): N C

10. NAME OF FATHER: Stephen Delph

11. BIRTHPLACE OF FATHER (State or Country): Virginia

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Leland Delph
(Address) Filer

15. Filed Jan 18 21
A. A. Newberry
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 18 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 15 20 1921 to Jan 17 21 1921
that I last saw h.....alive on Jan 17 21 1921
and that death occurred on the date stated above, at 11:30 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) A. A. Newberry M. D.
Jan 18 1921 (Address) Filer Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rock Cemetery — DATE OF BURIAL: Jan. 19 1921

20. UNDERTAKER: J. C. Drake — ADDRESS: Filer

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-18

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 38
Primary Registration District No. 2086
File No. 33226
Registered No. .....

1. PLACE OF DEATH
County of Twin Falls.
City of Filer (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Baby Nugent

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: ~~Male~~ Female

4. COLOR OR RACE: White

5. SINGLE, ~~MARRIED, WIDOWED OR DIVORCED~~ (Write the word.)

6. DATE OF BIRTH. Jan. (Month) 14 (Day) 1921 (Year)

7. AGE ..... Yrs. ..... Mos. 6 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Filer, Idaho.

10. NAME OF FATHER Otis Edward Nugent.

11. BIRTHPLACE OF FATHER (State or Country) Okla.

12. MAIDEN NAME OF MOTHER Fern May Skinner.

13. BIRTHPLACE OF MOTHER (State or Country) Okla.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) O. E. Nugent
(Address) Filer Idaho

15. Filed Jan 22 1921 A A Newberry Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan. (Month) 20 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I did not attended deceased from Jan 14 1921, to Jan. 20 1921, that I last saw her alive on Jan. 20 1921, and that death occured on the date stated above, at 9 P.M.

The CAUSE OF DEATH* was as follows:

Cardiac weakness.
(Duration) ..... Yrs. ..... mos. 6 ds.
Contributory (Secondary) Premature birth
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Frank A Dyer M. D.
Jan 21 1921. (Address) Filer, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Odd Cemetery — DATE OF BURIAL: Jan 22 1921

20. UNDERTAKER: J. E. Dyer — ADDRESS: Filer

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS – YORK CO., PTRS. & STRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 38

Primary Registration District No. 2086

File No. 33227

County of Twin Falls,

City of Twin Falls, Ida.

(No. ....., ... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME No Name Nugent

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White.

5. SINGLE, ~~MARRIED, WIDOWED, OR DIVORCED~~. (Write the word.): Single

6. DATE OF BIRTH. Jan. (Month) 14 (Day) 1921. (Year)

7. AGE ..... Yrs. ..... Mos. 9 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): Filer, Ida.

10. NAME OF FATHER: O. E. Nugent.

11. BIRTHPLACE OF FATHER (State or Country): Okla.

12. MAIDEN NAME OF MOTHER: Fern May Skinner.

13. BIRTHPLACE OF MOTHER (State or Country): Okla.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) O. E. Nugent

(Address) Filer Idaho

15.

Filed Jan 28 1921 A. A. Newberry Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 23- (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I ~~attended~~ did not deceased from Jan. 14 1921, to Jan 23- 1921, that I last saw h— alive on Jan 23 ~~191~~, and that death occured on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:

Cardiac Weakness.

(Duration) ..... Yrs. ..... mos. 9 ds.

Contributory (Secondary) Prematurity

(Duration ..... yrs. ..... mos ..... ds.

(Signed) Frank A. Draper. M. D.

Jan 24-21 (Address) Filer, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: I. O. O. F. Cemetery — DATE OF BURIAL: Jan 24 1921

20. UNDERTAKER: F. E. Drake — ADDRESS: Filer.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24658

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33228
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Twin Falls
City of Filer
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 35
Primary Registration District No. 3456
(No. ....., ... St.)

2. FULL NAME Baby Vandall

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: white
5. SINGLE. ~~MARRIED, WIDOWED OR DIVORCED.~~ (Write the word.)

6. DATE OF BIRTH. Jan (Month) 31 (Day) 1921 (Year)

7. AGE ..... Yrs. ..... Mos. 15 Ds. IF LESS than 1 day how many .... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Lester Vandall

11. BIRTHPLACE OF FATHER (State or Country) Kansas

12. MAIDEN NAME OF MOTHER Anna Paul

13. BIRTHPLACE OF MOTHER (State or Country) Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Lester Vandall
(Address) Filer

15. Filed Jan 31 1921 A. A. Newberry Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 31 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1-31- 1921 to 1-31- 1921 that I last saw him alive on 1-31- 1921 and that death occurred on the date stated above, at ~ M.

The CAUSE OF DEATH* was as follows:

Still-born

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) Dr. Cummings M. D.
1-31 1921 (Address) Twin Falls Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs....mos....days. In the State....yrs....mos....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Doe Cemetery — DATE OF BURIAL Jan 31 1921

20. UNDERTAKER D E Drake — ADDRESS Filer

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33229
Registered No. .....

MAR 13 1921

1. PLACE OF DEATH
County of Twin Falls
City of Filer
If death occurs away from usual residence, give facts called for under special information.

Registration District No. .....
Primary Registration District No. .....
(No. ....., ... St.)

2. FULL NAME Agnes Porter

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. Apr. (Month) 13 (Day) 1835 (Year)

7. AGE: 85 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many .... hrs. or ..... min.?'

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) Wife

9. BIRTHPLACE (State or Country) Scotland

10. NAME OF FATHER John Agnarson

11. BIRTHPLACE OF FATHER (State or Country) Scotland

12. MAIDEN NAME OF MOTHER Lizabeth Robertson

13. BIRTHPLACE OF MOTHER (State or Country) Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Marguerite Staley
(Address) .....

15. Filed Feb 21 191.... G. A. Newberry Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 19 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 1920 to May 1920 that I last saw h w alive on May 6 — 1920 and that death occurred on the date stated above, at .....M.

The CAUSE OF DEATH* was as follows:

.....
Cerebral hemorrhage.
.....
(Duration) ..... Yrs. ..... mos. 9 ds.

Contributory (Secondary) Arteriosclerosis
(Duration) 10 Yrs. ..... mos. ..... ds.

(Signed) F. A. Straight M. D.
Mar. 22 1921. (Address) Filer, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Filer Idaho — DATE OF BURIAL: Feb 21 1921

20. UNDERTAKER: F E Draig — ADDRESS

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

MAR 10 1921

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 36
Primary Registration District No.
File No. 33231
Registered No. 1

1. PLACE OF DEATH
County of Twin Falls
City of Kimberly
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mildred McEwen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Female	White	S (Write the word.)

6. DATE OF BIRTH: July (Month) 8 (Day) 1920 (Year)

7. AGE: ....Yrs....Mos....ds. IF LESS than 1 day how many....hrs. or....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Albert McEwen

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Melvina Mathews

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Albert McEwen
(Address) Kimberly Ida

15. Filed Feb 10 1921 J M Davis Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 9 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 26 1921 to Feb 9 1921 that I last saw h.. alive on Feb 9 1921 and that death occurred on the date stated above, at ....M.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) ....Yrs. ....mos. 14 ds.

Contributory (Secondary) Whooping cough

(Duration) ....yrs. ....mos. 21 ds.

(Signed) J M Davis M. D.

2-12-1921 (Address) Kimberly Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death....yrs....mos....days. In the State....yrs....mos....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Twin Falls Ida	2-10 1921
20. UNDERTAKER J E DeWitt	ADDRESS Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

MAR 10 1921

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Twin Falls

City of Kimberly

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 36

Primary Registration District No.

(No. , St.)

File No. 33231

Registered No. 2

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Eliese Hulet

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: w

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: S (Write the word.)

6. DATE OF BIRTH: July (Month) 26 (Day) 1921 (Year)

7. AGE: Yrs. 6 Mos. 21 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Idaho.

10. NAME OF FATHER F E Hulet

11. BIRTHPLACE OF FATHER (State or Country) Idaho

12. MAIDEN NAME OF MOTHER Ella McEuen

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A. McEuen

(Address) Twin

15. Filed Feb 16 1921 J. M. Davis Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Febr. (Month) 15 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 12 1921 to Feb 15 1921 that I last saw her alive on Feb 15 1921, and that death occurred on the date stated above, at 10½ P.M.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

Cerebro Spinal Meningitis

(Duration) Yrs. mos. 3 ds.

Contributory (Secondary) whooping Cough

(Duration) yrs. 1 mos. ds.

(Signed) J. M. Davis M. D.

3/16 1921 (Address) Kimberly

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Ida — DATE OF BURIAL: 2-16 1921

20. UNDERTAKER: J. E. DeWitt — ADDRESS: Twin Falls Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51083

MAR 10 1921

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 86
Primary Registration District No. 1010
File No. 33235
Registered No. 6

1. PLACE OF DEATH
County of Washington
City of Weiser
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Clarence S. Smackey

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word)

6. DATE OF BIRTH: Sept 17 1880 (Month) (Day) (Year)

7. AGE: 40 Yrs. 3 Mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Merchant
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mo

10. NAME OF FATHER: Thos Smackey

11. BIRTHPLACE OF FATHER (State or Country): Mo

12. MAIDEN NAME OF MOTHER: Emma Snapp

13. BIRTHPLACE OF MOTHER (State or Country): Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. L. Keadby
(Address) Emmett Ida.

15. Filed Jan 13th 1921 W. R. Hamilton Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 1. (Month) 12 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1-11-1921, to 1-12-1921, that I last saw h[illegible] alive on 1-12-1921, and that death occurred on the date stated above, at 5 P M.

The CAUSE OF DEATH* was as follows:

Hepatic Carcinoma

(Duration) ? Yrs. ..... mos. ..... ds.

Contributory (Secondary) Cholemia & Coma

(Duration) ..... yrs. ..... mos. 2 ds.

(Signed) Ernest O. Finney M. D.

1/13 1921 (Address) Weiser Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Midvale Idaho — DATE OF BURIAL 19

20. UNDERTAKER: Northam McCown — ADDRESS: Weiser, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MAR 10 1921

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 56
Primary Registration District No. 2112
File No. 3323?
Registered No. 7

1. PLACE OF DEATH
County of Washington
City of Weiser
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Andrew Jackson Brashears
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widower (Write the word.)

6. DATE OF BIRTH: June (Month) 27 (Day) 1847 (Year)

7. AGE: 73 Yrs. 6 Mos. 6 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: John Brashears

11. BIRTHPLACE OF FATHER (State or Country): No. Carolina

12. MAIDEN NAME OF MOTHER: Naoma Trigg

13. BIRTHPLACE OF MOTHER (State or Country): Tenn-

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A. Arthur Brashears
(Address) Weiser Idaho

15. Filed Jan 4th 1921 — W. R. Hamilton, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. (Month) 3. (Day) 1921. (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 30 1920 to Jan 3 1921. that I last saw h-in alive on Jan 3 1921. and that death occurred on the date stated above, at 8 P.M.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) ..... Yrs. ..... mos. 6 ds.
Contributory (Secondary) Oedema of Lungs
(Duration) ..... yrs. ..... mos. 2 ds.

(Signed) Ernest Feeney M. D.
1/4 1921 (Address) Weiser, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Middleton, Idaho — DATE OF BURIAL ..... 19.....

20. UNDERTAKER: Northam & McCown — ADDRESS: Weiser Idy

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

MAR 10 1921

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 86
Primary Registration District No. 1010
File No. 33234
Registered No. 8

1. PLACE OF DEATH
County of Washington
City of Weiser
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Franklin Hill

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Wht
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widowed

6. DATE OF BIRTH: Jan (Month) 29 (Day) 1849 (Year)

7. AGE: 71 Yrs. 11 Mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farming
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mo.

10. NAME OF FATHER: Richard Hill

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER: Rodha Wheeler

13. BIRTHPLACE OF MOTHER (State or Country): Pa.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ben Hill
(Address) Pocatello Idaho

15. Filed Jan 25 1921 W. R. Hamilton Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 24 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 30 1920 to Jan 24 1921, that I last saw him alive on Jan 10 1921, and that death occurred on the date stated above, at 6 P. M.
The CAUSE OF DEATH* was as follows:

Cancer in cornu of Rectum

(Duration) 3 Yrs. ..... mos. ..... ds.
Contributory (Secondary) Exhaustion
(Duration) ..... yrs. ..... mos. 3 ..... ds.

(Signed) Ernest O. Freiss M. D.
1/25 1921 (Address) Weiser Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Burley Idaho	19
20. UNDERTAKER	ADDRESS
Northcutt & McCann	Weiser Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

MAR 10 1921

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 86
Primary Registration District No. 1010
File No. 33235
Registered No. 5

1. PLACE OF DEATH
County of Washington
City of Weiser
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Max Draper Gwilliam
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): single

6. DATE OF BIRTH: April (Month) 23 (Day) 1920 (Year)

7. AGE: Yrs. 9 Mos. 6 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Weiser, Idaho

10. NAME OF FATHER: F. D. Gwilliam

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Lena Draper

13. BIRTHPLACE OF MOTHER (State or Country): Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) F. D. Gwilliam
(Address) Weiser Idaho

15. Filed Jan 30th 1921 W R Hamilton Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 29 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 26 1921, to Jan 29 1921, that I last saw he alive on Jan 29 1921, and that death occurred on the date stated above, at 1:05 P.M.

The CAUSE OF DEATH* was as follows:
Whooping Cough.

(Duration) ..... Yrs. ..... mos. 14 ds.
Contributory (Secondary) Pneumonia
(Duration) ..... yrs. ..... mos. 5 ds.

(Signed) O O Garrard M. D.
1/30 1921 (Address) Weiser Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Hillcrest Cemetery — DATE OF BURIAL: 1/30 1921

20. UNDERTAKER: Northam & McCaw — ADDRESS: Weiser Ida

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33241

Registered No. 31

1. PLACE OF DEATH

County of Ada

City of Meora (St.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED APR 8 1921 BUREAU OF VITAL STATISTICS

Registration District No. 124

Primary Registration District No. 2202

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary Rybka

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: August (Month) 2 (Day) 1875 (Year)

7. AGE: 45 Yrs. ... Mos. ... ds.

IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Bohemia

10. NAME OF FATHER: John ?

11. BIRTHPLACE OF FATHER (State or Country): Silesia

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Henry Rybka

(Address) Meora

15. Filed Mar. 24 1921 — Rue Bowell, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 22 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar. 17 1921, to Mar. 22 1921, that I last saw h.er alive on Mar. 21 1921, and that death occurred on the date stated above, at 9:30 A.M.

The CAUSE OF DEATH* was as follows:

Endocarditis - Acute

(Duration) ... Yrs. ... mos. 8 ds.

Contributory (Secondary): Myocarditis

(Duration) ... yrs. ... mos. ... ds.

(Signed) Rue Bowell M. D.

3/23 1921 (Address) Kuna Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Kuna Cemetery — DATE OF BURIAL: 3/24 1921

20. UNDERTAKER: None — ADDRESS:

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED APR 8 BUREAU OF STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Ada — Registration District No. 124

City of Kuna R R — Primary Registration District No. 2202 — St.)

File No. 33242

Registered No. 32

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Friese

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Single

6. DATE OF BIRTH: March (Month) 17 (Day) 1921 (Year)

7. AGE: ....Yrs. ....Mos. 5 ds. — IF LESS than 1 day how many....hrs. or....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kuna Ida RR1

10. NAME OF FATHER: Alexander Friese

11. BIRTHPLACE OF FATHER (State or Country): Russia

12. MAIDEN NAME OF MOTHER: Mary Wolder

13. BIRTHPLACE OF MOTHER (State or Country): Russia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Alexander Friese
(Address) Kuna Ida RR1

15. Filed March 23 1921 — Rue Bowell, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 22 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar. 17 1921 to Mar. 23 1921 that I last saw her alive on Mar 22 1921 and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:
Gastro enteritis

(Duration) ....Yrs. ....mos. 3 ds.
Contributory (Secondary): Convulsions
(Duration) ....yrs. ....mos. 2 ds.

(Signed) Rue Bowell M. D.
Mar 23 1921 (Address) Kuna Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Kuna Ida — DATE OF BURIAL: 3-25 1921

20. UNDERTAKER: None — ADDRESS:

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 122242
Registered No. 330

1. PLACE OF DEATH

County of Ada

City of Kuna RR1

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 124

Primary Registration District No. 2202

RECEIVED APR 11 1921 BUREAU OF VITAL STATISTICS

BUREAU OF STATI

2. FULL NAME Susan Glick

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Widow

6. DATE OF BIRTH: Jan. (Month) 1 (Day) 1844 (Year)

7. AGE: 77 Yrs. 2 Mos. 11 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House-
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Virginia

10. NAME OF FATHER: Wm G. Hatton

11. BIRTHPLACE OF FATHER (State or Country): Virginia

12. MAIDEN NAME OF MOTHER: Miss Jam Canterbury

13. BIRTHPLACE OF MOTHER (State or Country): ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Mrs. Wm Hatton
(Address): Kuna Ida RR1.

15. Filed March 14 1921 — Rue Bowell, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 11 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar. 5 1921 to Mar. 11 1921 that I last saw h.. alive on Mar. 11 1921 and that death occurred on the date stated above, at 10:25 A.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia
(Right Lower Lobe).

(Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary): Myocarditis ?

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Rue Bowell M. D.

March 14 1921 (Address) Kuna Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Nampa Ida	3-12 1921
20. UNDERTAKER: Fred K Robinson	ADDRESS: Nampa Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

RECEIVED
APR 8 1921
BUREAU OF VITAL STATISTICS

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APR 1 1921

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 1 124

Primary Registration District No. 2702

File No. 33244

Registered No. 33

County of Ada

City of Kuna R R (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Henrietta L Lowers

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widow

6. DATE OF BIRTH: January (Month) 31 (Day) 1840 (Year)

7. AGE: 81 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Penn.

10. NAME OF FATHER Alexander Stevens

11. BIRTHPLACE OF FATHER (State or Country) Ohio

12. MAIDEN NAME OF MOTHER Castle

13. BIRTHPLACE OF MOTHER (State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Lottie M. Young

(Address) .....

15. Filed March 30 1921 Rue Boswell Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 18 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3-12- 1921, to 3-18 1921 that I last saw her alive on 3-18 1921 and that death occurred on the date stated above, at 3:05 A.M.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia

..... (Duration) ..... Yrs. ..... mos. 7 ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F J Coleman M. D.

3-18-1921 (Address) Kuna Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Winfield Kansas — DATE OF BURIAL ..... 19.....

20. UNDERTAKER: Fred K. Robinson — ADDRESS: Kuna Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33245

Registered No. 10

1. PLACE OF DEATH

County of Ada

City of Meridian Id (St.)

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No. 11

RECEIVED APR 8 1921 BUREAU OF VITAL STATISTICS

2. FULL NAME Clark Ervin Clapp.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Male	White	Married (or Widowed)

6. DATE OF BIRTH: July (Month) 2. (Day) 1853 (Year)

7. AGE: 67 Yrs. 10 Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Penn

10. NAME OF FATHER: Edward C Clapp

11. BIRTHPLACE OF FATHER (State or Country): N. Y. State

12. MAIDEN NAME OF MOTHER: Eliza A. Graves.

13. BIRTHPLACE OF MOTHER (State or Country): Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Elton Clapp

(Address) Meridian Idaho

15. Filed 4-8 1921 H F Neal Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 1 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4-1 9 A. M. 1921, to 4-1 P. M. 1921 that I last saw him alive on 4-1 1921 and that death occurred on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

acute indigestion

(Duration) Yrs. mos. ds.

Contributory (Secondary) Arterial Sclerosis

(Duration) yrs. mos. ds.

(Signed) H F Neal M. D.

4-2 1921 (Address) Meridian Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR ~~REMOVAL~~: Meridian Cemetery — DATE OF BURIAL: 4-3 1921

20. UNDERTAKER: W P Maher — ADDRESS: Meridian Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33246
Registered No. 11

RECEIVED
APR 9 19
BUREAU OF VITAL STATISTICS

Registration District No.
Primary Registration District No.

1. PLACE OF DEATH

County of Ada
City of Meridian
(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Dan L. Sims

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH June (Month) 23 (Day) 1911 (Year)

7. AGE 9 Yrs. 9 Mos. 16 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Meridian

10. NAME OF FATHER Elmer E Sims

11. BIRTHPLACE OF FATHER (State or Country) Ill.

12. MAIDEN NAME OF MOTHER Grace I. Daly.

13. BIRTHPLACE OF MOTHER (State or Country) Boise Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E E Sims

(Address) Meridian Idaho

15. Filed 4-8 1921 H F Neal Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 7 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 19... was called to her death 19..., that I last saw h... alive on 19..., and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Measles 3 W.
Bronchial Pneumonia

(Duration) Yrs. mos. 16 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) H. F. Neal M. D.

4-7 1921 (Address) Meridian

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Meridian — **DATE OF BURIAL** April 8 1921

20. UNDERTAKER Bradley Meridian — **ADDRESS** Idaho

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

Tallman,

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 3?247

Registered No. 98

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No. 410 W. State St.)

2. FULL NAME Jack States

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F	White	Widow

6. DATE OF BIRTH: July (Month) 10 (Day) 1857 (Year)

7. AGE: 64 Yrs. 1 Mos. 19 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mo.

10. NAME OF FATHER: E. Culpepper

11. BIRTHPLACE OF FATHER (State or Country): Virginia

12. MAIDEN NAME OF MOTHER: Sarah J. Street

13. BIRTHPLACE OF MOTHER (State or Country): Ills

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. F. Boydston
(Address) McCall Idaho

15. Filed Mar 31 1920 — Boydston — R. H. Pratt, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 29 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1920 to May 29 1921, that I last saw h[illegible] alive on May 29, 1921, and that death occurred on the date stated above, at 10 9 M.

The CAUSE OF DEATH* was as follows:
Mitral stenosis

(Duration) 30 Yrs. [illegible] mos. [illegible] ds.
Contributory (Secondary) Auricular fibrillation
(Duration) 6 yrs. mos. ds.

(Signed) M. F. Tallman M. D.
3/31 1921 (Address) Boise, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Morris Hill Cemetery	Mar 31 1921
20. UNDERTAKER	ADDRESS
Summers & Turbs	Boise Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 33248
Registered No. 78

1. PLACE OF DEATH

County of Ada

City of Boise (No. 901 Resseguie St.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
APR 7 1921
BUREAU OF VITAL STATISTICS

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary Valentine

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widow

6. DATE OF BIRTH: Jan (Month) 31 (Day) 1872 (Year)

7. AGE: 49 Yrs. 1 Mos. 14 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Oregon

10. NAME OF FATHER: James Toney

11. BIRTHPLACE OF FATHER (State or Country): Ill.

12. MAIDEN NAME OF MOTHER: Lottie Willis

13. BIRTHPLACE OF MOTHER (State or Country): Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Edith Valentine Crane

(Address) 901 Resseguie St

15. Filed Mar 16 1921

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 3 (Month) 15 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 24 1921, to Mar 10 1921, that I last saw h[illegible] alive on Mar 10 1921, and that death occurred on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:

Chronic Intestinal Nephritis

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F. A. Tibbey Jr M. D.

3/16 1921 (Address) Overland Bldg

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: May 16 1921

20. UNDERTAKER: Summers & Krebs — ADDRESS: Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

Ward.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33249
Registered No. 75

1. PLACE OF DEATH

Registration District No. 2
Primary Registration District No. 1004

County of Ada
City of Boise (1014 Eastman St.)

RECEIVED
APR 7 1921
BUREAU OF VITAL STATISTICS

If death occurs away from usual residence, give facts called for under special information.

2. Charles Breach.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
M.	White	Married (or Widowed)

6. DATE OF BIRTH: Sept 22 – 1842 (Month) (Day) (Year)

7. AGE: 78 Yrs. 5 Mos. 16 ds. IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired Farmer
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): England.

10. NAME OF FATHER: Frederick Breach

11. BIRTHPLACE OF FATHER (State or Country): England.

12. MAIDEN NAME OF MOTHER: Ann E. Love

13. BIRTHPLACE OF MOTHER (State or Country): England.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): John L. Breach.
(Address): Boise Idaho

15. Filed March 12 1921 — R. V. Craft, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar 10 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 10 1921 to March 10 1921 that I last saw him alive on March 10 1921, and that death occurred on the date stated above, at 11:15 P M.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) ... Yrs. ... mos. 1 ds.
Contributory (Secondary) Arterio-sclerosis
(Duration) 10 yrs. ... mos. ... ds.

(Signed) Roscoe B Ward M. D.
3/12 1921 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Masonic Cemetery.	Mar 13 1921
20. UNDERTAKER	ADDRESS
Summers & Cobbs.	Boise Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33250
Registered No. 74

RECEIVED
APR 7 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Ada — Registration District No. 7
City of Boise — Primary Registration District No. 1704
(If outside limits of city or village give township) (St. Luke's Hospital)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Preston Liddiard.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male.	White.	Single.

6. DATE OF BIRTH: Apr. - 1 - 1913
(Month) (Day) (Year)

7. AGE: 7 Yrs. 11 Mos. 9 ds.
If LESS than 1 day how many ____ hrs. or ____ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Boise Idaho.

10. NAME OF FATHER: John Liddiard

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Louie Daniels.

13. BIRTHPLACE OF MOTHER (State or Country): Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wm McBratney
(Address) Boise. Idaho.

15.
Filed Mar 12 1921 — R H Pratt — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mch 10 - 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 5 1921, to Mar 10 1921, that I last saw him alive on Mar 16 1921, and that death occurred on the date stated above, at 2 P M.

The CAUSE OF DEATH* was as follows:
Retropharyngeal abscess + caries of abdominal vertebrae.
(Duration) ____ Yrs. ____ mos. ____ ds.

Contributory (Secondary)
(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) A. M. Jacquemin M. D.
3/10 1921 (Address) Boise. Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 3/13/21

20. UNDERTAKER: W. McBratney — ADDRESS: Boise Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3251
Registered No. 79

1. PLACE OF DEATH

Registration District No. 7
Primary Registration District No. 1104

County of Ada RECEIVED
City of Boise APR 7 1921 (If not in limits of city or village give township) Ada St.)

If death occurs away from usual residence, give facts called for under special information.

BUREAU OF VITAL STATISTICS

2. FULL NAME Michaelle Gabica

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: July (Month) 15th (Day) 1882 (Year)

7. AGE: 38 Yrs. ... Mos. ... ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housekeeper
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Spain

10. NAME OF FATHER: Josef Bendochea

11. BIRTHPLACE OF FATHER (State or Country): Spain

12. MAIDEN NAME OF MOTHER: Pilar Navarra

13. BIRTHPLACE OF MOTHER (State or Country): Spain

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Victor Gabica
(Address) Orana Ida

15. Filed Mar 16 1921 P. H. Pratt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar (Month) 15th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 9 1921, to Mar 15 1921, that I last saw h[illegible] alive on Mar 15 1921, and that death occurred on the date stated above, at ... M.

The CAUSE OF DEATH* was as follows:
Vincents Angina of Mouth and Pharynx
(Duration) ... Yrs. ... mos. ... ds.
Contributory (Secondary) Acute Bright's Disease
(Duration) ... yrs. ... mos. ... ds.

(Signed) H. H. Tuttle M. D.
3/16 1921 (Address) Overland Bldg

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence Orana Idaho

19. PLACE OF BURIAL OR REMOVAL: St Johns Cemetery — DATE OF BURIAL: 3/17 1921

20. UNDERTAKER: Eckreber & Sidenfade — ADDRESS: (Boise)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33252

Registered No. 88

RECEIVED
APR 7 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 7

Primary Registration District No. 1004

County of Ada

City of Boise (If outside limits of city or village give township) St. Alphonsus Hospital (Ward or St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mammie Marshall.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: January — 1868
(Month) (Day) (Year)

7. AGE: 53 Yrs. — Mos. — ds.

IF LESS than 1 day how many..... hrs. or..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Texas.

10. NAME OF FATHER: McKnab.

11. BIRTHPLACE OF FATHER (State or Country): Dont Know.

12. MAIDEN NAME OF MOTHER: Dont Know.

13. BIRTHPLACE OF MOTHER (State or Country): Dont Know.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wm McGratney
(Address) Boise Idaho

15. Filed 3/24 1921 R V Ball Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 22 — 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 24 1916 to March 23 1921 that I last saw h.. alive on March 23 1921 and that death occurred on the date stated above, at 11 P M.

The CAUSE OF DEATH* was as follows:

Cysto Sarcoma

(Duration) 8 Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) R E Sluntz M. D.

3/23 1921 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 3/25 1921

20. UNDERTAKER: W McGratney — ADDRESS: Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 1004
File No. 33203
Registered No. 87

RECEIVED
APR 7 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Ada
City of Boise (If outside limits of city or village, give township) 410 State St.)

If death occurs away from usual residence, give facts called for under special information.

2. NAME Katherine J. Dunning

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: July (Month) 2nd (Day) 1850 (Year)

7. AGE: 70 Yrs. ... Mos. ... ds.

IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Weston, Missouri

10. NAME OF FATHER: Daniel Quinn

11. BIRTHPLACE OF FATHER (State or Country): Pennsylvania

12. MAIDEN NAME OF MOTHER: Katherine J. Quinn

13. BIRTHPLACE OF MOTHER (State or Country): Pennsylvania

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. H. Dunning

(Address) Boise, Idaho

15.

Filed ... 19...

Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 23 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mch ... 1921, to March 23 1921 that I last saw h... alive on March 23 1921, and that death occurred on the date stated above, at 1 A. M.

The CAUSE OF DEATH* was as follows:

Diabetes

... (Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary) ...

... (Duration) ... yrs. ... mos. ... ds.

(Signed) Dr. Collester M. D.

... 19... (Address) ...

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death? ...

Former or usual residence Boise Idaho

19. PLACE OF BURIAL OR REMOVAL: Harris Hill Cemetery — **DATE OF BURIAL:** 3/24 1921

20. UNDERTAKER: Schreiber & Sidenfaden — **ADDRESS:** Boise

Dr. Collester

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33654
Registered No. 86

1. PLACE OF DEATH

RECEIVED
APR 7 1921
BUREAU OF VITAL STATISTICS

Registration District No. 7
Primary Registration District No. 1004
County of Ada
City of Boise (No. 215 Main 13 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Hulda M. Bailey

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Jan (Month) 11 (Day) 1846 (Year)

7. AGE: 75 Yrs. 2 Mos. 10 ds.
IF LESS than 1 day how many..... hrs. or.....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Josh Bailey

11. BIRTHPLACE OF FATHER (State or Country): Pen.

12. MAIDEN NAME OF MOTHER: Sophia ?

13. BIRTHPLACE OF MOTHER (State or Country): U. S. A.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R. L. Bailey.
(Address) Boise

15. Filed Mar 22 1921 R. J. Cook Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 21 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mch 20 1921 to Mch 21 1921
that I last saw her alive on Mch 21 1921
and that death occurred on the date stated above, at 3 P. M.
The CAUSE OF DEATH* was as follows: Hemiplegia (Stroke of paralysis).

(Duration) ..... Yrs. ..... mos. 1 ds.
Contributory (Secondary) Chronic nephritis
(Duration) 5 yrs. ..... mos. ..... ds.

(Signed) M. W. Dalman M. D.
3/24 1921 (Address) Boise.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 3/23 1921

20. UNDERTAKER: Schneider & Siddenfaden — ADDRESS: Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

Shurtz

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33265
Registered No. 85

1. PLACE OF DEATH
County of Ada
City of Boise
If death occurs away from usual residence, give facts called for under special information.

RECEIVED
APR 7 1921
BUREAU OF VITAL STATISTICS

Registration District No. 7
Primary Registration District No. 1004
No. 311 Elm St.)

2. FULL NAME Levi J. Gable

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Nov. (Month) 23 (Day) 1845 (Year)

7. AGE: 75 Yrs. 3 Mos. 28 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired Merchant
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Penn.

10. NAME OF FATHER: John Gable

11. BIRTHPLACE OF FATHER (State or Country): Penn

12. MAIDEN NAME OF MOTHER: Susannah Mary

13. BIRTHPLACE OF MOTHER (State or Country): Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H. Brandt
(Address) Boise Idaho

15. Filed Mar 22 1921 R. H. Smith Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 21 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 17 1921, to March 21 1921, that I last saw h— alive on March 20 1921, and that death occurred on the date stated above, at 6A M.

The CAUSE OF DEATH* was as follows:

Valvular Heart disease

(Duration) 30 Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Rheumatism M. D.

3/21 1921 (Address) 1 P E Shurtz

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Mar 22 1921

20. UNDERTAKER: Summers & Drbe — ADDRESS: Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 4
Primary Registration District No. 1004
File No. 33256
Registered No. 849

RECEIVED
APR 7 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Ada
City of Boise (If outside limits, give township) 535 S. 13 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Emily Bird Ruhl

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: March (Month) 22 (Day) 1863 (Year)

7. AGE: 57 Yrs. 11 Mos. 29 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER: William Parsons

11. BIRTHPLACE OF FATHER (State or Country): Vermont

12. MAIDEN NAME OF MOTHER: Isabelle Matheus

13. BIRTHPLACE OF MOTHER (State or Country): Mass Jersey

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C R Haman
(Address) Boise Idaho,

15. Filed Mar 22 1921 R. H. Coats Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 21 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 20 1921, to Mar 21 1921 that I last saw her alive on Mar 21 1921, and that death occurred on the date stated above, at 7 P. M.
The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) P P French M. D.
3-22 1921 (Address) 417 Overland Bldg Boise

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Mar 23 1921

20. UNDERTAKER: Cummings & Fuhs — ADDRESS: Boise Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33257

Registered No. 83

Registration District No. V

Primary Registration District No. 1004

1. PLACE OF DEATH

County of Ada

City of Boise (If outside limits give township) No. 115 W. 19 St.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
APR 7 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME John L Hunter

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widower

6. DATE OF BIRTH: May (Month) 1 (Day) 1840 (Year)

7. AGE: 80 Yrs. 10 Mos. 18 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mich

10. NAME OF FATHER: John Hunter

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. S. Hunter
(Address) Boise, Idaho.

15. Filed Mar 21 1921 R. H. Peale Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar (Month) 19 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 15 1921, to Mar 19 1921, that I last saw him alive on Mar 15 1921, and that death occurred on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Duodenum and Head of Pancreas.

(Duration) 1 Yrs. mos. ds.

Contributory (Secondary) Intestinal Hemorrhage

(Duration) yrs. mos. 7 ds.

(Signed) F. M. Braxton M. D.

Mar 20 1921 (Address) Boise Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Ypsilanti, Mich — DATE OF BURIAL: Mar 21 1921

20. UNDERTAKER: Summers & Krebs — ADDRESS: Boise Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33258
Registered No. 82

1. PLACE OF DEATH

Registration District No. 7
Primary Registration District No. 1004
County of Ada
City of Boise (No. 27 Y Madison St.)

RECEIVED
APR 7 1921
BUREAU OF VITAL STATISTICS

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Infant Reed.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Mar 18 (Month) (Day) 1921 (Year)

7. AGE: — Yrs. — Mos. — ds.
IF LESS than 1 day how many — hrs. or — min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: Frank E. Reed.

11. BIRTHPLACE OF FATHER (State or Country): England.

12. MAIDEN NAME OF MOTHER: Esthel Glenn

13. BIRTHPLACE OF MOTHER (State or Country): Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Frank E. Reed
(Address) Boise Idaho.

15. Filed 3/19/21 19.. R. K. Craft
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 18 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 18 1921, to Mar 18 1921
that I last saw h[illegible] alive on Mar 18 1921,
and that death occurred on the date stated above, at 8 P. M.
The CAUSE OF DEATH* was as follows:
Died at birth

(Duration) Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) P P French M. D.
Mar 19 1921 (Address) Boise Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery. DATE OF BURIAL: Mar 19 1921

20. UNDERTAKER: Summers & Webb. ADDRESS: Boise Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51068

FORM V. S. No. 5-25 M. 1-19.

Frank.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33259

Registered No. 89

1. PLACE OF DEATH

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 8

Primary Registration District No. 1204

(No. 410 State Street St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

RECEIVED
APR 7 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME Marie Angeline Van Sickle

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Feb 22 (Month) (Day) 1871 (Year)

7. AGE: 50 Yrs. 0 Mos. 25 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Scott Wallace

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A. W. Knox

(Address) Thurman Idg

15. Filed Mar 18 1921 R. H. Prato Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar (Month) 17 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 29 1921, to Mar 17 1921 that I last saw her alive on Mar 16 1921 and that death occurred on the date stated above, at 1 A.M.

The CAUSE OF DEATH* was as follows:

Traumatic gangrene both legs (RT leg amputated)

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Chr. parenchymatous nephritis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Ralph Falk M. D.

3/18 1921 (Address) Boise

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery DATE OF BURIAL: Mar 18 1921

20. UNDERTAKER: Summers & Krebs ADDRESS: Boise Idaho

FORM V. S. No. 5-25, M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33261
Registered No. 68

1. PLACE OF DEATH

RECEIVED
APR 7 1921
BUREAU OF VITAL STATISTICS

Registration District No. 7
Primary Registration District No. 1004
County of Ada
City of Boise (No. 410 State St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Edmund Wolfe

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1 (Year)

7. AGE: 18 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ada County, Idaho

10. NAME OF FATHER: Anthony Wolfe

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Maud Thompson

13. BIRTHPLACE OF MOTHER (State or Country): Pa.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Anthony Wolfe
(Address) Boise, Idaho

15. Filed Mar 2 1921 — P. H. Pratt, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar 1st 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 20 1919, to Feb 28 1921, that I last saw h~~im~~ alive on Feb 28 1921, and that death occurred on the date stated above, at 8 A. M.

The CAUSE OF DEATH* was as follows:
Pneumonia following
Acute Pangtranous
Appendicitis
(Duration) Yrs. 2 mos. 18 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A A Higgs M. D.
19..... (Address) Boise Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence Ada County, Ida.

19. PLACE OF BURIAL OR REMOVAL: St Johns Cemetery — DATE OF BURIAL: 3/3 1921

20. UNDERTAKER: Schreiber & Siebenfaden — ADDRESS: Boise, Idaho

Dr. 4-7-21

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35265

Registered No. 66

1. PLACE OF DEATH

County of Ada

City of Boise (No. 1004 St. Luke's Hospital St.)

Registration District No. 7

Primary Registration District No.

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
APR 7 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME Serena Cooper Watts

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: July 26 - 1845
(Month) (Day) (Year)

7. AGE: 75 Yrs. 7 Mos. 2 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: David Cooper

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wm McBratney
(Address) Boise, Idaho.

15. Filed Mar 1 1921 R. H. Pratt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. 28, 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 18 1921, to Feb. 28 1921, that I last saw her alive on February 1921, and that death occurred on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) Yrs. 1½ mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Wm. Allen Caldwell M. D.

3/1 1921 (Address) Boise, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 3/2 1921

20. UNDERTAKER: Wm McBratney — ADDRESS: Boise Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
APR 7 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 7

Primary Registration District No. 1004

File No. 33264

Registered No. 69

County of Ada

City of Boise (If outside limits, give township) 440 State St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William Waldo Bauer Jr

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	White	Infant

6. DATE OF BIRTH: March (Month) 2 (Day) 1921 (Year)

7. AGE: 0 Yrs. 0 Mos. 2 ds. IF LESS than 1 day how many ___ hrs. or 5 min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business or establishment in which employed (or employer): none

9. BIRTHPLACE (State or Country): Boise, Ida

10. NAME OF FATHER: William Waldo Bauer, M.D.

11. BIRTHPLACE OF FATHER (State or Country): Wisconsin

12. MAIDEN NAME OF MOTHER: Florence Anne Marvyne

13. BIRTHPLACE OF MOTHER (State or Country): Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Capt. Bauer MD,
(Address) St Alphonsus Hospital

15. Filed Mar 9- 1921 R. H. Arnold Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 4 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3-2 1921, to 3-4 1921, that I last saw h[im] alive on March 4 1921, and that death occurred on the date stated above, at 8 A. M.

The CAUSE OF DEATH* was as follows:

Non closure of Foramen Ovale

(Duration) ___ Yrs. ___ mos. 2 ds.

Contributory (Secondary) Prematurity

(Duration) ___ yrs. ___ mos. ___ ds.

(Signed) D P Higgs M. D.

3-4 1921 (Address) 1622 Wash St Boise Id

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ___ yrs. ___ mos. ___ days. In the State ___ yrs. ___ mos. ___ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Elgin Hills	4/2 1921

20. UNDERTAKER	ADDRESS
Schreiber & Siddenfaden	Boise Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33265
Registered No. 97

RECEIVED
APR 7 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Ada
City of Boise
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 7
Primary Registration District No. 1004
(No. 725 D. 10. St.)

2. FULL NAME Curtis W. Hagan
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Sept 9 (Month) (Day) 1866 (Year)

7. AGE: 54 Yrs. 6 Mos. 21 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Water Master
(b) General nature of industry, business or establishment in which employed (or employer): U.S.R.D.

9. BIRTHPLACE (State or Country): Penn

10. NAME OF FATHER: John Hagan

11. BIRTHPLACE OF FATHER (State or Country): Penn

12. MAIDEN NAME OF MOTHER: Susan Myers

13. BIRTHPLACE OF MOTHER (State or Country): Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Floyd L. Hagan
(Address) Boise Idaho

15. Filed Mar 31 1921 R. [illegible]
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 30 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 26 1921, to March 30 1921, that I last saw h[illegible] alive on March 29 1921, and that death occurred on the date stated above, at 12 45 M.
The CAUSE OF DEATH* was as follows:
Cyanic heart disease
(Duration) 3 Yrs. ..... mos. ..... ds.
Contributory (Secondary) Influenza
3 Yrs V/m (Duration) 3 yrs. ..... mos. ..... ds.
(Signed) D O Higgs M. D.
3 31 1921 (Address) 1622 Wash St

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Re[illegible] Residents.)
At place of death ..... yrs. [illegible] days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Apr 2 1921
20. UNDERTAKER: Summers & Kelso — ADDRESS: Boise Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
APR 7 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 33260
Registered No. 96

1. PLACE OF DEATH
County of Ada
City of Boise (If outside limits, give township) (Street and number, or location) 1109 Harrison Blvd. (St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jessie L. Oakes.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (or widowed)

6. DATE OF BIRTH: Nov 6 (Month) (Day) 1865 (Year)

7. AGE: 55 Yrs. 4 Mos. 22 ds.
IF LESS than 1 day how many ____ hrs. or ____ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home.
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Oregon

10. NAME OF FATHER: Nathan W. Wallace.

11. BIRTHPLACE OF FATHER (State or Country): Indiana.

12. MAIDEN NAME OF MOTHER: Sarah Vaught.

13. BIRTHPLACE OF MOTHER (State or Country): Ohio.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. L. Vernetta
(Address) Lillooet

15. Filed March 31 1921
Mrs. F. H. Prate
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 26 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 9 1919, to Mar 26 1921, that I last saw her alive on Mar 26 1921, and that death occurred on the date stated above, at 6.30 P.M.

The CAUSE OF DEATH* was as follows:
Arterio-sclerosis
(Duration) 5 Yrs. mos. ds.
Contributory (Secondary) Cerebral Hemorrhage
(Duration) yrs. mos. 4 hrs.

(Signed) T. N. Braxton M. D.
Mar 30 1921 (Address) Boise, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery | DATE OF BURIAL: March 31 1921

20. UNDERTAKER: Summers & Cobb. | ADDRESS: Boise Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 9

Primary Registration District No. 1004

File No. 33268

Registered No. 94

County of Ada RECEIVED

City of Boise APR 7 1921 410 State St.)

BUREAU OF VITAL STATISTICS

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Moses R. Spencer

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: March 1 1848.
(Month) (Day) (Year)

7. AGE: 72 Yrs. 10 Mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Prospector Sheepherder
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Putnam Co Indiana

10. NAME OF FATHER: Tomes Spencer

11. BIRTHPLACE OF FATHER (State or Country): South Carolina

12. MAIDEN NAME OF MOTHER: Jane Russell

13. BIRTHPLACE OF MOTHER (State or Country): Do Cund-

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A Schneeberger
(Address) Boise Ida

15. Floyd Cunningham, Greeley Kans.

Filed ..... 19 .....

R. N. Pruett
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 23 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5:40 P.M. 3/23 1921, to 5:43 P.M. 3/23 1921, that I last saw him alive on 5:43 P.M. 3/23 1921, and that death occurred on the date stated above, at 5:45 P.M.

The CAUSE OF DEATH* was as follows:

Patient was dying when I saw him and I was unable to get history from attendants.
Probable diagnosis-Paralytic stroke.

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John T. Rutledge M. D.

3/24 1921. (Address) St. Alphonsus Hosp.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 3/28 1921

20. UNDERTAKER: Schneeberger & Siedentopf — ADDRESS: Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
APR 7 1921
BUREAU OF VITAL STATISTICS

Registration District No. 5
Primary Registration District No. 1004
File No. 33260
Registered No. 95

1. PLACE OF DEATH
County of Ada
City of Boise (Not in limits 15 No 12 St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Frederica K. Witman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widow (Write the word.)

6. DATE OF BIRTH: March (Month) 3rd (Day) 1837 (Year)

7. AGE: 84 Yrs. 0 Mos. 24 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Pennsylvania

10. NAME OF FATHER: David Krause

11. BIRTHPLACE OF FATHER (State or Country): Pennsylvania

12. MAIDEN NAME OF MOTHER: Catherine Orr

13. BIRTHPLACE OF MOTHER (State or Country): Pennsylvania

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. M. Taylor
(Address) Boise, Idaho

15. Filed Mar 28 1921 — P. H. Pratt, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 27th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 18th 1921, to Mch 27th 1921, that I last saw h~~e~~r alive on Mch 27th 1921, and that death occurred on the date stated above, at 3 P. M.
The CAUSE OF DEATH* was as follows:
Fall from chair striking head — not able to take food afterwards
(Duration) 9 Yrs. mos. ds.
Contributory (Secondary) Senility —
(Duration) yrs. mos. ds.
(Signed) J. M. Taylor M. D.
Mch 27 1921 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cem — DATE OF BURIAL: Mar 28 1921

20. UNDERTAKER: Summers & Webb. — ADDRESS: Boise Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33270

Registered No. 74

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Ada

City of Boise

Registration District No. 2

Primary Registration District No. 1004

(No. 1911 N. 18th St.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
APR 7 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME Patrick Sweeney

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: (Month) (Day) 1851 (Year)

7. AGE: 70 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Watchman P. S. L.

(b) General nature of industry, business or establishment in which employed (or employer): Pocatello, Idaho

9. BIRTHPLACE (State or Country): Ireland

10. NAME OF FATHER: Jeremiah Sweeney

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Mary Foy

13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Margt Sweeney

(Address) Boise, Idaho

15.

Filed ..... 19 .....

Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar 26th 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 9 1920 to Mar 24 1921 that I last saw him alive on March 24 1921, and that death occurred on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Arterio-Sclerosis - and Senility

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) L. O. McCall M. D.

3/26 1921 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Pocatello Idaho — DATE OF BURIAL: 3/29 1921

20. UNDERTAKER: Schreiber & Sedenfeldt — ADDRESS: Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 7 Boise

Primary Registration District No. 1904

File No. 33271

County of Ada

City of Boise No. 110 E. Bannock St.)

Registered No. 91

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

RECEIVED
APR 7 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME Infant Sanders

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	White	Single

6. DATE OF BIRTH: March 25 1921 (Month) (Day) (Year)

7. AGE: ~ Yrs. ~ Mos. ~ ds. IF LESS than 1 day how many 6 hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Boise Idaho

10. NAME OF FATHER: H. R Sanders

11. BIRTHPLACE OF FATHER (State or Country): Kansas

12. MAIDEN NAME OF MOTHER: Hazel V. Jacobs

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H R Sanders
(Address) Wilson Idaho

15. Filed Mar 26 1921 P. A. Pratt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 25 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 25 1921 to March 25 1921 that I last saw him alive on March 25 1921 and that death occurred on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:

Atelectasis

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Hans Baer M. D.

3-26 1921 (Address) Boise Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Wilson Idaho. DATE OF BURIAL: Mar 26 1921

20. UNDERTAKER: Summers & Krebs ADDRESS: Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Ada — RECEIVED — Registration District No. ..... Primary Registration District No. 1004

City of Boise — APR 7 1921 — No. 410 State St. — File No. 33272

If death occurs away from usual residence, give facts called for under special information. — BUREAU OF VITAL STATISTICS — 2. FULL NAME William George Winn — Registered No. 70

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Male	White	Single (Write the word.)

6. DATE OF BIRTH: Sept (Month) 16 (Day) 1902 (Year)

7. AGE: 18 Yrs. 6 Mos. 5 ds. — IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Col.

10. NAME OF FATHER: Paul Winn

11. BIRTHPLACE OF FATHER (State or Country): Neb.

12. MAIDEN NAME OF MOTHER: May Kiger

13. BIRTHPLACE OF MOTHER (State or Country): Neb.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H. J. Gallier
(Address) 609 North 6th St.

15. Filed Mar 24 1921 — R. H. Pratt, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 21 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 4 1921, to March 21 1921, that I last saw h.. alive on March 21 1921, and that death occurred on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:
Chronic Parenchymatous nephritis
(Duration) 1 Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) M. V. Tallman M. D.
3/22 1921 (Address) Boise

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
St Johns Cemetery	3/26 1921
20. UNDERTAKER: Fenner & Sidenfaden	ADDRESS: Boise

Tallman

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED APR 7 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH — Registration District No. 8
Primary Registration District No. 2004
File No. 33273
Registered No. 78

County of Ada
City of Boise (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

U.S.P.H.S. Hospital #52, Boise Barracks

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Freeze William A.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
male	white	Single

6. DATE OF BIRTH
(Month) (Day) 1889 (Year)

7. AGE
32 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Tennessee

10. NAME OF FATHER William Freeze

11. BIRTHPLACE OF FATHER (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (State or Country) Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W.H. Allen, Surgeon in Charge
(Address) Boise Barracks, Boise, Idaho

15. Filed May 1- 1921 — P. H. Peate, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
February (Month) 27 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 12, 1921, to Feb. 27, 1921, that I last saw him alive on Feb. 27, 1921, and that death occurred on the date stated above, at 5A. M.

The CAUSE OF DEATH* was as follows:
Shock and heart failure following operation.

(Duration) No Yrs. no mos. 2 ds.
Contributory (Secondary) Operation
(Duration) No yrs. no mos. 2 ds.

a.j.c. (Signed) W.H.Allen, Surgeon in Charge, M. D.
2-27 1921 (Address) Boise Barracks, Boise Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. 46 days. In the State ..... yrs. ..... mos. 46 days
Where was disease contracted if not at place of death? Seattle, Wash. 1920
Former or usual residence McCoy, Oregon

19. PLACE OF BURIAL OR REMOVAL McCoy - Oregon — DATE OF BURIAL ..... 19.....

20. UNDERTAKER C.W. McBratney — ADDRESS, Boise Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

Registration District No. 8

Primary Registration District No. 2 or 4

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33274

Registered No. 17

1. PLACE OF DEATH

County of Ada

City of Boise (No. U. S. P. H. S. Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED APR 7 1921 BUREAU OF VITAL STATISTICS

NAME James Hollandsworth

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: January (Month) 29 (Day) 1888 (Year)

7. AGE: 33 Yrs. 1 Mos. 4 ds.

IF LESS than 1 day how many ~~hrs.~~ or ~~min.~~?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Civil Service Govt. Emp.

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Nebraska

10. NAME OF FATHER: Robt. Hollandsworth

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Elizabeth Brown

13. BIRTHPLACE OF MOTHER (State or Country): Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm McBratney

(Address) Boise Idaho.

15. Filed Mar 4 1921

R. H. Coutts
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 3 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 1 1921, to March 3, 1921 that I last saw him alive on Mar. 3. 1921 7:30 A.M. and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Tumor (Brain)

(Duration) Yrs. 4 mos. ds.

Contributory (Secondary) Injured

(Duration) yrs. 4 mos. ds.

(Signed) W. H. Allen, Surgeon in Charge M. D.

3-3 1921 (Address) Boise Barracks, Boise, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. 2 days. In the State Unknown yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? Payette, Idaho, 1920

Former or usual residence Payette, Idaho

19. PLACE OF BURIAL OR REMOVAL: Payette, Idaho — DATE OF BURIAL ..... 19.....

20. UNDERTAKER: W. McBratney ADDRESS Boise Idaho.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33275
Registered No. 70

1. PLACE OF DEATH

County of Ada

City of Boise; (No. 3 Miles West of Boise)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED APR 7 1921 BUREAU OF VITAL STATISTICS

Registration District No. 8

Primary Registration District No. 2004

NAME: Elizabeth Lass

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widow

6. DATE OF BIRTH: Dec 28 (Month) (Day) 1 (Year)

7. AGE: 84 Yrs. 2 Mos. 11 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Indiana.

10. NAME OF FATHER: Celose

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Perry Silver

(Address)

15.

Filed ..... 19 .....

Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 4 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 4th 1921 to March 4th 1921 that I last saw her alive on March 4th 1921 and that death occurred on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows: Virginia Peritonitis

(Duration) — Yrs. — mos. — ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. Lundbeck M. D.

March 5 1921 (Address) Boise Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cem — DATE OF BURIAL: March 5 1921

20. UNDERTAKER: Summers & Kirbo — ADDRESS: Boise Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M-1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

RECEIVED APR 7 1921 BUREAU OF VITAL STATISTICS

Registration District No. 8

Primary Registration District No. 2004

(No.) Ada County Hospital (St.)

File No. 33276

Registered No. 276

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Rozillia Kingsford

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married. (Write the word.)

6. DATE OF BIRTH: Mch - 10 - 1881
(Month) (Day) (Year)

7. AGE: 39 Yrs. 11 Mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah.

10. NAME OF FATHER: Dunam Van Leuvan

11. BIRTHPLACE OF FATHER (State or Country): Ohio.

12. MAIDEN NAME OF MOTHER: Annie N. Larsen

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wm. McBratney
(Address) Boise. Idaho.

15. Filed Apr 7 - 1921 R. L. Boothe
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mch - 6 - 1921
(Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 25 1921 to Mar 6 1921 that I last saw her alive on Mar 4 1921 and that death occurred on the date stated above, at 7a M.

The CAUSE OF DEATH* was as follows:
Enteritis & Abortion

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Cerebral Hemorrhage
(Duration) ..... yrs. ..... mos. 7 ds.

(Signed) T. N. Bratton M. D.
3/7 1921 (Address) Boise Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Downey - Idaho. DATE OF BURIAL 19

20. UNDERTAKER: W. McBratney ADDRESS Boise, Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33277

Registered No. 33

1. PLACE OF DEATH

County of Ada

City of near Boise (No. 2 Miles South of Boise St.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
APR 7 1921
BUREAU OF VITAL STATISTICS

Registration District No. 8

Primary Registration District No. 3004

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME George Bower Williams

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: May (Month) 9 (Day) 1920 (Year)

7. AGE: Yrs. 9 Mos. 27 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Boise Idaho

10. NAME OF FATHER: Fred E. Williams

11. BIRTHPLACE OF FATHER (State or Country): Conn

12. MAIDEN NAME OF MOTHER: Mary L. Bower

13. BIRTHPLACE OF MOTHER (State or Country): Conn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Fred E. Williams.

(Address) R.D. #4 Boise.

15. Filed Mar 8 1921 R. E. Utah Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 6th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 3 1921, to March 6th 1921, that I last saw him alive on March 5th 1921, and that death occurred on the date stated above, at 7 A. M.

The CAUSE OF DEATH* was as follows:

Convulsions - Broncho Pneumonia - Whooping cough

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary): Whooping cough

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Olin Bower M. D.

3-7 1921 (Address) Boise Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Mar 8 1921

20. UNDERTAKER: Summers & Reed — ADDRESS: Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH 8

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
APR 7 1921
BUREAU OF VITAL STATISTICS

Registration District No. 7009

File No. 33279

Registered No. 24

1. PLACE OF DEATH

County of Ada

City of Mar B. Soldiers Home St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Isaac Troutman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	White	Widower

6. DATE OF BIRTH

1 (Month) (Day) 85 (Year)

7. AGE

70 Yrs. — Mos. — ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Veteran Spanish

(b) General nature of industry, business or establishment in which employed (or employer) American War

9. BIRTHPLACE (State or Country) Unknown.

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (State or Country) Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E. L. Bennett.

(Address)

15.

Filed Mar 12 1921 R. H. Pratt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

3 (Month) 11 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1919 to Mar 11 1921 that I last saw him alive on Mar 11 1921 and that death occurred on the date stated above, at 4 M.

The CAUSE OF DEATH* was as follows:

Bulbar Paralysis
Glosso-Labio-Laryngeal Paralysis

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Fred A. Fellows M. D.

3/12/1921 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Morris Hill Cem	Mar 13 1921
20. UNDERTAKER	ADDRESS
Summers & Kebs.	Boise Ida.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33280

Registered No. 24

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APR 7 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 8

Primary Registration District No. 2004

County of Ada

City of Boise (or) South Boise (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Rina Bahler

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Dec. (Month) 7 (Day) 1867 (Year)

7. AGE: 53 Yrs. 3 Mos. 11 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Norway

10. NAME OF FATHER: Samuel Olsen

11. BIRTHPLACE OF FATHER (State or Country): Norway

12. MAIDEN NAME OF MOTHER: Mathilde

13. BIRTHPLACE OF MOTHER (State or Country): Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) G. Bahler

(Address) Boise Ida.

15. Filed March 9, 1921 R. N. Reed Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 18 (Day) 1921. (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....

that I last saw her alive on March 18 1921

and that death occurred on the date stated above, at 11:45 M.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

(Duration) 2 Yrs. ..... mos. ..... ds.

Contributory (Secondary) Rheumatism Chronic

(Duration) 15 yrs. ..... mos. ..... ds.

(Signed) R. E. Sheets M. D.

3/17 1921 (Address) Boise Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 3/21/1921

20. UNDERTAKER: Schreiber & Siebenthaler — ADDRESS: Boise

Shanty

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33281
Registered No. 27

RECEIVED
APR 7 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
Registration District No. 8
Primary Registration District No. 2004
County of Ada
City of Boise (No. 1005 Soldiers Home St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Leroy A Clemans

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.)
M	White	widower

6. DATE OF BIRTH: March 17 (Month) (Day) 1847 (Year)

7. AGE: 74 Yrs. — Mos. 7 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Veteran Civil War
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Unknown

10. NAME OF FATHER: Samuel T. Clemans

11. BIRTHPLACE OF FATHER (State or Country): Georgia

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Nellie E Johnson
(Address) 499 E 9th N - Portland Oregon

15. Filed March 24 1921 P. H. Pratt Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar 24 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3/22 1921 to 3/24 1921 that I last saw him alive on 3/23 1921, and that death occurred on the date stated above, at 5 A M.

The CAUSE OF DEATH* was as follows:
Cerebral hemorrhage R. Side

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Arterio - Sclerosis
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Fred. A. Terry Jr. M. D.
3/24 1921 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cem — DATE OF BURIAL: Mar 25 1921

20. UNDERTAKER: Summers & Keb. — ADDRESS: Boise Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 8

Primary Registration District No. 2209

File No. 33282

Registered No. 28

County of Ada

City of (No. 3 Miles South of Boise St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

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APR 7 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME Squire T. Long

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: May (Month) 17 (Day) 1846 (Year)

7. AGE: 74 Yrs. 10 Mos. 10 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: Edward Long

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Percella Truitt

13. BIRTHPLACE OF MOTHER (State or Country): Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Oliver T. Long

(Address) Boise Idaho

15. Filed Mar 28 1921

R. H. Pratt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 27 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 14, 1921, to March 27, 1921, that I last saw him alive on March 27 1921, and that death occurred on the date stated above, at 9 P M.

The CAUSE OF DEATH* was as follows:

Heart failure due to senile degeneration of heart muscles

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Myocarditis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. C. Cannon M. D.

March 27 1921 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Mar 29 1921

20. UNDERTAKER: Summers & Trefz — ADDRESS: Boise Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
APR 7 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

8

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
Registration District No.
Primary Registration District No. 2007
File No. 33283
County of Ada
City of Boise (If outside limits, give township) U.S.P.H.S.Hospital #52 (St.)
Registered No. 29

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George H. Cramer

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH: Nov. (Month) 26 (Day) 1888 (Year)

7. AGE: 32 Yrs. 4 Mos. 3 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kansas

10. NAME OF FATHER: Theodore Willism Cramer

11. BIRTHPLACE OF FATHER (State or Country): Wisconsin

12. MAIDEN NAME OF MOTHER: Ella Dean

13. BIRTHPLACE OF MOTHER (State or Country): Wisconsin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wm.McBratney
(Address) Boise, Idaho

15. Filed 3/30/21 19.....
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 29, 1921 (Day) (Year) 19.....

17. I HEREBY CERTIFY, That I attended deceased from Mar. 14 19 21 to Mar. 29, 1921 19..... that I last saw h.im alive on Mar. 29 1921 19..... and that death occurred on the date stated above, at 1:50 P. M.

The CAUSE OF DEATH* was as follows:
Tuberculosis, pulmonary, chronic

unknown (Duration) Yrs. mos. ds.
Operation for adhesions peritoneum
Contributory (Secondary)
(Duration) 2 yrs. mos. ds.

(Signed) W.H.Allen, Surgeon in Charge (Reserve) M. D.
3/30 19 21 (Address) Boise, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State unknown yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? In France
Former or usual residence Richland, Oregon

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Richland, Oregon	19.....
20. UNDERTAKER: W McBratney	ADDRESS: Boise Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33284

Registered No. 30

RECEIVED
APR 7 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Ada Registration District No. 8

City of Boise (or Township) Primary Registration District No. 2004

(If outside limits, give 1/2 Miles West of Boise St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sarah Albertine Judson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widowed

6. DATE OF BIRTH: Apr 24, 1848
(Month) (Day) (Year)

7. AGE: 72 Yrs. 11 Mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio.

10. NAME OF FATHER: Ebenezer Manning.

11. BIRTHPLACE OF FATHER (State or Country): N. Y.

12. MAIDEN NAME OF MOTHER: Lois Foote

13. BIRTHPLACE OF MOTHER (State or Country): N. Y.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wm McBratney
(Address) Boise Idaho.

15. Filed Mar 30 1921 R. M. Pratt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mch 29 1921
(Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 23 1921, to Mar 29 1921, that I last saw her alive on Mar 28 1921, and that death occurred on the date stated above, at 6.20 A.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

(Duration) ..... Yrs. ..... mos. 6 ds.

Contributory (Secondary) Pulmonary Oedema

(Duration) ..... yrs. ..... mos. 12 hrs. ds.

(Signed) T. N. Brayton M. D.

3/29/21 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery

DATE OF BURIAL: 3/31/21 19

20. UNDERTAKER: W. McBratney

ADDRESS: Boise Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33285
Registered No.

Registration District No.
Primary Registration District No.
(No. St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Adams
City of Indian Valley

2. FULL NAME Alvzie Isabelle Murphy

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: March (Month) 10 (Day) 1871 (Year)

7. AGE: 43 Yrs. Mos. 28 ds.
IF LESS than 1 day: how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Arkansas

10. NAME OF FATHER: Elisha Woods

11. BIRTHPLACE OF FATHER (State or Country): Alabama

12. MAIDEN NAME OF MOTHER: Mary Matilda Baker

13. BIRTHPLACE OF MOTHER (State or Country): Arkansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Thomas Murphy
(Address): Indian Valley

15. Filed 3/31 1921
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 8 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 25 1920, to Jan 8 1921, that I last saw h.er alive on Jan 7 1921, and that death occurred on the date stated above, at 1:50 M.

The CAUSE OF DEATH* was as follows:

~~Pneumonia~~ Septic Ulcer

(Duration) 1 Month Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) W M Brown M. D.

1-10 1921 (Address) Council

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Indian Valley
DATE OF BURIAL: 1-10 1921

20. UNDERTAKER: Anderson
ADDRESS: Cambridge

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33287

Registered No.

1. PLACE OF DEATH

County of Adams

City of (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Frank S. Whitney

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE:

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: October (Month) 1 (Day) 1848 (Year)

7. AGE: 72 Yrs. 3 Mos. 22 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Penobscot Co, Maine

10. NAME OF FATHER: Timothy Whitney

11. BIRTHPLACE OF FATHER (State or Country): unknown

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) R. E. Cameron

(Address) Council Ida.

15. Filed Jan 31 1921

W. M. Brown
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: January (Month) 23 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....

that I last saw h.. alive on ..... 19.....

and that death occurred on the date stated above, at 9 P.M.

The CAUSE OF DEATH* was as follows: Valvular Disease of heart

(Duration) Not known yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) W. M. Brown M. D.

Jan 24 1921 (Address) Council Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence Indian Valley

19. PLACE OF BURIAL OR REMOVAL: Loos

DATE OF BURIAL: Jan 24 1921

20. UNDERTAKER: W. Brown

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33288

Registration District No. 63
Primary Registration District No.
RECEIVED APR 11 1921 BUREAU OF VITAL STATISTICS STATE OF IDAHO

1. PLACE OF DEATH
County of Bear Lake
City of Bloomington (If outside limits, give township) (St.)
If death occurs away from usual residence, give facts called for under special information.

Registered No.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lillian Gertrude Jarvis

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: December (Month) (Day) 1868 (Year)

7. AGE: 53 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Postmistress
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Joshua Jarvis

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Mary Ann Johnson

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A. E. Jarvis
(Address) Bloomington, Idaho

15. Filed April 2 1921 Mrs J. S. Skinner Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 31 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 15 1920 to Mar. 15 1921, that I last saw her alive on 1921, and that death occurred on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:
Carcinoma of Stomach.

(Duration) Yrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) R. L. Sutton M. D.
4/1 1921 (Address) Paris Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Bloomington Idaho
DATE OF BURIAL: Apr 3 1921

20. UNDERTAKER: Bishop Hart
ADDRESS: Bloomington Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33289
Registered No.

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BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Bear Lake
City of Bloomington (If outside limits, give township.) St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME James C. Laborne Thomas

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married
6. DATE OF BIRTH: Mar (Month) 16 (Day) 1843 (Year)
7. AGE: 78 Yrs. Mos. 21 ds.
IF LESS than 1 day how many hrs. or min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer & Stock
(b) General nature of industry, business or establishment in which employed (or employer): grower
9. BIRTHPLACE (State or Country): Kemper Co. Miss
10. NAME OF FATHER: Joseph Marshall Thomas
11. BIRTHPLACE OF FATHER (State or Country): N. Carolina
12. MAIDEN NAME OF MOTHER: Mary Ann Thomas
13. BIRTHPLACE OF MOTHER (State or Country): N. C.
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Perton Thomas
(Address) Bloomington Ida
15. Filed 4-6 1921 Mrs. J. S. Skinner Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar (Month) 31 (Day) 1921 (Year)
17. I HEREBY CERTIFY, That I attended deceased from June 1 1920 to Mar 31 1921 that I last saw him alive on Mar 15 1921 and that death occurred on the date stated above, at M.
The CAUSE OF DEATH* was as follows:
Arteriosclerosis.
(Duration) Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) W. A. Sutton M. D.
4/6/21 (Address) Paris Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Bloomington — DATE OF BURIAL: April 9-21
20. UNDERTAKER: Bishop & Hart — ADDRESS: Bloomington Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33291
Registered No.

1. PLACE OF DEATH
County of Bear Lake
City of Montpelier (No. ..... St.)
Registration District No. 52
Primary Registration District No. 21 32
If death occurs away from usual residence, give facts called for under special information.

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BUREAU OF VITAL STATISTICS

2. FULL NAME Charles Stanley Nate

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write one word.): Single

6. DATE OF BIRTH: 25 of Oct (Month) Oct (Day) 1 [illegible] (Year)

7. AGE: 20 Yrs. 3 Mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Dingle Idaho

10. NAME OF FATHER: Henry William Nate

11. BIRTHPLACE OF FATHER (State or Country): Paris Idaho

12. MAIDEN NAME OF MOTHER: Mary Gongellah Sawyer

13. BIRTHPLACE OF MOTHER (State or Country): Salt Lake City Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Henry William Nate
(Address) Dingle Idaho

15. Filed 4-1-1921 N. A. King Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 2 (Month) 1 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1-28 1921, to 2 1 1921 that I last saw h[illegible] alive on 2-1 1921 and that death occurred on the date stated above, at 2:30 P.M.
The CAUSE OF DEATH* was as follows:
Died suddenly
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Geo. E. Chidley M. D.
2/1 1921 (Address) Montpelier

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Dingle Idaho — DATE OF BURIAL: Feb. 6 1921

20. UNDERTAKER: F. M. Williams — ADDRESS: Montpelier Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33292
Registered No.

RECEIVED
APR 11 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Bear Lake
City of Montpelier (No. St.)
Registration District No. 52
Primary Registration District No. 2136
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Geo Vincent Sparks.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Feb. (Month) 9 (Day) 1905 (Year)

7. AGE: 15 Yrs. 11 Mos. 27 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farm Laborer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Cary, Idaho.

10. NAME OF FATHER: John A. Sparks.

11. BIRTHPLACE OF FATHER (State or Country): Lehi Utah.

12. MAIDEN NAME OF MOTHER: Anna Estenholdt.

13. BIRTHPLACE OF MOTHER (State or Country): Denmark.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Johnny A. Sparks
(Address) Montpelier, Idaho.

15. Filed 4-1-1921
A. H. Kemp
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 5 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 29 1920 to Feb 5 1921 that I last saw h.. alive on Feb 4 1921, and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Nephritis

(Duration) Yrs. 6 mos. ds.

Contributory (Secondary) Uraemia Poisoning

(Duration) yrs. mos. 4 ds.

(Signed) L. P. Gaeckler M. D.

2/5 1921 (Address) Montpelier Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Dingle, Idaho. DATE OF BURIAL: Feb 6. 1921

20. UNDERTAKER: F. M. Williams ADDRESS: Montpelier Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

RECEIVED
APR 11 1921
BUREAU OF VITAL STATISTICS

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 67
Primary Registration District No. 2136
File No. 33293
Registered No.
County of Bear Lake
City of Montpelier (If not in incorporated limits, give township.) St.)
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Sidney Warren Kent

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Nov (Month) 22 (Day) 1852 (Year)

7. AGE: 68 yrs. 1 mos. 24 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Sidney B. Kent

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Mary M. Daly

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Riley Kent
(Address) Logan, Utah

15.
Filed 4-1- 1921 H. K. Kinney Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan (Month) 15 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 8th 1921, to Jan 15 1921
that I last saw h... alive on Jan. 15 1921
and that death occurred on the date stated above, at 9 A.M.
The CAUSE OF DEATH* was as follows:
Effects of injury

(Duration) — yrs. 6 mos. — ds.
Contributory (Secondary)
(Duration) — yrs. — mos. — ds.
(Signed) E. F. Sawyer M. D.
Jan 1921 (Address) Montpelier Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Wardboro — DATE OF BURIAL: Jan. 18 1921

20. UNDERTAKER: F. M. Williams — ADDRESS: Montpelier Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

GYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

RECEIVED APR 11 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 052
County of Bear Lake Primary Registration District No. 2134
City of Montpelier (No. ....., St.)
File No. 33295
Registered No. .....
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Dean F. Loertscher

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH: 12 (Month) 24 (Day) 1920 (Year)

7. AGE: — yrs. — mos. 17 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Montpelier Ida

10. NAME OF FATHER: George Loertscher

11. BIRTHPLACE OF FATHER (State or Country): Switzerland

12. MAIDEN NAME OF MOTHER: Elizabeth Zumwalt

13. BIRTHPLACE OF MOTHER (State or Country): Switzerland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) George Loertscher Jr.
(Address) Montpelier Ida

15. Filed 4-1-1921 H. N. Kemp Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan. (Month) 10 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 7 1921, to Jan. 10 1921, that I last saw him alive on Jan. 10 1921, and that death occurred on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... yrs. ..... mos. 4 ds.

Contributory .....
(Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Elmer C. Hinckley M. D.

1/10 1921 (Address) Montpelier

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Montpelier Idaho	Jan 11 1921

20. UNDERTAKER: F. M. Williams ADDRESS: Montpelier

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

GYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 3 20M.1-16-17

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH: Registration District No. 2 [illegible] 2135

County of Bear Lake. Primary Registration District No. [illegible]

File No. 33301

City of Montpelier (No. [illegible], St.)

Registered No. [illegible]

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Isaac Van Tuyle.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Sept (Month) 11 (Day) 1851 (Year)

7. AGE: 69 yrs. 3 mos. 30 ds.

IF LESS than 1 day how many .....hrs. or .....mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer): Retired 1 year

9. BIRTHPLACE (State or Country): England.

10. NAME OF FATHER: Isaac Tuyle

11. BIRTHPLACE OF FATHER (State or Country): England.

12. MAIDEN NAME OF MOTHER: Sarah Evans

13. BIRTHPLACE OF MOTHER (State or Country): England.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Isaac V. Tuyle
(Address) Montpelier Ida.

15.
Filed 4 - 1 - 1917
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan. (Month) 10 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 17 1920, to Jan 5th 1921, that I last saw h[illegible] alive on Jan 10 1921, and that death occurred on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) — yrs. — mos. 26 ds.

Contributory (Secondary) —

(Duration) — yrs. — mos. — ds.

(Signed) E. J. Lewyn M. D.

19 (Address) Montpelier Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Ovid, Idaho. DATE OF BURIAL: Jan 13 1921

20. UNDERTAKER: F. M. Williams ADDRESS: Montpelier Idaho

SYMS - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Filed 1 - 1 - 1917
Local Registrar F. M. Williams Montpelier Idaho

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33303

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Bear Lake

City of .....

Registration District No. 53

Primary Registration District No. 2132

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Ann Hoge

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Sept. (Month) 12 (Day) 1888 (Year)

7. AGE: 32 Yrs. 5 Mos. 8 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Jacob A. Wahlen

11. BIRTHPLACE OF FATHER (State or Country): Switzerland

12. MAIDEN NAME OF MOTHER: Nancy Thomas

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) Paris

15. Filed 2/10/21. 191.....

Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 20 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 4 1921 to Feb 20 1921, that I last saw h.er alive on Feb 20 1921 and that death occured on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Premature Child birth

Erysipelas Paralysis Intestinal & Urinary Bladder Hypostatic pneumonia

(Duration) ..... Yrs. ..... mos. 16 ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) C. O. Moore M. D.

Mar 8 1921 (Address) Paris Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Paris Ida.

DATE OF BURIAL: Feb. 23 1921

20. UNDERTAKER .....

ADDRESS .....

IMPORTANT.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33304
Registered No. .....

1. PLACE OF DEATH.
County of Bear Lake
City of .....
Registration District No. .....
Primary Registration District No. .....
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Anona Hoge

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Feb (Month) 5 (Day) 1921 (Year)

7. AGE ..... Yrs. ..... Mos. 1 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER William B. Hoge

11. BIRTHPLACE OF FATHER (State or Country) Idaho

12. MAIDEN NAME OF MOTHER Mary Ann Wahlen

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) W. Brook Hoge
(Address) Paris Idaho

15. Filed 2/10/21 1921 ..... Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24854

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Feb (Month) 5 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 5 1921 to Feb 5 1921, that I last saw h[illegible] alive on Feb 5 1921, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Premature

.....(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
.....(Duration ..... yrs. ..... mos. ..... ds.

(Signed) C. O. Moser M. D.
Mar 8 1921 (Address) Paris Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Paris Ida. DATE OF BURIAL: Feb 7 1921

20. UNDERTAKER ..... ADDRESS .....

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33305
Registered No.

1. PLACE OF DEATH
County of Bear Lake
City of Liberty
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 53
Primary Registration District No. 2132.
(No. ..... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Myrle Matthews

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Oct. 4 1917 (Month) (Day) (Year)

7. AGE: 3 Yrs. 4 Mos. 17 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Child.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Bloomington

10. NAME OF FATHER: Alonzo H Matthews

11. BIRTHPLACE OF FATHER (State or Country): Liberty

12. MAIDEN NAME OF MOTHER: Charlotte Hulme

13. BIRTHPLACE OF MOTHER (State or Country): Bloomington

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A H Matthews
(Address) Liberty Ida

15. Filed 3/21/21 19 ..... P J Sutton Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb 19 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 1, 1920 19 ..... to Feb 19 1921
that I last saw her alive on Feb 10 1921
and that death occurred on the date stated above, at 6 A.M.
The CAUSE OF DEATH* was as follows:
Diabetis Mellitus

..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) P J Sutton M. D.
3/20/21. (Address) Paris Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Liberty
DATE OF BURIAL: 2/22 19 21.

20. UNDERTAKER
ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bear Lake.

City of Geo Town.

If death occurs away from usual residence, give facts called for under special information.

Registration District No.....

Primary Registration District No.....

(No....., ...St.)

File No. 33306

Registered No.....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Nels C. Nelson Sr.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Jan (Month) 26. (Day) 1826 (Year)

7. AGE: .....Yrs.....Mos.....ds.

IF LESS than 1 day how many.....hrs. or.....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer.

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Denmark.

10. NAME OF FATHER: Serren Nelson.

11. BIRTHPLACE OF FATHER (State or Country): Denmark.

12. MAIDEN NAME OF MOTHER: Anna C.

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15. Filed 2/10/21. 19..... P. Dunton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 4 (Day) 1921. (Year)

17. I HEREBY CERTIFY, That I attended deceased from .....19....., to .....19.....,

that I last saw h..... alive on .....19.....,

and that death occurred on the date stated above, at 4 15 M.

The CAUSE OF DEATH* was as follows:

Old Age.

.....(Duration) .....Yrs.....mos.....ds.

Contributory (Secondary) .....

.....(Duration) .....yrs.....mos.....ds.

(Signed) X Nels C. Nelson Jr. M. D.

Feb 6 1921 (Address) Burley Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Blomington. DATE OF BURIAL: Feb. 6 1921.

20. UNDERTAKER: Bishop & Hart. ADDRESS: Blomington

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bear Lake — Registration District No. 53

City of Paris — Primary Registration District No. 2132

(No. ..... St.)

File No. 33307

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Thomas Joyns Smedley

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Male	White	Married (Write the word.)

6. DATE OF BIRTH: Aug (Month) 16" (Day) 1837 (Year)

7. AGE: 83 Yrs. 6 mos 7 ds. — IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Brickmaker
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: Thomas

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Joyns

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H. C. Smedley
(Address) Paris, Idaho

15. Filed Feb 24, 1921 — O. J. Sutton, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 23" (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ~~Feb. 20~~, 1921, to Feb. 22nd 1921, that I last saw him alive on the 22nd Feb 1921, and that death occurred on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) O. J. Sutton M. D.

Feb 24 1921 (Address) Paris

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Paris Ida. — DATE OF BURIAL: 3/26 1921

20. UNDERTAKER — ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2132
Primary Registration District No. 53
File No. 33308
Registered No.

1. PLACE OF DEATH
County of Bear Lake
City of St Charles
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Maxwell D. Pugmire
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Boy
4. COLOR OR RACE: White American
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: May (Month) 13 (Day) 1916 (Year)

7. AGE: 4 Yrs. 8 Mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho. Bear Lake Co

10. NAME OF FATHER: Henry Matthew Pugmire

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Grace Gardner

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H. Matthew Pugmire
(Address) St Charles Ida

15. Filed 3/10/21 19.... Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 8 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 1 1921 to Feb 8 1921; that I last saw h.... alive on Feb 7 1921; and that death occurred on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia.

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) J. Sutton M. D.

3/9/21 (Address) Paris Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: St Charles Ida — DATE OF BURIAL: Feb 11 1921

20. UNDERTAKER: Bishop Hunt — ADDRESS: St Charles

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

MAR 10 1921

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 46

County of Benewah

RECEIVED
APR 11 1921
BUREAU OF VITAL STATISTICS

Primary Registration District No. 2123

File No. 33202

City of ..... (No. ..... St.)

Registered No. 3[illegible]02

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Henrick Rudolf Brede

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): widower

6. DATE OF BIRTH: Sept (Month) 19 (Day) 1857 (Year)

7. AGE: 63 Yrs. 4 Mos. 20 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Sunkelsdorf Germany

10. NAME OF FATHER: Rudolf Brede

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Gosch

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Gothard Brede
(Address) Plummer Idaho

15. Filed Mch 25 1921 — H. L. Jaynes, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 9 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2-5 1921, to 2-9 1921 that I last saw him alive on 2-8 1921 and that death occurred on the date stated above, at 1 A.M.

The ~~CAUSE~~ OF DEATH* was as follows: Tuberculosis Pulmonary

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Malnutrition

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. A. Mozier M. D.

19 ..... (Address) Tekoa Wn.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Golden Rod - Tekoa — DATE OF BURIAL: 2-11 1921

20. UNDERTAKER: C. L. Sohlberg — ADDRESS: Tekoa

WN

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-1 RECEIVED APR 1 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 46
Primary Registration District No. 2123
File No. 33316
Registered No. 2

1. PLACE OF DEATH.
County of Benewah
City of ..... (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Charles Coorse

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married
6. DATE OF BIRTH. 7 (Month) 10 (Day) 1849 (Year)
7. AGE: 71 Yrs. 8 Mos. 15 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): England
10. NAME OF FATHER: John Coorse
11. BIRTHPLACE OF FATHER (State or Country): England
12. MAIDEN NAME OF MOTHER: —
13. BIRTHPLACE OF MOTHER (State or Country): England
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mary Coorse
(Address) Tekoa Wash
15. Filed Mch 31 1921 H. L. Jensen Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 3 (Month) 26 (Day) 1921 (Year)
17. I HEREBY CERTIFY, That I attended deceased from 3-25 1921, to 3-26 1921, that I last saw him alive on 3-26 1921, and that death occured on the date stated above, at 4.30 P.M.
The CAUSE OF DEATH* was as follows:
Pneumonia
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) E. A. Smith M. D.
19..... (Address) Latah Wash.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs..5..mos.....days. In the State.....yrs..5...mos.....days
Where was disease contracted if not at place of death?
Former or usual residence: Tekoa Wash

19. PLACE OF BURIAL OR REMOVAL: Oakesdale Wash — DATE OF BURIAL: 3-28 1921
20. UNDERTAKER: C. L. Schubert — ADDRESS: Tekoa W

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SORS. 24654

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 1 33311

Registered No. 55

1. PLACE OF DEATH

County of Bonneville

City of Vennel

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
APR 11 1921
BUREAU OF VITAL STATISTICS

Registration District No. 31

Primary Registration District No. .....

2. FULL NAME Cornelius Michael

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M.	Indian	Infant

6. DATE OF BIRTH: Oct 5 1920 (Month) (Day) (Year)

7. AGE: ..... Yrs. 5 Mos. 24 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Vennel Ida

10. NAME OF FATHER Mich Michael

11. BIRTHPLACE OF FATHER (State or Country) Idaho

12. MAIDEN NAME OF MOTHER Mary Antelope

13. BIRTHPLACE OF MOTHER (State or Country) Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mich Michael

(Address) Vennel

15. Filed March 30 1921 J. E. Bihran Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 29 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....,

that I last saw h..... alive on ..... 19.....,

and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Pneumonia

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

..... 19..... (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Vennel Ida	March 30 1921
20. UNDERTAKER	**ADDRESS**
J. Falcon	Vennel

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 13312
Registered No. 34

1. PLACE OF DEATH
County of Bonner
City of Dennett (No. , St.)
Registration District No. 31
Primary Registration District No.
If death occurs away from usual residence, give facts called for under special information.

APR 11 BUREAU OF STATISTICS

2. FULL NAME Catherine Daniel
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.
4. COLOR OR RACE: Indian
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Infant

6. DATE OF BIRTH: Sept 3 (Month) (Day) 1920 (Year)

7. AGE: Yrs. 6 Mos. 13 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Bernard Daniel

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Culpy

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Daniel Quinnamossa
(Address) Dennett, Ida

15. Filed March 17 1921 J. L. Bilman Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 16 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Was always sickly, but received no treatment from Doctor
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) ..... M. D.
..... 19..... (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Dennett Ida
DATE OF BURIAL: March 17 1921

20. UNDERTAKER: J. Falcon
ADDRESS: Dennett

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33313
Registered No.

RECEIVED
APR 11 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH. Registration District No.
County of Benewah Primary Registration District No.
City of DeLine (or) (Ward of ..... St.)
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Liza Stewart

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	white.	Widowed

6. DATE OF BIRTH: April 25 (Month) (Day) 1842 (Year)

7. AGE: 78 yrs. 10 mos. 13 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): N. Canada

10. NAME OF FATHER: Fintin Bergin

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Mary Wheelan

13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. A. Nelson
(Address) Colfax Wash

15.
Filed ..... 191 .....
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March 14 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 3 1921, to Mch 14 1921 that I last saw h[illegible] alive on Mch 10 1921 and that death occurred on the date stated above, at 8 P.M.

The CAUSE OF DEATH*, was as follows:
"Uremia"

(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary): Fracture of femur
(Duration) ..... yrs. 2 mos. 10 ds.
(Signed) J. A. Nelson M. D.
3/15 1921 (Address) Tekoa, Wash.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Spokane. Wash.	March 16 1921

20. UNDERTAKER	ADDRESS
L. L. Bruning & S	Colfax. Wash

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
APR 11 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 32

Primary Registration District No. 2029

File No. 33314

Registered No. 95

County of Benewah

City of St Maries (St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Thomas J Wright

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Sept 1 (Month) (Day) 1881 (Year)

7. AGE: 39 Yrs. 6 Mos. 21 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wis.

10. NAME OF FATHER: Joseph Wright

11. BIRTHPLACE OF FATHER (State or Country): Ill.

12. MAIDEN NAME OF MOTHER: Melissie Craig

13. BIRTHPLACE OF MOTHER (State or Country): Ken.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant): Joseph Wright

(Address): Hamilton Mont.

15. Filed March 22 1921

H E Hurst
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 22 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ~ 19..., to ~ 19...,

that I last saw h... alive on ~ 19...,

and that death occurred on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:

Struck on head by falling tree and killed instantly.

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) H. L. Alcorn Coroner
Benewah Co. Ida.

3/22 1921 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Woodlawn

DATE OF BURIAL: 3/24 1921

20. UNDERTAKER: H E Hurst Co

ADDRESS: St Maries

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
APR 11 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
Registration District No. 32
Primary Registration District No. 2049
File No. 33315
Registered No. 12
County of Bonneville
City of Emida (No. St.) Ida
If death occurs away from usual residence, give facts called for under special information.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Albert Oxylen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: June 22 (Month) (Day) 1864 (Year)

7. AGE: 26 Yrs. 5 Mos. 6 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Sweeden Dalarna Co

10. NAME OF FATHER: John Oxylen

11. BIRTHPLACE OF FATHER (State or Country): Sweeden Dalarna Co

12. MAIDEN NAME OF MOTHER: Amalgia magnuson

13. BIRTHPLACE OF MOTHER (State or Country): Sweden Dalarna Co

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Oxylen
(Address) Emida Ida

15. Filed March 21 1921 W E Hunt Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 18 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....
and that death occurred on the date stated above, at 6 P.M.
The CAUSE OF DEATH* was as follows:
Tuberculosis
(General)
afflicted since child hood
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) John O Oxylen M D
19..... (Address) Emida Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Emida cemetary	3/22 1921
20. UNDERTAKER	ADDRESS
Mitchell & Meagu	St. Maries

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

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MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33317

Registered No. 10

1. PLACE OF DEATH

County of Benewah

City of St Maries (If not in incorporated limits, so state.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED APR 11 1921 BUREAU OF VITAL STATISTICS

Registration District No. 32

Primary Registration District No. 2049

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Edward F. Dubray

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Dec. (Month) 24 (Day) 1876 (Year)

7. AGE: 44 Yrs. 3 Mos. 11 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER: Charles Dubray

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Rose Gorhgone

13. BIRTHPLACE OF MOTHER (State or Country): New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs E. F. Dubray

(Address) Coeur d'Alene Idaho

15. Filed March 14 1921

H E Brandt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 13 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 4 1921, to March 13 1921, that I last saw him alive on March 12 1921, and that death occurred on the date stated above, at 3:50 A.M.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

(Duration) Yrs. 1 mos. ds.

Contributory (Secondary): Peritonitis resulting from perforation.

(Duration) yrs. mos. 4 ds.

(Signed) C. A. Robins M. D.

3/15 1921 (Address) St. Maries, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. 10 days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? Unknown

Former or usual residence Calder, Idaho

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL ..... 19.....

20. UNDERTAKER: H E Brandt Co | ADDRESS: St Maries

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

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FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 32

Primary Registration District No. 2049

County of Bonneville

City of St Maries (No. ..... St.)

File No. 33318

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mattie L Brown

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: married (Write the word.)

6. DATE OF BIRTH: July (Month) 3rd (Day) 1878 (Year)

7. AGE: 42 Yrs. 7 Mos. 29 ds. 1 hr. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: housewife

(b) General nature of industry, business or establishment in which employed (or employer): /

9. BIRTHPLACE (State or Country): Windsor Co, Woodstock, Vermont

10. NAME OF FATHER: Mr. Sterns Clough

11. BIRTHPLACE OF FATHER (State or Country): Putney, Vermont

12. MAIDEN NAME OF MOTHER: Loraine L. Spaulding.

13. BIRTHPLACE OF MOTHER (State or Country): Chester Vermont

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) F. H. Brown

(Address) St Maries Ida.

15. Filed March 14 1921 — H E Hunt, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 13 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 3 1921, to Mar 13 1921, that I last saw her alive on Mar 12 1921, and that death occurred on the date stated above, at 1 A M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ..... Yrs. ..... mos. 10 ds.

Contributory (Secondary) Bronchial Heart trouble

(Duration) 2 yrs. ..... mos. ..... ds.

(Signed) C B Smith M. D.

Mar 15 1921 (Address) St Maries Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Woodlawn — DATE OF BURIAL: Mar 15 1921

20. UNDERTAKER: H E Hunt Co — ADDRESS: St Maries

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

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FORM V. S. No. 5-25 M. 1-19.

Corrected Copy

CERTIFICATE OF DEATH

RECEIVED NOV 7 1925 BUREAU OF VITAL STATISTICS

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 2194
File No. 83321
Registered No.

1. PLACE OF DEATH
County of Bingham
City of Woodville (St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Victor Tollefson
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH: November (Month) 19 (Day) 1899 (Year)

7. AGE: 21 Yrs. 1 Mos. 29 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Electrician
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Hanse Tollefson

11. BIRTHPLACE OF FATHER (State or Country): Norway

12. MAIDEN NAME OF MOTHER: Anna Holland

13. BIRTHPLACE OF MOTHER (State or Country): Nebraska

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) X Emma Tollefson (Mother)
(Address) Rexburg, Idaho.

15. Filed Nov 4 1925 Mrs Charles E Pickett Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. (Month) 18 (Day) 1921 (Year)

17. I HEREBY CERTIFY, ~~That I attended deceased from~~ ~~19~~ ..... to ~~19~~ ..... that I last saw h~~im~~ ~~alive~~ on ~~19~~ ..... and that death occurred on the date stated above, at 6:30 P.M.
The CAUSE OF DEATH* was as follows:

Accidently electrocuted

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E. Egli Coroner M. D.
1-18 1921 (Address) Blackfoot, Idaho Bingham Co

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Shelley, Idaho	Jan. 20 1921
20. UNDERTAKER	**ADDRESS**
C.C. Hayes.	Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 2194
File No. 33322
Registered No. 34

1. PLACE OF DEATH
County of Bingham
City of Goshen (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Orlan Munson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Aug. (Month) 25 (Day) 1921 (Year)

7. AGE: 2 Yrs. 5 Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Baby. None
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Goshen Ida.

10. NAME OF FATHER: Julius Neils Munson

11. BIRTHPLACE OF FATHER (State or Country): Nyrum Utah

12. MAIDEN NAME OF MOTHER: Julia Jorgenson

13. BIRTHPLACE OF MOTHER (State or Country): Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. A. Munson
(Address) Shelley Ida.

15. Filed March 26 1921 Mrs Hales E. Peterson Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. (Month) 18 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 10 1921, to Jan 18 1921, that I last saw h[im] alive on Jan 18 1921, and that death occurred on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:

Acute Pneumonia

(Duration) ..... Yrs. ..... mos. 9 ds.

Contributory (Secondary) Bronchial Pneumonia

(Duration) ..... yrs. ..... mos. 4 ds.

(Signed) J. P. Egbert M. D.

Jan. 19 1921 (Address) Shelley Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Goshen — DATE OF BURIAL: Jan 1921

20. UNDERTAKER: Peffer Mortuary — ADDRESS: Idaho Falls.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers,* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL *septicemia,*" "PUERPERAL *peritonitis,*" etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 2194
File No. 33323
Registered No. 23

1. PLACE OF DEATH
County of Bingham
City of Blackfoot
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Claris Wright

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: January 27 1921 (Month) (Day) (Year)

7. AGE: ✓ Yrs. ✓ Mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Blackfoot, Ida.

10. NAME OF FATHER: Artie Wright

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Lillian Wright

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Artie Wright
(Address) Blackfoot Ida

15. Filed Feb 9 1921 Mrs Hulda E. Tatum Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 8 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 6 1921, to Jan 7 1921, that I last saw him alive on Jan 7 1921, and that death occurred on the date stated above, at 4 A M.

The CAUSE OF DEATH* was as follows:
Broncho pneumonia

(Duration) ..... Yrs. ..... mos. 3 ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. O. Hamptons M. D.
2/9 1921 (Address) Blackfoot Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Grove City Cemetery | DATE OF BURIAL: Feb 9 1921

20. UNDERTAKER: E. L. Eggli | ADDRESS: Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. **PLACE OF DEATH**

Registration District No. 121

County of Bingham

Primary Registration District No. 2195

City of Blackfoot

(No. Duell Road West Blackfoot)

File No. 33326

Registered No. 22

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Martha Weeks

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widow

6. DATE OF BIRTH: July (Month) 5 (Day) 1840 (Year)

7. AGE: 80 Yrs. 7 Mos. 2 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Virginia

10. NAME OF FATHER: Stidham

11. BIRTHPLACE OF FATHER (State or Country): Virginia

12. MAIDEN NAME OF MOTHER: Dont Know

13. BIRTHPLACE OF MOTHER (State or Country): Dont Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Needer

(Address) Blackfoot

15. Filed Feb 8 1921 Mrs Nadie E. Patrie, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 7 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 5 1921, to Feb 7 1921, that I last saw h[illegible] alive on Feb 7 1921, and that death occurred on the date stated above, at 12:30 A.M.

The CAUSE OF DEATH* was as follows:

Pneumonia - lobar

(Duration) ..... Yrs. ..... mos. 3 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F. W. Mitchell M. D.

2/7 1921 (Address) Blackfoot Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Sunset City cemetery | DATE OF BURIAL ..... 19.....

20. UNDERTAKER: E. J. Funk | ADDRESS: Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 2194
(No. N E Blackfoot St.)
File No. 33227
Registered No. 247

1. PLACE OF DEATH
County of Bingham
City of Blackfoot
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lorenzo Lachoneus Miles
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: December 3 1867 (Month) (Day) (Year)

7. AGE: 53 Yrs. 2 Mos. 9 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Springville Utah

10. NAME OF FATHER: Wm M. Miles

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Martha J Curtis

13. BIRTHPLACE OF MOTHER (State or Country): Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Mrs. Maggie Miles
(Address): N E Blackfoot

15. Filed Feb. 14 1921 Mrs Nalie E Foster Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: February 12 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 1 1920 to Febr. 12 1921 that I last saw h.. alive on Jany 18 1921 and that death occurred on the date stated above, at 6A M.

The CAUSE OF DEATH* was as follows:
Diabetis Mecelitus

(Duration) 5 Yrs. — mos. — ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Joseph B Davis M. D.
2-12 1921. (Address) Blackfoot Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Moreland Ida. DATE OF BURIAL: Feb 15 1921

20. UNDERTAKER: Ed L Eyli. ADDRESS: Blackfoot

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bingham

City of Blackfoot

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 121

Primary Registration District No. 1007

(No. 809 S. University St.)

File No. 33328

Registered No. 25

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Bernice Vance

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Dec. (Month) 19 (Day) 1920 (Year)

7. AGE: 1 Yrs. 2 Mos. 3 ds. IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Blackfoot Idaho

10. NAME OF FATHER: Hyrum S. Vance

11. BIRTHPLACE OF FATHER (State or Country): Fairview Utah

12. MAIDEN NAME OF MOTHER: Serna Broadbent

13. BIRTHPLACE OF MOTHER (State or Country): Santaquin Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) H. S. Vance

(Address) Blackfoot Ida

15. Filed Feb 22 1921 Mrs. Isabel E. Yates Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 22 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 15 1921 to Feb 22 1921 that I last saw h.er alive on Feb 21 1921 and that death occurred on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) — Yrs. — mos. 10 ds.

Contributory (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) C. W. Beck M. D.

2/22/1921 (Address) Blackfoot, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Grove City Cemetery | DATE OF BURIAL: Mar 1921

20. UNDERTAKER: Ed L. Eyl | ADDRESS: Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 1907
(No. 508 N. University St.)

File No. 33329
Registered No. 26

1. PLACE OF DEATH
County of Bingham
City of Blackfoot
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Dorothy Jeanette Pizer

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Female	White	Single (Write the word.)

6. DATE OF BIRTH: Feb (Month) 23 (Day) 1921 (Year)

7. AGE: ....Yrs. ....Mos. 1 ds. 1
IF LESS than 1 day how many....hrs. or....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Blackfoot Ida.

10. NAME OF FATHER: Guy Pizer

11. BIRTHPLACE OF FATHER (State or Country): Pa.

12. MAIDEN NAME OF MOTHER: Ruth Orvilla Eskelsen

13. BIRTHPLACE OF MOTHER (State or Country): Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Guy Pizer
(Address) Blackfoot

15. Filed Feb 24 1921 Mrs Nalcie E. Patrick Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 23 (Day) 19 21 (Year)

17. I HEREBY CERTIFY, That I attended deceased ~~from~~ on 2/13 19 21, to ....19....
that I last saw h.... alive on 2/23 19 21
and that death occurred on the date stated above, at 9:30 P. M.
The CAUSE OF DEATH* was as follows:
Premature ? mo.

....(Duration) ....Yrs. ....mos. ....ds.
Contributory (Secondary)
....(Duration) ....yrs. ....mos. ....ds.

(Signed) J. O. Hamplin M. D.
2/24 19 21 (Address) Blackfoot Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Grove City Cem. DATE OF BURIAL: Feb 25 1921

20. UNDERTAKER: Ed L. Egli ADDRESS: Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

Permit No 27

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 121

Primary Registration District No. 2194

(No. ....., ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33330

Registered No. 27

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Bingham

City of Blackfoot Ida

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lupita Rico

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Brown

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1880 (Year)

7. AGE: 41 Yrs. — Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Mexico

10. NAME OF FATHER: Dont Know

11. BIRTHPLACE OF FATHER (State or Country): Dont Know

12. MAIDEN NAME OF MOTHER: Dont Know

13. BIRTHPLACE OF MOTHER (State or Country): Dont Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Records Idaho Insane Asylum per J. Brown

(Address) P.O. Box 338 Blackfoot, Idaho

15. Filed Feb 25 1921 Mrs Nadine E. Palmer Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

February (Month) 23 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 20 1920, to Feb. 23 21 1920, that I last saw h[illegible] alive on 2/23/21" 191, and that death occured on the date stated above, at 10 A. M.

The CAUSE OF DEATH* was as follows:

Coma due to Uraemic Poisoning

(Duration) Yrs. 9 mos. 3 ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.)

(Signed) [signature] M. D.

2/24 1921 (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. 9 mos. 3 days. In the State. — yrs. — mos. — days

Where was disease contracted if not at place of death? Dont Know

Former or usual residence Twin Falls Idaho

19. PLACE OF BURIAL OR REMOVAL: Asylum Cemetery — DATE OF BURIAL: 2-24 1921

20. UNDERTAKER: G. J. Wright — ADDRESS: Blackfoot

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33331
Registered No. 25

Registration District No. 121
Primary Registration District No. 2141
(No. Idaho Insane Asylum St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Bingham
City of Blackfoot

2. FULL NAME Opal Evans

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. (Month) (Day) 1893 (Year)

7. AGE: 28 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Near Parma, Idaho

10. NAME OF FATHER John A. Evans

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) the asylum records Martha E. Hyde
(Address) Blackfoot, Idaho

15. Filed Feb 25 1921 Mrs Nalvie E. Patterson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
February (Month) 24 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 12 1919, to Feb. 24 1921, that I last saw h[illegible] alive on Feb. 24 1921, and that death occured on the date stated above, at 3:00 P.M.

The CAUSE OF DEATH* was as follows:
Status Epilepticus - a confirmed epileptic Demont - Epileptic for 17 years. Had epileptic seizures continuously for 3 days
(Duration) 3 Yrs. ..... mos. ..... ds.
Contributory (Secondary) Epilepsy
(Duration) 17 yrs. ..... mos. ..... ds.
(Signed) [illegible] M.D.
2-28 1921 (Address) Blackfoot, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 6 yrs. 7 mos. 17 days. In the State 28 yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? Not known
Former or usual residence Near Parma, Idaho

19. PLACE OF BURIAL OR REMOVAL: Idaho Cemetery — DATE OF BURIAL: 191

20. UNDERTAKER: E. Peck — ADDRESS: Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STUB - YORK CO., PTRS. & STNRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 2194
File No. 33332
Registered No. 29

1. PLACE OF DEATH.
County of Bingham
City of Blackfoot. (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary Conrad

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. July (Month) 6th (Day) 1920. (Year)

7. AGE: Yrs. 1 Mos. 18 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Frank Conrad.

11. BIRTHPLACE OF FATHER (State or Country) Austria Hungary

12. MAIDEN NAME OF MOTHER Jeannette Dull

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) .....
(Address) Thomas H. Ironwood

15. Filed Feb. 26 1921 Orro Nelson Jr. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Feb (Month) 26 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 25 1921, to Feb 26 1921, that I last saw her alive on Feb 26 1921, and that death occured on the date stated above, at 6 9 M.

The CAUSE OF DEATH* was as follows:
Broncho Pneumonia
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Acute cold
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. J. Simmons M. D.
Feb 26 1921 (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Firm Cemetery — DATE OF BURIAL: 2-27 1921

20. UNDERTAKER: E. J. Funk — ADDRESS: Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRNE - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 2174
File No. 33333
Registered No. 95

1. PLACE OF DEATH
County of Bingham
City of Blackfoot
(No. Rick Lane St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Maurita Pearl Merkley
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Dec. (Month) 26 (Day) 1920 (Year)

7. AGE: Yrs. 2 Mos. 1 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Blackfoot Idaho

10. NAME OF FATHER: Marion Merkley

11. BIRTHPLACE OF FATHER (State or Country): St Charles Idaho

12. MAIDEN NAME OF MOTHER: Pearl Barker

13. BIRTHPLACE OF MOTHER (State or Country): St Charles Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Marion Merkley
(Address) Blackfoot Idaho

15. Filed Feb-28 1921 Myrtle Thatcher Clerk
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 27 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 25 1921, to Feb 27 1921, that I last saw her alive on Feb 27 1921, and that death occurred on the date stated above, at 9a. M.
The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia
(Duration) ..... Yrs. ..... mos. 4 ds.
Contributory (Secondary) W hooping cough
(Duration) ..... yrs. ..... mos. 20 ds.

(Signed) W W Beck M. D.
2/28 1921 (Address) Blackfoot, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: St Charles Idaho
DATE OF BURIAL: On arrival 19

20. UNDERTAKER: Egli Egli
ADDRESS: Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 2194
File No. 33334
Registered No. 31

1. PLACE OF DEATH

County of Bingham
City of Blackfoot
(No. 2 mile East Blackfoot)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Thomas Huber Hodson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widower

6. DATE OF BIRTH: Nov (Month) 10 (Day) 1846 (Year)

7. AGE: 74 Yrs. 3 Mos. 18 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mo

10. NAME OF FATHER: John Hodson

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Maria Gillar

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. V. Hodson
(Address) Blackfoot Idaho

15. Filed Mar 2 1921 Mrs Helen E. Petree
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: February (Month) 28 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 1920 to Feb 28th 1921 that I last saw h~~im~~ alive on October 15 1920 and that death occurred on the date stated above, at 11:45 A.M.

The CAUSE OF DEATH* was as follows:
Cancer of face
Epithelioma

(Duration) ..... Yrs. 11 mos. — ds.

Contributory (Secondary)
(Duration) — yrs. — mos. ..... ds.

(Signed) Joseph B Davis M. D.
3-1 1921 (Address) Blackfoot Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Ferncliff cemetery | DATE OF BURIAL ..... 19.....

20. UNDERTAKER: Eq Funk | ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 116
Primary Registration District No. 2195
File No. 33335
Registered No. 47

1. PLACE OF DEATH.
County of Bingham
City of Aberdeen
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary Effie Bowman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Nov (Month) 28 (Day) 1919 (Year)

7. AGE: ....Yrs. 2 Mos. 9 ds.
IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: \
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: William J Bowman

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Mary Amanda Taggart

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) W J Bowman
(Address) Aberdeen Ida

15. Filed 2-6 191 21 M C Markham Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 6 (Day) 21 191 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191....., to ..... 191.....,
that I last saw h.....alive on ..... 191.....,
and that death occured on the date stated above, at 3 P.M.
The CAUSE OF DEATH* was as follows:
Probably pneumonia
no physician in attendance

.....(Duration) .....Yrs. .....mos. .....ds.
Contributory (Secondary)
.....(Duration .....yrs. .....mos. .....ds.
(Signed) M. C. Markham M. D.
2/7 192 (Address) Aberdeen Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: I.O.O.F. Cemetery Aberdeen Idaho
DATE OF BURIAL: 2/8 191 21

20. UNDERTAKER: Friends
ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOOKS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 116

Primary Registration District No. 2195

(No. ....., ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33336

Registered No. .....

1. PLACE OF DEATH.

County of Bingham

City of Aberdeen

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Rev. Leonhard Dirks

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH. Feb 22 (Month) (Day) 1877 (Year)

7. AGE: 43 Yrs. 11 Mos. 27 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Farmer and

(b) General nature of industry, business, or establishment in which employed (or employer)..... Clergyman

9. BIRTHPLACE (State or Country) Germany.

10. NAME OF FATHER David Dirks

11. BIRTHPLACE OF FATHER (State or Country) Germany.

12. MAIDEN NAME OF MOTHER Eva ——

13. BIRTHPLACE OF MOTHER (State or Country) Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Toews

(Address) Aberdeen Ida

15. Filed Feb 20 21 191 M. C. Martinson Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb 18 21 191 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 14 1921, to Feb 18 1921, that I last saw h[illegible] alive on Feb 18 1921, and that death occured on the date stated above, at [illegible] M.

The CAUSE OF DEATH* was as follows:

Endocarditis

(Duration) ..... Yrs. 10 mos. ..... ds.

Contributory (Secondary) Cerebral Embolism

(Duration ..... yrs. ..... mos. 4 ds.

(Signed) M. C. Martinson M. D.

2/20 1921 (Address) Aberdeen Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Mennonite Cemetery Aberdeen Ida — DATE OF BURIAL 2/22 191 21

20. UNDERTAKER Friends — ADDRESS

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 57

County of Blaine Primary Registration District No. 2022

City of Bicaba (No. ....., ... St.)

File No. 33338

Registered No. 7

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Priscilla A Neal

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH: April (Month) 8 (Day) 1888 (Year)

7. AGE: 32 yrs. 10 mos. 25 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Dawson Co. Kansas

10. NAME OF FATHER: H C Hurford

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER: Hotchkiss

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A A Neal
(Address) Bicaba Idaho

15. Filed Apr. 1 1921 R. H. Wright Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH 1V 51 3 1st. Mar. (Month) 3 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 191..., to ....., 191...,
that I last saw h..... alive on ....., 191...,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Angina Pectoris
(Duration) ..... yrs. ..... mos. few hrs. ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Robert H. Wright M. D.
3-4 1921 (Address) Hailey, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Hailey, Ida. DATE OF BURIAL: 3-6 1921

20. UNDERTAKER: T. D. Harris ADDRESS: Hailey

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19780

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 57

County of Blaine Primary Registration District No. 2022

City of Hailey (No. ..... St.)

File No. 33339

Registered No. 8

If death occurs away from usual residence, give facts called for under special information.

APR 11 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME Edna E. Holland.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married. (Write the word.)

6. DATE OF BIRTH: Sept. 27. (Month) (Day) 1847 (Year)

7. AGE: 73 yrs. 6 mos. 9 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife.
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa.

10. NAME OF FATHER: Wm Jobe.

11. BIRTHPLACE OF FATHER (State or Country): Arkansas.

12. MAIDEN NAME OF MOTHER: Elizabeth Gray

13. BIRTHPLACE OF MOTHER (State or Country): Tennessee.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Lizzie Sundown
(Address) Hailey, Ida.

15. Filed Apr-1 1921 R. H. Wright Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Mar. 6 1921.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 28 1921, to Mar 6 1921, that I last saw her alive on Mar 6 1921, and that death occurred on the date stated above, at 12 30 M.

The CAUSE OF DEATH* was as follows:

Nephritis

(Duration) yrs. 1 mos. 7 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. J. Plummer M. D.

3-28-1921 (Address) Hailey Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Hailey Ida. DATE OF BURIAL: Mar 8 1921

20. UNDERTAKER: N. D. Harris ADDRESS: Hailey -

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 57

County of Blaine Primary Registration District No. 2022

City of Bellevue (No. ....., ... St.)

File No. 33340

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Petrea Amida Morris

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Single

6. DATE OF BIRTH: May (Month) 17 (Day) 1918 (Year)

7. AGE: ..... yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Bellevue

10. NAME OF FATHER Mart. Morris

11. BIRTHPLACE OF FATHER (State or Country) Indiana

12. MAIDEN NAME OF MOTHER Isabel Johnson

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Isabel Morris
(Address) Bellevue, Ida

15. Filed Apr 1 1921 R. H. Wright
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH White
Mar (Month) 7 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 28 1921 to Mar 7 1921
that I last saw her alive on " " 1921
and that death occurred on the date stated above, at 10:30 A.M.

The CAUSE OF DEATH* was as follows:
Bronchial Pneumonia

(Duration) ..... yrs. ..... mos. 7 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Robert H. Wright M. D.
3-8 1921 (Address) Hailey Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Bellevue, Ida	3-9 1921

20. UNDERTAKER	ADDRESS
R. D. Harris	Hailey

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33341
Registered No. 10

1. PLACE OF DEATH. Registration District No. 57
County of Custer. Primary Registration District No. 207
City of Obsidian (If not in limits, give township) St.)
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

BUREAU OF VITAL STATISTICS

2. FULL NAME Joseph M. Laning.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male.	White.	Widowed.

6. DATE OF BIRTH: July (Month) 7. (Day) 1840 (Year)

7. AGE: 80 yrs. 8 mos. 1 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer.
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio.

10. NAME OF FATHER: ✓

11. BIRTHPLACE OF FATHER (State or Country): ✓

12. MAIDEN NAME OF MOTHER: ✓

13. BIRTHPLACE OF MOTHER (State or Country): ✓

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) X E. E. Laning
(Address) Hailey, Ida.

15. Filed Apr-1 1921 R. H. Wright Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH No M. D. March. (Month) 8. (Day) 1921. (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Probable Paralysis.

..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary)
..... (Duration) ..... yrs. ~~mos.~~ 4 ds.
(Signed) None. M. D.
19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Hailey, Idaho. DATE OF BURIAL: 3-11 1921

20. UNDERTAKER: R. D. Harris ADDRESS: Hailey

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33342
Registered No. 3

RECEIVED
APR - 1 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH.
County of Blaine
City of Carey
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 57
Primary Registration District No. 2095

2. FULL NAME .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Wht.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Jan. (Month) 8 (Day) 1921 (Year)

7. AGE ..... Yrs. ..... Mos. 2 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work... Infant.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho. Blaine Co.

10. NAME OF FATHER Irvin Eldredge.

11. BIRTHPLACE OF FATHER (State or Country) Utah.

12. MAIDEN NAME OF MOTHER Nettie Pace.

13. BIRTHPLACE OF MOTHER (State or Country) Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Irvin E. Eldredge
(Address) Carey, Ida

15. Filed 3-1 1921 R. H. Wright
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Jan. (Month) 30 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ~ 191~, to ~ 191~, that I last saw h~ alive on ~ 191~, and that death occured on the date stated above, at 12:40 P. M.

The CAUSE OF DEATH* was as follows:
W. Whooping Cough.
(Duration) ~ Yrs. ~ mos. 10 ds.
Contributory (Secondary) .....
(Duration ~ yrs. ~ mos. ~ ds.
(Signed) Houston E. Snyder M. D.
2-1 1921 (Address) Carey - Ida -

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Carey, Ida. DATE OF BURIAL: 2-1 1921

20. UNDERTAKER ✓ ADDRESS ✓

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED
APR - 1 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33343

Registered No. 4

1. PLACE OF DEATH. Registration District No. 57

County of Blaine Primary Registration District No. 7075

City of Carey (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Baptie Jr.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Infant

6. DATE OF BIRTH. Feb. (Month) 12 (Day) 1921 (Year)

7. AGE: ~~6 hours~~ Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many 5 hrs. or 45 min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Carey Idaho

10. NAME OF FATHER: John Baptie

11. BIRTHPLACE OF FATHER (State or Country): Scotland

12. MAIDEN NAME OF MOTHER: Enid J Green

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) John Baptie
(Address) Carey, Ida

15. Filed 3-1 1921 R. H. Wright Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH ~~X~~ Feb. (Month) 13 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 12 1921, to Feb 13 1921, that I last saw h... alive on Feb 13 1921, and that death occured on the date stated above, at 5:45 A.M.

The CAUSE OF DEATH* was as follows:
Premature birth

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) Knowlton & Snyder M. D.

2-15 1921 (Address) Carey Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Carey, Ida — DATE OF BURIAL: 2-14 1921

20. UNDERTAKER: ✓ — ADDRESS: ✓

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SOBS. 24658

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED APR 1 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 57
County of Blaine Primary Registration District No. 2075
City of Carey St.)
File No. 33344
Registered No. 5

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Milford S. Edwards.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Infant
6. DATE OF BIRTH. Dec. (Month) 19 (Day) 1921 (Year)
7. AGE ... Yrs. 1 ~~2~~ Mos. 15 ds. IF LESS than 1 day how many ... hrs. or ... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work... Infant
(b) General nature of industry, business, or establishment in which employed (or employer)...
9. BIRTHPLACE (State or Country) Blaine Co Idaho
10. NAME OF FATHER Sa Fill H. Edwards.
11. BIRTHPLACE OF FATHER (State or Country) Idaho
12. MAIDEN NAME OF MOTHER Margaret Justesen
13. BIRTHPLACE OF MOTHER (State or Country) Utah
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Safell Edwards
(Address) Carey.
15. Filed 3-1 1921 R. H. Wright Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. (Month) 7 (Day) 1921 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Jan. 4 1921, to Feb. 6 1921, that I last saw him alive on Feb. 6 1921, and that death occured on the date stated above, at 3:20 P.M.
The CAUSE OF DEATH* was as follows:
Bronco Pneumonia
(Duration) Yrs. mos. 3 ds.
Contributory (Secondary) Whooping Cough
(Duration yrs. mos. 3 ds.
(Signed) Houston & Snyder M. D.
2-7 1921 (Address) Carey Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Carey, Ida — DATE OF BURIAL: 2-8 1921
20. UNDERTAKER ✓ — ADDRESS —

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24858

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 78
Primary Registration District No. 2158
File No. 33645
Registered No.

1. PLACE OF DEATH

County of Bonner
City of Sandpoint
(No. City Hospital. St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME George Shephard.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH: July, 10, 1842 (Month) (Day) (Year)

7. AGE: 79 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ind

10. NAME OF FATHER: ----- Shephard.

11. BIRTHPLACE OF FATHER (State or Country): Ind

12. MAIDEN NAME OF MOTHER: Unknown.

13. BIRTHPLACE OF MOTHER (State or Country): "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) County Farm
(Address) Sandpoint, Ida.

15. Filed Mch 4 1921 Floyd Wendle Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. 26 -21. (Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb-10 1921, to Feb-26 1921, that I last saw him alive on Feb-25- 1921, and that death occurred on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) Yrs. mos. ds.

Contributory (Secondary) Floyd Wendle

(Duration) yrs. mos. ds.

(Signed) Floyd Wendle M. D.

Feb, 1921. (Address) Sandpoint, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Sandpoint, Ida. DATE OF BURIAL: Mar, 1, 1921.

20. UNDERTAKER: B.W.Pugh. ADDRESS: Sandpoint, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33216

Registered No.

1. PLACE OF DEATH

County of Bonner

City of Sandpoint

Registration District No. 19

Primary Registration District No. 2155

(No. City Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Charles Simpkins.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH: Oct. 9, 1841. (Month) (Day) (Year)

7. AGE: 80 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Butcher.

(b) General nature of industry, business or establishment in which employed (or employer): Retired.

9. BIRTHPLACE (State or Country): Ill.

10. NAME OF FATHER: Jno Simpkins.

11. BIRTHPLACE OF FATHER (State or Country): England.

12. MAIDEN NAME OF MOTHER: Unknown.

13. BIRTHPLACE OF MOTHER (State or Country): Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Will Simpkins.

(Address) Worley, Ida.

15. Filed Mch. 4 1921 Floyd Wendle Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. 22, 21. (Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan-1 1921, to Feb-22 1921, that I last saw him alive on Feb-22 1921, and that death occurred on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia.

(Duration) Yrs. mos. 10 ds.

Contributory (Secondary): Asthma.

(Duration) yrs. mos. ds.

(Signed) Floyd Wendle, M. D.

Mar. 1, 1921. (Address) Sandpoint, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Sandpoint, Ida. DATE OF BURIAL: Feb. 24, 21. 19

20. UNDERTAKER: B. W. Pugh, ADDRESS: Sandpoint, Ida.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3334?
Registered No.

1. PLACE OF DEATH

Registration District No.
Primary Registration District No. 2 1 5
County of Bonner
City of Sandpoint (No. No. Boyer Ave., St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charles Riffle.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH: June, 15, -39. 1 (Month) (Day) (Year)

7. AGE: 82 Yrs. Mos. ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher.
(b) General nature of industry, business or establishment in which employed (or employer): Retired.

9. BIRTHPLACE (State or Country): Penna.

10. NAME OF FATHER: Ames Riffle.

11. BIRTHPLACE OF FATHER (State or Country): Vermont.

12. MAIDEN NAME OF MOTHER: Malinda Thorp.

13. BIRTHPLACE OF MOTHER (State or Country): Penna.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) M.M. Riffle,
(Address) Sandpoint, Ida.

15. Filed Mch 4 1921 Floyd Wendle Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. 22, -2I. 19 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 12 19?1, to 19, that I last saw h. im alive on Feb 12 19?1, and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Cancer Potash

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) E. Underwood M. D.

Mar. 1 1921 (Address) Sandpoint, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Sandpoint, Ida. DATE OF BURIAL: Feb. 24. 1921.

20. UNDERTAKER: B?W. Pugh, ADDRESS: Sandpoint, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH O. F. Sandpoint,

Registration District No. 78

Primary Registration District No. 2115

File No. 33348

County of Bonner

City of Sandpoint

(No. Selle, Ida. St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Matt Erikson.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Nov. (Month) 30 (Day) 1881 (Year)

7. AGE: 40 Yrs. Mos. ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher.
(b) General nature of industry, business or establishment in which employed (or employer): Active.

9. BIRTHPLACE (State or Country): Finland.

10. NAME OF FATHER: Erik Hill.

11. BIRTHPLACE OF FATHER (State or Country): Finland.

12. MAIDEN NAME OF MOTHER: Bettie Finman.

13. BIRTHPLACE OF MOTHER (State or Country): Finland.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Matt Erikson.
(Address) Selle, Ida.

15. Filed Jan 4 1921

Floyd Wendle
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan, 25, -21. 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 5 1920, to Jan 25 1921, that I last saw h...im alive on Jan 4 1921, and that death occurred on the date stated above, at 5:20 a M.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) Yrs. 8 mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) O. F. Pugh M. D.

Jan. 27 1921. (Address) Sandpoint, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Sandpoint, Ida. DATE OF BURIAL: Jan, 29-21 19

20. UNDERTAKER: B.W.Pugh, ADDRESS: Sandpoint, Ida.

FORM V. S. No. 5-25 M. 1-19. Wallentine

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 78

Primary Registration District No. 2155

File No. 33349

County of Bonner

City of Sandpoint (No. On Ranch, St.)

Registered No. ....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs. Ruth Brooks.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Oct. 2, (Month) (Day) 1895 (Year)

7. AGE: 26 Yrs. ... Mos. ... ds.

IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife.

(b) General nature of industry, business or establishment in which employed (or employer): At Home.

9. BIRTHPLACE (State or Country): Nebr.

10. NAME OF FATHER: E.M.Crowell.

11. BIRTHPLACE OF FATHER (State or Country): N.Y.

12. MAIDEN NAME OF MOTHER: Thankfull Bush.

13. BIRTHPLACE OF MOTHER (State or Country): N.Y.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E.M. Crowell.

(Address) Sandpoint, Ida.

15. Filed Mch 4 1921 Floyd B Wendle Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. 3, -21. (Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 2 1921, to Feb 3 1921, that I last saw h. alive on Feb 3 1921, and that death occurred on the date stated above, at 3 P M.

The CAUSE OF DEATH* was as follows:

Lethargic Encephalitis

(Duration) Yrs. 0 mos. 17 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) W P Wallentine M. D.

Feb 23 1921. (Address) Sandpoint, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: (On Ranch) Near Sandpoint, DATE OF BURIAL: Feb, 5, 21

20. UNDERTAKER: B.W.Pugh, ADDRESS: Sandpoint, Iad.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33550
Registered No. 2

1. PLACE OF DEATH

County of Bonner
City of Sandpoint
(No. City Hospital. St.)

Registration District No. 78
Primary Registration District No. 2155

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Peter A. Skarp.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widowed (Write the word.)

6. DATE OF BIRTH: July 30, 1846 (Month) (Day) (Year)

7. AGE: 75 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher.
(b) General nature of industry, business or establishment in which employed (or employer): Active.

9. BIRTHPLACE (State or Country): Sweden.

10. NAME OF FATHER: Unknown.

11. BIRTHPLACE OF FATHER (State or Country): Sweden.

12. MAIDEN NAME OF MOTHER: Unknown.

13. BIRTHPLACE OF MOTHER (State or Country): Sweden.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A.E.Skarp.
(Address) Westmond, Ida.

15. Filed Feb 4 1921 Floyd Wendt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. 3, 1921. (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12-31 1920, to Feb. 3 1921 that I last saw him alive on Feb. 3 1921, and that death occurred on the date stated above, at 1:30 P.M.

The CAUSE OF DEATH* was as follows:
Chronic prostatic hypertrophy

(Duration) 1 Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) W P Macentire M. D.
Feb, 2-3 1921. (Address) Sandpoint, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Westmond, Ida. DATE OF BURIAL: Feb, 5, -21. 19

20. UNDERTAKER: B. W. Pugh, ADDRESS: Sandpoint, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19. Nuckol

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 78
Primary Registration District No. 2151
File No. 33351
Registered No.

1. PLACE OF DEATH

County of Bonner
City of Sandpoint
(No. Ponderay, Ida. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Earnestine Wigdon.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Married

6. DATE OF BIRTH: Sept. 15 (Month) (Day) 1864. (Year)

7. AGE: 57 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife.
(b) General nature of industry, business or establishment in which employed (or employer): At Home.

9. BIRTHPLACE (State or Country): Germany.

10. NAME OF FATHER: Fred Wentland.

11. BIRTHPLACE OF FATHER (State or Country): Germany.

12. MAIDEN NAME OF MOTHER: Unknown.

13. BIRTHPLACE OF MOTHER (State or Country): Germany.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Sam Wigdon.
(Address) Ponderay, Ida.

15. Filed Feb 4 1921 Floyd Wendle Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. 9, -21. (Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb-1 1921, to Feb-9 1921, that I last saw her alive on Feb-9 1921, and that death occurred on the date stated above, at 6P M.

The CAUSE OF DEATH* was as follows:

Pneumonia.

(Duration) Yrs. mos 10 ds.

Contributory (Secondary) Goitre

(Duration) 2 yrs. mos. ds.

(Signed) Floyd Wendle M. D.

Feb, 1921. (Address) Sandpoint, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Sandpoint, Ida. DATE OF BURIAL: Feb, 12, -21 19

20. UNDERTAKER: B. W. Pugh, ADDRESS: Sandpoint, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

Kendall

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 78

Primary Registration District No. 2 17-1

File No. 33352

County of Bonner

City of Sandpoint (No. Kooteani, Ida. St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME (Infant) Luckey.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Single.

6. DATE OF BIRTH: Feb. 10, -21. (Month) (Day) 1 (Year)

7. AGE: ...Yrs. 2 Mos. ...ds. IF LESS than 1 day how many ...hrs. or ...min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ida.

10. NAME OF FATHER: M.S.Lucky.

11. BIRTHPLACE OF FATHER (State or Country): Kans. Feb

12. MAIDEN NAME OF MOTHER: Blanche Swanger.

13. BIRTHPLACE OF MOTHER (State or Country): Ohio.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) M.S.Lucky.
(Address) Kooteani, Ida.

15. Filed March 4 19 21 Floyd Wendle Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. 12, -21. (Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb-10 19 21, to Feb-12 19 21, that I last saw h...er... alive on Feb-11 19 21, and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows: Valvular Heart Disorder

...(Duration) ...Yrs. ...mos. 2 ...ds.

Contributory (Secondary)

...(Duration) ...yrs. ...mos. ...ds.

(Signed) Floyd Wendle M. D.

19 21. (Address) Sandpoint, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ...yrs. ...mos. ...days. In the State ...yrs. ...mos. ...days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Sandpoint, Ida,	Feb, 12, 19 21.

20. UNDERTAKER	ADDRESS
B.W.Pugh,	Sandpoint, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19. Wendle

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33353
Registered No.

1. PLACE OF DEATH

Registration District No. 78
Primary Registration District No. 2183

County of Bonner
City of Sandpoint.
(No. County Farm. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Frank B. Carter.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widowed. (Write the word.)

6. DATE OF BIRTH: Oct. 20, 1853. (Month) (Day) (Year)

7. AGE: 68 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Shingle Weaver
(b) General nature of industry, business or establishment in which employed (or employer): Employed.

9. BIRTHPLACE (State or Country): Penna.

10. NAME OF FATHER: ------ Carter.

11. BIRTHPLACE OF FATHER (State or Country): Mich.

12. MAIDEN NAME OF MOTHER: Unknown.

13. BIRTHPLACE OF MOTHER (State or Country): "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Fay G. Carter.
(Address) Clarks Fork, Ida.

15. Filed Feb 7 1921 Hoyt Wendle Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb, 7, -21. 19 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan- 1918, to Feb-7- 1921 that I last saw h.im alive on Feb-7- 1921, and that death occurred on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia -.

(Duration) Yrs. mos. 12 ds.

Contributory (Secondary) Asthma

(Duration) 2 yrs. mos. ds.

(Signed) Floyd Wendle M. D.

1921. (Address) Sandpoint, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Sandpoint, Ida. DATE OF BURIAL: Feb, 8, 1921

20. UNDERTAKER: B.W. Pugh, ADDRESS: Sandpoint, Ida.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33354

Registered No.

1. PLACE OF DEATH

County of Bonner

City of Sandpoint (No. First & Pine St.)

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 78

Primary Registration District No. 2155

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ellen Johnson.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: July, 18 (Month) 1918 (Day) 1 (Year)

7. AGE: 3 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: At Home.

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mont.

10. NAME OF FATHER: Earl Johnson.

11. BIRTHPLACE OF FATHER (State or Country): Wyo.

12. MAIDEN NAME OF MOTHER: Unknown.

13. BIRTHPLACE OF MOTHER (State or Country): "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Pinkerton.

(Address) Sandpoint, Ida.

15. Filed Mch 4 1921 Floyd Wendle Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. 3 *21. 19 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 30th 1921, to Feb. 3rd 1921, that I last saw her alive on Feb. 3rd 1921, and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Whooping-Cough complicated with Pneumonia

(Duration) Yrs. mos. 14 ds.

Contributory (Secondary) Whooping cough

(Duration) yrs. mos. ds.

(Signed) T. A. Peet M.D.

Feb, 1921. (Address) Sandpoint, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Sandpoint, Ida. DATE OF BURIAL: Feb. 4. -21

20. UNDERTAKER: B. W. Pugh, ADDRESS: Sandpoint, Ida.

V. S. No. 1—30M—3-20

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

not counted

RECEIVED APR

Reg. District 78 Prime. Reg. Dist 2153

PLACE OF DEATH

Washington State Board of Health

BUREAU OF VITAL STATISTICS

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Record No. 33355

Registered No. Idaho

County of

City or Town of

Registration Dist. No. No. On board Spokane & International near Sandpoint

(if death occurred in a hospital or institution, give its NAME instead of street and number)

2. FULL NAME Georgina Beattie

(a) Residence No. St.;
(Usual place of abode)

(b) If non-resident, give city or town, and state Cranbrook, B.C.

(c) How long in Registration Dist. yrs. mos. ds.; how long in U. S. if of foreign birth yrs. mos. ds.

Personal and Statistical Particulars

3. Sex	4. Color or Race	5. Single, Married, Widowed or Divorced (Write the word)
Female	White	Married

5. (a) If married, widowed, or divorced:
Husband of
or Wife of R. E. Beattie

6. Date of birth: Sept (Month) 14 (Day) 1874 (Year)

7. Age: 46 yrs. 7 mos. 17 ds. If less than one day: hrs. or min.

8. Occupation of deceased:
(a) Trade, professioon, or particular kind of work Hw
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. Birthplace (City or town)
(State or country) Scotland

PARENTS

10. Name of Father David Henderson
11. Birthplace of Father (City or town) (State or Country) Scotland
12. Maiden name of Mother Elizabeth Christie
13. Birthplace of Mother (City or town) (State or Country) Scotland

14. Informant R.E.Beattie
Address Cranbrook, B.C.

15. Filed Apr 7, 1921 Floyd C Wendle Registrar.

Medical Certificate of Death

16. Date of death Mar 31, 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased
from , 192, to , 192
that I last saw h alive on , 192
and that death occurred on the date stated above, at 7:15p.m.
(State the disease causing death, or, in deaths from violent causes, state: (1) Means and nature of injury; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL).
The CAUSE OF DEATH was as follows:

READ DETAILS ON OTHER SIDE

(Primary) Cancer of Liver
(See 1 and 3 other side)
(Duration) yrs. mos. ds.
on information of Dr Keo,
CONTRIBUTORY (Secondary) MacKinnon, Cranbrook, B.C.
(See 2 other side)
(Duration) yrs. mos. ds.

18. Where was disease contracted if not at the place of death?
(a) Did an operation precede death? Date of
(b) Was there an autopsy?
(c) What test confirmed diagnosis?
(Signed) H A Henderson M. D.
, 192 Address Deputy Coroner,

19. Place of Burial, Cremation or Removal: Cranbrook, B.C. Date of Burial: Apr 1, 1921

20. Undertaker: SMITH & CO. Address

I HEREBY CERTIFY, upon honor, That I have made the effort but was unable to secure answers to questions
(Insert numbers of unanswered questions) (Signature of Undertaker)

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED APR 9 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 85

County of Bonner

Primary Registration District No. 2185

File No. 38356

City of PRIEST RIVER (No. ..... St.)

Registered No. 34

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary Ann Bombeno

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Single

6. DATE OF BIRTH

March (Month) 9 (Day) 1921 (Year)

7. AGE

..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many 1 hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Priest River, Ida.

10. NAME OF FATHER Bruno Bombeno

11. BIRTHPLACE OF FATHER (State or Country) Italy

12. MAIDEN NAME OF MOTHER Josephine Naccarato

13. BIRTHPLACE OF MOTHER (State or Country) Italy

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Bruno Bombeno

(Address) PRIEST RIVER

15. Filed April 1 1921 C. P. Gethoff Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March (Month) 15 (Day) 1921 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 15 19..., to March 15 1921 19..., that I last saw her alive on March 15 1921 19..., and that death occurred on the date stated above, at 9.45 P.M.

The CAUSE OF DEATH* was as follows:

Premature birth.

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) C. P. Gethoff M. D.

16 March 1921 (Address) PRIEST RIVER

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL PRIEST RIVER

DATE OF BURIAL Mar 16 1921

20. [redacted] Neighbor Tony Jaccomazzi

ADDRESS PRIEST RIVER

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

RECEIVED APR 9 1921 VITAL STATISTICS

PLACE OF DEATH ~~Washington~~ Idaho

State Board of Health

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Record No. 33357

Registered No. 35

County of Bonner

City or Town of Newport

Registration Dist No. 85 No. Army 2125

(If death occurred in a hospital or institution, give its NAME instead of street and number)

2. FULL NAME Victor Cecil Hamilton

(a) Residence No. ..... St.;
(Usual place of abode)

(b) If non-resident, give city or town, and state .....

(c) How long in Registration Dist. ..... yrs. ..... mos. ..... ds.; how long in U. S. If of foreign birth ..... yrs. ..... mos. ..... ds.

Personal and Statistical Particulars

3. Sex	4. Color or Race	5. Single, Married, Widowed or Divorced (Write the word)
male	white	married

5. (a) If married, widowed or divorced:
Husband of Westa Vane Hamilton
or
Wife of .....

6. Date of birth: April (Month) 5 (Day) 1892 (Year)

7. Age: 28 yrs. 11 mos. 13 ds. If less than one day: ..... hrs. ..... or min.

8. Occupation of deceased:
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. Birthplace (City or town) .....
(State or Country) Sumner Wash

PARENTS

10. Name of Father E. D. Hamilton
11. Birthplace of Father (City or town) (State or Country) Penn.
12. Maiden name of Mother .....
13. Birthplace of Mother (City or town) (State or Country) Penn.

14. Informant Mrs Victor Hamilton
Address Newport Wash

15. Filed Apr 9 1921 C. P. Gettle Registrar

Medical Certificate of Death

16. Date of death March 17 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 17 1921, to Mar 17 192..
that I last saw h..... alive on ....., 192..
and that death occurred on the date stated above, at 12 30 m.
(State the disease causing death, or, in deaths from violent causes, state: (1) Means and nature of injury; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL).
The CAUSE OF DEATH was as follows:

READ DETAILS ON OTHER SIDE

(Primary) Uremia
(See 1 and 3 other side)

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Acut Nephritis
(See 2 other side)

(Duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at the place of death? .....

(a) Did an operation precede death? No Date of .....

(b) Was there an autopsy? No

(c) What test confirmed diagnosis? Clinical

(Signed) J. T. Phillips M. D.

Mar 18, 1921 Address Newport

19. Place of Burial, Cremation or Removal: Spokane Wash — Date of Burial: Spokane Mar 21 1921

20. Undertaker: William Davis — Address: Newport Wash.

I HEREBY CERTIFY, upon honor, That I have made the effort but was unable to secure answers to questions .....
(Insert numbers of unanswered questions) (Signature of Undertaker)

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1—30M—3-20

Idaho

PLACE OF DEATH ~~Washington~~ State Board of Health

33358

Record No.

RECEIVED

APR 9 1921

BUREAU OF VITAL STATISTICS

County of Bonner

City or Town of Nweport

CERTIFICATE OF DEATH

Registered No. 31

Registration Dist No. 2185

(If death occurred in a hospital or institution, give its NAME instead of street and number)

2. FULL NAME William H. Neier

(a) Residence No. ..... St.;
(Usual place of abode)

(b) If non-resident, give city or town, and state .....

(c) How long in Registration Dist. ..... yrs. ..... mos. ..... ds.; how long in U. S. if of foreign birth ..... yrs. ..... mos. ..... ds.

Personal and Statistical Particulars

3. Sex	4. Color or Race	5. Single, Married, Widowed or Divorced (Write the word)
Male	White	Widowed

5. (a) If married, widowed, or divorced:
Husband of .....
or
Wife of .....

6. Date of birth: June (Month) | I6 (Day) | I86I (Year)

7. Age: 60 yrs. 9 mos. I ds. If less than one day: ..... hrs. ..... or min.

8. Occupation of deceased:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. Birthplace (City or town) .....
(State or Country) Mich

PARENTS

10. Name of Father: D Meier
11. Birthplace of Father (City or town) (State or Country): Pa
12. Maiden name of Mother: Carline Young
13. Birthplace of Mother (City or town) (State or Country): Pa

14. Informant: Claud Meier
Address: Newport Wash

15. Filed: Apr 1, 1921 C. P. Gehlff Registrar.

Medical Certificate of Death

16. Date of death: March (Month) 20 (Day) 192I (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mch 16, 192I, to Mch 19, 192I
that I last saw h..... alive on Mch 19, 192I
and that death occurred on the date stated above, at 6 Am.
(State the disease causing death, or, in deaths from violent causes, state: (1) Means and nature of injury; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL).
The CAUSE OF DEATH was as follows:

READ DETAILS ON OTHER SIDE.

(Primary) Chronic Intestitial Nephritis
(See 1 and 2 other side)

(Duration) 15 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Uremia
(See 2 other side)

(Duration) ..... yrs. 36 hrs mos. ..... ds.

18. Where was disease contracted if not at the place of death? .....

(a) Did an operation precede death? ..... Date of .....

(b) Was there an autopsy? .....

(c) What test confirmed diagnosis? .....

(Signed) D. V. C. Cleveland M. D.

Mar 21, 192I Address Newport

19. Place of Burial, Cremation or Removal: Newport — Date of Burial: Mar 22, 192I

20. Undertaker: William Davis — Address: Newport Wash

I HEREBY CERTIFY, upon honor, That I have made the effort but was unable to secure answers to questions .....
(Insert numbers of unanswered questions)

(Signature of Undertaker)

V. S. No. 1—30M—8-20

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 21-1
File No. 33360
Registered No. 14

1. PLACE OF DEATH.
County of Bonneville.
City of Idaho Falls.
(No. 199 Capital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Infant Seip.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Feb. 22 1921 (Month) (Day) (Year)

7. AGE ~~Ds~~ Yrs. Mos. ds.
IF LESS than 1 day how many 6 hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer)...

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: Roy Seip

11. BIRTHPLACE OF FATHER (State or Country): Kansas.

12. MAIDEN NAME OF MOTHER: Laura Reynolds.

13. BIRTHPLACE OF MOTHER (State or Country): Col.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Cliff Hayes
(Address) Idaho Falls

15. Filed Feb 26 1921
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb 22 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 22 1921, to Feb 22 1921, that I last saw him alive on Feb 22 1921 and that death occured on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:
Premature Birth

(Duration) Yrs. mos. ds.

Contributory (Secondary)
(Duration yrs. mos. ds.

(Signed) [illegible] M. D.
19 (Address) Idaho Falls.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Rose Hill. DATE OF BURIAL: Feb 23 1921

20. UNDERTAKER: Cliff Hayes. ADDRESS: Idaho Falls

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 21V-0

File No. 33361
Registered No. 13

1. PLACE OF DEATH.
County of Bonneville
City of Idaho Falls
(No. 19th & Hoyt St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Virgie F Williams

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH. June 30 1905
(Month) (Day) (Year)

7. AGE 16 Yrs. 6 Mos. ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Nurse
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho.

10. NAME OF FATHER Frank Williams

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Marion C Swenson

13. BIRTHPLACE OF MOTHER (State or Country) Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Marion C Williams
(Address) Idaho Falls

15. Filed Jan 26 1921 [signature] Local Registrar

SYMS - YORK CO., PTRS. & BOOKS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Jan. 4 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 24 1920, to Jan 4 1921, that I last saw h— alive on Jan 1921, and that death occured on the date stated above, at 4 A.M.

The CAUSE OF DEATH* was as follows:
Pneumonia. Influenza
& Cardiac Failure.

10
(Duration) 1 Yrs. mos. / ds.

Contributory (Secondary) Senile Decay

(Duration) yrs. mos. ds.

(Signed) [signature] M. D.
19 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Sugar City Ida	1/6 1921

20. UNDERTAKER	ADDRESS
Cliff Hayes	Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

Shoshone

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 21-0
File No. 33362
Registered No. 12

1. PLACE OF DEATH.
County of Bonneville
City of Idaho Falls. (No. Spencer Hosp. St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Thomas A. Blackburn

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Jan. (Month) 27 (Day) 1895 (Year)

7. AGE: 26 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Rancher.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho.

10. NAME OF FATHER Alfred Blackburn

11. BIRTHPLACE OF FATHER (State or Country) England.

12. MAIDEN NAME OF MOTHER Dora Castle

13. BIRTHPLACE OF MOTHER (State or Country) Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Dora Castle Blackburn
(Address) Swan Valley Idaho

15. Filed Jan. 26 1921 — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan. (Month) 21 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan-19 1921, to Jan-21 1921, that I last saw h[e] alive on Jan-21 1921 and that death occured on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:
convulsion, which affected nerve centers governing respiration

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) H. B. Spencer M. D.
Jan 21 1921 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Lyman Idaho. DATE OF BURIAL: Jan 25 1921

20. UNDERTAKER: Cliff Hayes ADDRESS: Idaho Falls.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Exact statement should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 2110
(No. 4 5 mile n. W Idaho Falls St.)

File No. 33363
Registered No. 11

1. PLACE OF DEATH.
County of Bonneville
City of Idaho Falls
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME J W Thompson.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH. Aug. (Month) 27 (Day) 1841 (Year)

7. AGE: 75 Yrs. 5 Mos. 29 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Rancher.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Ky.

10. NAME OF FATHER Thompson.

11. BIRTHPLACE OF FATHER (State or Country) Ky

12. MAIDEN NAME OF MOTHER Don't Know.

13. BIRTHPLACE OF MOTHER (State or Country) " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs K. Thompson.
(Address) Lorrie Ida.

15. Filed 2/26 1921 W Spencer Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Feb. (Month) 25 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 18 1921, to Feb 25 1921, that I last saw h— alive on Feb-18 1921, and that death occured on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:
Chronic Valvular heart disease

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W Spencer M. D.
2/26 1921 (Address) Idaho Falls Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Brownsville Ore. DATE OF BURIAL: 1921

20. UNDERTAKER: Gifford Hayes. ADDRESS: Idaho Falls

W. Spencer.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYNS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 2170
File No. 39304
Registered No. 10

1. PLACE OF DEATH
County of Bannock
City of Ida Falls
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charles Conway Hinckley
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Child

6. DATE OF BIRTH: Aug. (Month) 31 (Day) 1907 (Year)

7. AGE: 13 Yrs. 5 Mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Rexburg Ida

10. NAME OF FATHER: Ira N. Hinckley

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Emma Keppner

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ira N Hinckley
(Address) Rexburg

15. Filed 2-14 1921 [signature] Local Registrar
Dr Hatch

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feby (Month) 13 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 1 1921, to Feb 13 1921, that I last saw h[im] alive on Feb 13 1921, and that death occurred on the date stated above, at 5-30 M.

The CAUSE OF DEATH* was as follows:
Pneumonia for one week
Complete atelectasis

(Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [signature] M. D.
2/14 1921 (Address) Ida Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence Ship

19. PLACE OF BURIAL OR REMOVAL: Rexburg, Ida. DATE OF BURIAL: 2/14 1921

20. UNDERTAKER: [signature] ADDRESS: Ida Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 2130
File No. 32365
Registered No. 7

1. PLACE OF DEATH
County of Bonneville
City of Idaho Falls
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Hallis Carnell Drake

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Mall	White	Infant

6. DATE OF BIRTH: January (Month) 25 (Day) 1921 (Year)

7. AGE: 0 Yrs. 0 Mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho Falls

10. NAME OF FATHER Arthur Drake

11. BIRTHPLACE OF FATHER (State or Country) Ennis Idaho

12. MAIDEN NAME OF MOTHER Catherine Hall

13. BIRTHPLACE OF MOTHER (State or Country) Ennis Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Arthur Drake
(Address) City

15. Filed Feb 8 1921
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feby. (Month) 7 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 7 1921, to Feb 7 1921, that I last saw him alive on Feb 7 1921, and that death occurred on the date stated above, at 2:15 M.

The CAUSE OF DEATH* was as follows:

Inanition

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) O E Rogers M. D.

1921 (Address) Idaho Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Ennis, Idaho	2/9 1921

20. UNDERTAKER	ADDRESS
E Dunwoody	Ida Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 22266
Registered No. 2

Registration District No. 73
Primary Registration District No. 7310

1. PLACE OF DEATH
County of Bannock
City of Idaho Falls
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Julius Ehlers Jr.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH: January (Month) 13 (Day) 1857 (Year)

7. AGE: 64 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Austria

10. NAME OF FATHER: Joachim Ehlers

11. BIRTHPLACE OF FATHER (State or Country): Prussia

12. MAIDEN NAME OF MOTHER: ?

13. BIRTHPLACE OF MOTHER (State or Country): ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Julius Ehlers Jr
(Address) City

15. Filed 2/8 1921 [signature] Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: January (Month) 17 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....,
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at 7 a M.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
No medical attendance
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) [signature] M. D.
2/8 1921 (Address) Idaho Falls Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Idaho Falls	1/19 1921
20. UNDERTAKER: [illegible] Greenwood	ADDRESS: Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 2 1 3 0
File No. 22267
Registered No. 7

1. PLACE OF DEATH
County of Bannock
City of Idaho Falls
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Culbert L. King Sr
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: ~~Married~~ (Write the word.)

6. DATE OF BIRTH: June (Month) 11 (Day) 1856 (Year)

7. AGE: 64 Yrs. 6 Mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Stock Raising
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Culbert King

11. BIRTHPLACE OF FATHER (State or Country): U. S.

12. MAIDEN NAME OF MOTHER: Esther McCullaugh

13. BIRTHPLACE OF MOTHER (State or Country): U. S.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. L. King
(Address) R.D. 3 City

15. Filed 2/6 1921 C. Kennard
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: January (Month) 7 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at 1 P. M.
The CAUSE OF DEATH* was as follows: Unknown
No medical attendance
Probably myocarditis
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) C. Kennard M. D.
2/6 1921 (Address) Idaho Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence Ship

19. PLACE OF BURIAL OR REMOVAL: Manti, Utah
DATE OF BURIAL: Jan 9 1921

20. UNDERTAKER: E. E. Linwood
ADDRESS: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 2178
File No. 3370
Registered No. 4

1. PLACE OF DEATH
County of Bannock
City of Idaho Falls
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Russel James Jorgeson
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Infant

6. DATE OF BIRTH: Nov (Month) 11 (Day) 1920 (Year)

7. AGE: 0 Yrs. 2 Mos. 7 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ida Co

10. NAME OF FATHER: Nels C Jorgeson

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: Svedin — Frazier

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) N C Jorgeson
(Address) Ida Falls

15. Filed 2/8 1921 — Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jany (Month) 18 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1-12-1921, to Jan 18-1921 that I last saw h— alive on Jan. 17-1921, and that death occurred on the date stated above, at 9 P M.

The CAUSE OF DEATH* was as follows:

Pneumonia following Whooping Cough.

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) J C Hollister M. D.

1/20 1921 (Address) Idaho Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Ida Falls	1/20 1921
20. UNDERTAKER	ADDRESS
C E Linwood	Ida Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

J C Hollister

FORM V. S. No. 5-25 M. 1-19.

RECEIVED APR 1 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5816
Registered No.

1. PLACE OF DEATH
Registration District No.
Primary Registration District No.
County of Butte
City of Arco (Ward, St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James Eckstrom
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single
6. DATE OF BIRTH: Oct. 30 (Month) (Day) 1919 (Year)
7. AGE: 1 Yrs. 10 Mos. 4 ds. IF LESS than 1 day how many hrs. or min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)
9. BIRTHPLACE (State or Country): Idaho
10. NAME OF FATHER: John Eckstrom
11. BIRTHPLACE OF FATHER (State or Country): Arizona
12. MAIDEN NAME OF MOTHER: Violet Cooper
13. BIRTHPLACE OF MOTHER (State or Country): Utah
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Eckstrom
(Address) Arco Ida
15. Filed 3-17-1921 H H Maumon Local Registrar
Arco Ida

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar. (Month) 10 (Day) 1921 (Year)
17. I HEREBY CERTIFY, That I attended deceased from 3-5-1921 to 3-10-1921 that I last saw h[illegible] alive on 3-10-1921 and that death occurred on the date stated above, at 6 P.M.
The CAUSE OF DEATH* was as follows:
Broncho Pneumonia
(Duration) Yrs. mos. 5 ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) H H Maumon M. D.
3/7 1921 (Address) Arco Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Arco Ida — DATE OF BURIAL: 3-13-1921
20. UNDERTAKER: Eckstrom — ADDRESS: Arco.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5014

1. PLACE OF DEATH

Registration District No. 59

County of Butte

Primary Registration District No. 2129

City of Arco (No. ..... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ruth E Ekstrom

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6. DATE OF BIRTH: Apr. (Month) 4 (Day) 1918 (Year)

7. AGE: 2 Yrs. 11 Mos. 8 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: John Ekstrom

11. BIRTHPLACE OF FATHER (State or Country): Arizona

12. MAIDEN NAME OF MOTHER: Hattie Cooper

13. BIRTHPLACE OF MOTHER (State or Country): Violet Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E E Ekstrom

(Address) Arco Ida

15. Filed 3/17/1921 A M Cannon Local Registrar acting

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar. (Month) 12 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 8 1921 to Mar 12 1921 that I last saw h.. alive on Mar 12 1921 and that death occurred on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

..... (Duration) ..... Yrs. ..... mos. 4 ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A M Cannon M. D.

3/17 1921 (Address) Arco Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Arco Ida — DATE OF BURIAL: 3-13 1921

20. UNDERTAKER: E E Ekstrom — ADDRESS: Arco Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33275
Registered No.

1. PLACE OF DEATH
County of Butte
City of arco
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 59
Primary Registration District No. 2129
(No. ..... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Eva Shutt

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6. DATE OF BIRTH: July (Month) 24 (Day) 1919 (Year)

7. AGE: 1 Yrs. 8 Mos. 21 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Blackfoot, Ida

10. NAME OF FATHER: Jacob Shutt

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Edith Dawson

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jacob Shutt
(Address) arco Ida

15. Filed 3/17 1921 J. M. Cannon
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar (Month) 15 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 13 1921 to Mar 15 1921 that I last saw h.er alive on Mar 15 1921 and that death occurred on the date stated above, at 4 9 M.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Cannon M. D.
3/15 1921 (Address) arco Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Blackfoot — DATE OF BURIAL: 3/16 1921

20. UNDERTAKER: Ryle — ADDRESS: Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
APR 11 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 58 d

County of Camas

Primary Registration District No. 2138

File No. 3327 6

City of Conal

(No. ..... , ... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charles Babington

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): widowed

6. DATE OF BIRTH: March (Month) 2 (Day) 1846 (Year)

7. AGE: 75 Yrs. ..... Mos. 17 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Rancher

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: —

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Camas Co Courier

(Address) Fairfield, Idaho

15. Filed April 11 1921 — L Wilencheck, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 14 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from No Phy 19..., to ..... 19....., that I last saw him alive on ..... 19....., and that death occurred on the date stated above, at ..... M. The CAUSE OF DEATH* was as follows: In attendance. Cause Unknown

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) L Wilencheck M. D.

4-11 1921 (Address) Fairfield, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL ..... 19.....

20. UNDERTAKER | ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED
APR 11 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 2005
File No. 3[illegible]78
Registered No. 46

1. PLACE OF DEATH
County of Canyon
City of Caldwell (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Eugene L. Conway
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	white	married

6. DATE OF BIRTH: April (Month) 14 (Day) 1893 (Year)

7. AGE: 27 Yrs. 11 Mos. 26 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: M. P. Conway

11. BIRTHPLACE OF FATHER (State or Country): Canada

12. MAIDEN NAME OF MOTHER: Francis H. Spurgo

13. BIRTHPLACE OF MOTHER (State or Country): Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. W. Conway
(Address) 224 Dearborn

15. Filed April-11-1921 John G. Meyer Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr. (Month) 10 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19....., that I last saw h..... alive on ..... 19....., and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Acute dilatation of the heart
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Violent running
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Paul L. Conway M. D.
..... 19..... (Address) Caldwell Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Canyon Hill	4-13 1921

20. UNDERTAKER	ADDRESS
CASE FURNITURE CO.	Caldwell

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Montgomery

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED
APR 11 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 2004
File No. 33379
Registered No. 45

1. PLACE OF DEATH
County of Canyon
City of Caldwell (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lewis Clark Post
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (or Widowed or Divorced)

6. DATE OF BIRTH: Sept (Month) 1 (Day) 1847 (Year)

7. AGE: 73 Yrs. 7 Mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Wesley Post

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Jane Miller

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Clarence Post
(Address) Caldwell R. D. #2

15. Filed April 11— 1921 — Jos. L. Meyer — Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 9 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 5, 1921, to Apr 8 1921, that I last saw him alive on Apr 8 1921, and that death occurred on the date stated above, at 12 P.M.

The CAUSE OF DEATH* was as follows:
Chronic valvular heart disease
(Duration) 5 Yrs. ..... mos. ..... ds.
Contributory (Secondary): pyaurhea alveolaris
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G. D. Montgomery M. D.
Apr 9 1921 (Address) Caldwell Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill — DATE OF BURIAL: 4-11 1921

20. UNDERTAKER: E. M. Peckham — ADDRESS: Caldwell

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Front

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED APR 8 1921 STATE OF IDAHO

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33380
Registered No. 44

1. PLACE OF DEATH

Registration District No. 3
Primary Registration District No. 1005
County of Canyon
City of Caldwell (If outside limits of city or village, write RURAL and give name of township.) St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Jane Ackley

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	

6. DATE OF BIRTH: Dec (Month) 14 (Day) 1855 (Year)

7. AGE: 65 Yrs. 3 Mos. 21 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Missouri

10. NAME OF FATHER Stuart Hall

11. BIRTHPLACE OF FATHER (State or Country) Virginia. Mississippi.

12. MAIDEN NAME OF MOTHER Jerelda Dare.

13. BIRTHPLACE OF MOTHER (State or Country) Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Geo. H. Ackley
(Address)

15. Filed April 6th 1921 John S. Meyer. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr (Month) 5 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1 1921, to Apr 6 1921, that I last saw her alive on Apr 6 1921, and that death occurred on the date stated above, at 12 A M.

The CAUSE OF DEATH* was as follows:
Carcinoma of uterus

(Duration) 2 Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) W. Montgomer M. D.
Apr 6 1921 (Address) Caldwell Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill — DATE OF BURIAL: 4-7 1921

20. UNDERTAKER: C. V. Peckham — ADDRESS: Caldwell Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 3

Primary Registration District No. 1005

File No. 33281

Registered No. 43

County of Canyon

City of Caldwell (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED APR 11 1921 BUREAU OF VITAL STATISTICS

2. FULL NAME Mrs. Eleanor Anna Welch

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Dec 16 1880 (Month) (Day) (Year)

7. AGE: 40 Yrs. ..... Mos. 17 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Nebraska

10. NAME OF FATHER: J. S. Frank

11. BIRTHPLACE OF FATHER (State or Country): Wisconsin

12. MAIDEN NAME OF MOTHER: Anna Ammerman

13. BIRTHPLACE OF MOTHER (State or Country): Wisc.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Guy C. Welch
(Address) 818 Blaine

15. Filed Feb. 4 1921 John L. Meyer Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr. (Month) 3 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mch 24 1921 to April 2 1921 that I last saw h.r alive on April 2 1921, and that death occurred on the date stated above, at 11 M.

The CAUSE OF DEATH* was as follows:
Acute Dilation of Stomach
.....(Duration) ..... Yrs. ..... mos. 10 ds.
Contributory (Secondary) Insanity - Epileptic
.....(Duration) 10 yrs. ..... mos. ..... ds.

(Signed) S. R. Dudley M. D.
..... 19..... (Address) Caldwell Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill — DATE OF BURIAL: 4-4 1921

20. UNDERTAKER: CASE FURNITURE CO. — ADDRESS: Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 3

County of Canyon

Primary Registration District No. 2005

City of Caldwell (No.) County Poor Farm (St.)

File No. 33382

Registered No. 42

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME. [illegible]

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

RECEIVED APR 11 1921 BUREAU OF VITAL STATISTICS

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	[illegible]

6. DATE OF BIRTH

[illegible] 1 [illegible]
(Month) (Day) (Year)

7. AGE

71 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) [illegible]

(Address) Caldwell

15. Filed Mar. 29 1921

John A. Meyer
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 25 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 16 1921, to March 14 1921, that I last saw h.im. alive on March 14 1921, and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Cancer of Face

(Duration) 1 Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) M. Tracey M. D.

3-28 1921 (Address) Caldwell Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL [illegible] DATE OF BURIAL 3 29 19

20. UNDERTAKER CASE FURNITURE CO. ADDRESS Caldwell

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33384
Registered No. 40

Registration District No. 3
Primary Registration District No. 2005

RECEIVED
APR 1 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Canyon

City of Caldwell (If outside limits of city or village, write the name of township.) St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME J. H. Hanson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1886 (Year)

7. AGE: 35 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Sheepherder
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. R. Evans (Coroner)
(Address) Caldwell Ida

15. Filed Mar. 28 1921 John V. Meyer Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 3 (Month) 25 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 14 1921, to March 25 1921, that I last saw h[illegible] alive on March 1925, and that death occurred on the date stated above, at 4P M.

The CAUSE OF DEATH* was as follows:

Pneumonia

..... (Duration) ..... Yrs. ..... mos. 14 ds.

Contributory (Secondary) Coeld & Exposure

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) S. B. Headley M. D.

19..... (Address) Caldwell Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill — DATE OF BURIAL: 3-28 1921

20. UNDERTAKER: CASE FURNITURE CO. — ADDRESS: Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 1005
File No. 33385
Registered No. 39

RECEIVED
APR 11 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Canyon
City of Caldwell (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Dr. Harry Minor Steele

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
male	white	Married

6. DATE OF BIRTH: Aug (Month) 2 (Day) 1872 (Year)

7. AGE: 48 Yrs. 7 Mos. 19 ds. — IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Oculist
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Pennsylvania

10. NAME OF FATHER: David Steele

11. BIRTHPLACE OF FATHER (State or Country): Don't know

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Elizabeth K. Steele
(Address) Caldwell Ida

15. Filed Mar. 25 1921 — John L. Meyer — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 21 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 12 1921, to March 21 1921, that I last saw h.s alive on March 21 1921, and that death occurred on the date stated above, at 1.45 M.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) 24 hrs Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F. O. Smith D.C. M. D.

19..... (Address) Caldwell Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Canyon Hill	Mar. 25 1921

20. UNDERTAKER	ADDRESS
C. V. Peckham	Caldwell Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 3

Primary Registration District No. 2004

County of Canyon

City of Caldwell (No. ..... St.)

File No. 33286

Registered No. 38

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Justafson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: 12 (Month) ..... (Day) 1863 (Year)

7. AGE: 57 Yrs. 3 Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: farmer

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER: Justaf Erekson

11. BIRTHPLACE OF FATHER (State or Country): Sweaden

12. MAIDEN NAME OF MOTHER: Mary Carlson

13. BIRTHPLACE OF MOTHER (State or Country): Sweaden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John L. Meyer

(Address) Caldwell Ida

15. Filed Mar. 24 1921 John L. Meyer Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 3 (Month) 21 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 17 1921, to March 21 1921, that I last saw h.im alive on March 21 1921, and that death occurred on the date stated above, at 40 M.

The CAUSE OF DEATH* was as follows:

Cardiac (Senile)

Heart Block (Myocarditis)

(Duration) 2+ Yrs. ..... mos. ..... ds.

Contributory (Secondary) Senile Anaemia.

(Duration) 3+ yrs. ..... mos. ..... ds.

(Signed) S. B. Dudley M. D.

..... 19..... (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. 5 days. In the Caldwell Sanitarium State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill

DATE OF BURIAL: 3-24 1921

20. UNDERTAKER: CASE FURNITURE CO.

ADDRESS: Caldwell

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED
APR 11 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 2005
File No. 33387
Registered No. 37

1. PLACE OF DEATH

County of Canyon
City of Caldwell (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Richard Clay King

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Divorced (write the word)

6. DATE OF BIRTH: Dec (Month) 14 (Day) 1861 (Year)

7. AGE: 59 Yrs. 3 Mos. 6 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Stockman
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: James King.

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Orit Simon

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A. Lamont D. King
(Address) Caldwell Ida.

15. Filed Mar. 22 1921 John L. Jones
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 20 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1920, to Mar 1921 that I last saw h~~im~~ alive on Mar 10 1921 and that death occurred on the date stated above, at 5.45 P.M.

The CAUSE OF DEATH* was as follows:
Cardio-renal disease
high blood pressure
causing heart dilitation
(Duration) 7 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A. L. Montgomery M.D.
Mar 1 19 21 (Address) Caldwell Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill — DATE OF BURIAL: 3-22-1921

20. UNDERTAKER: V. Buckman — ADDRESS: Caldwell

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED APR 11 1921 BUREAU OF VITAL STATISTICS STATE OF IDAHO

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 4

Primary Registration District No. 2004

File No. 33388

Registered No.

1. PLACE OF DEATH

County of Ownyhee

City of ..... (If not in incorporated limits, give township.) ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Melchior Waldvogel

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: June (Month) 12 (Day) 1847 (Year)

7. AGE: 74 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Switzerland

10. NAME OF FATHER: Geo Waldvogel

11. BIRTHPLACE OF FATHER (State or Country): Switzerland

12. MAIDEN NAME OF MOTHER: Do not know

13. BIRTHPLACE OF MOTHER (State or Country): Switzerland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mary Waldvogel

(Address) Nyssa Ida

15. Filed April 9 1921 Pearle Dodds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 28 (Day) 21 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....

that I last saw h..... alive on ..... 19.....,

and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Death due to accidental discharge of 22 Cal. rifle in hands of one L. E. Waldvogle. Officials of Owyhee notified but no investigation made as far as I know

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Pearle Dodds Regstrar M. D.

..... 19..... (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Kohlerlawn Cem

DATE OF BURIAL: 4/ 1921

20. UNDERTAKER: F R Roberson

ADDRESS: Nampa Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

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FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33389
Registered No.

1. PLACE OF DEATH
County of Canyon
City of Nampa (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

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APR 11 1921
BUREAU OF VITAL STATISTICS

Registration District No. 7
Primary Registration District No. 1004

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Almeda Carpenter

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widow

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1853 (Year)

7. AGE: 67 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country):

10. NAME OF FATHER:

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country):

No other particulars available

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Ida Adler
(Address) Nampa Ida

15. Filed April 9 1921 Pearle Dodds Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 10 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1 1917, to Mar 8 1921 that I last saw her alive on Mar 8 1921 and that death occurred on the date stated above, at 7 P. M.
The CAUSE OF DEATH* was as follows:
Epilepsy
(Duration) 10 Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... Yrs. ..... mos. ..... ds.
(Signed) H. F. Ross M. D.
Mar 11 1921 (Address) Nampa Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Nampa Ida	3-12 1921
20. UNDERTAKER	ADDRESS
J K Robinson	Nampa

Ross

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33390

Registered No. .....

1. PLACE OF DEATH. RECEIVED APR 11 1921 BUREAU OF VITAL STATISTICS

Registration District No. 7

Primary Registration District No. 1006

County of Canyon

City of Nampa (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jacob Teeples Jr

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. (Month) 10 (Day) ..... (Year) 1894

7. AGE: 25 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Nevada

10. NAME OF FATHER: Jacob Teeples Sr.

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Dora Poyntz

(Address) Nampa

15. Filed April 9 1921 Pearle Dodds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (Month) Mch (Day) 13 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 9 1918, to Mch 13 1921, that I last saw him alive on Mch 13 1921, and that death occured on the date stated above, at 5 a M.

The CAUSE OF DEATH* was as follows:

Chronic interstitial Nephritis

(Duration) 3 Yrs. 11 mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Dora Poyntz M. D.

19 ..... (Address) Nampa Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. 2 yrs. 9 mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? Blackfoot Idaho

Former or usual residence Blackfoot Idaho

19. PLACE OF BURIAL OR REMOVAL: Firth Idaho — DATE OF BURIAL ..... 191.....

20. UNDERTAKER: Fred K Robinson — ADDRESS Nampa Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33391
Registered No.

RECEIVED
APR 11 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Canyon
City of Nampa
(No. , St.)

Registration District No. 7
Primary Registration District No. 106

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Agnes May Simonson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
female	white	single

6. DATE OF BIRTH: Apr. (Month) 24 (Day) 1891 (Year)

7. AGE: 29 Yrs. 11 Mos. 12 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Stenographer + bookkeeper
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Whitehall, Mich.

10. NAME OF FATHER: John H. Simonson

11. BIRTHPLACE OF FATHER (State or Country): Norway

12. MAIDEN NAME OF MOTHER: Birgitta S. Johnson

13. BIRTHPLACE OF MOTHER (State or Country): Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Alex. B. Simonson
(Address) Sandusky, Mich.

15. Filed April 9 19 Pearle Dodds
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 6 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 2 1921, to April 6 1921
that I last saw her alive on April 6 1921
and that death occurred on the date stated above, at 5-2 A. M.
The CAUSE ~~OF~~ DEATH* was as follows:
Tuberculosis
Pulmonary
(Duration) Yrs. 6 mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) J. P. Murray M. D.
April 6 1921 (Address) Nampa Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Whitehall, Mich. DATE OF BURIAL 19

20. UNDERTAKER: Fred K Robinson ADDRESS Nampa Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY; PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33392

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

RECEIVED
APR 11 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH.

Registration District No. 7

Primary Registration District No. 1006

County of Canyon

City of Nampa (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ena Howard Gossett

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. June (Month) 28 (Day) 1912 (Year)

7. AGE: 8 Yrs. 2 Mos. 29 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... None

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Grassy Nev.

10. NAME OF FATHER B. F. Gossett

11. BIRTHPLACE OF FATHER (State or Country) Nev.

12. MAIDEN NAME OF MOTHER Flora E. Green

13. BIRTHPLACE OF MOTHER (State or Country) Nev.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Dora Poynter

(Address) Nampa Idaho

15. Filed April 1 1921 Pearle Dodds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 30 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 25 1921, to March 30 1921, that I last saw him alive on March 30 1921, and that death occured on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(Duration) ..... Yrs. ..... mos. 5 ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Dora Poynter M. D.

3/30/1921 (Address) Nampa Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. 2 yrs. 4 mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence Boise Idaho

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: April 1 1921

20. UNDERTAKER: Summers & Kibbe — ADDRESS: Boise Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

BYNS - YORK CO., PTRS. & BORS. 24653

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33393
Registered No.

1. PLACE OF DEATH

County of Canyon
City of Nampa
If death occurs away from usual residence, give facts called for under special information.

RECEIVED
APR 15
BUREAU OF VITAL STATISTICS

Registration District No. 7
Primary Registration District No. 1062
(No. Nazarin's Sanitarium St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Margaret M. Legard

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widow (Write the word.)

6. DATE OF BIRTH: July (Month) 6 (Day) 1849 (Year)

7. AGE: 71 Yrs. ... Mos. ... ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House Wife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Denmark

10. NAME OF FATHER: Claus Muhs

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) [illegible]
(Address) Nampa Ida

15. Filed April 9 1921 Pearle Dodds
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar (Month) – 20 (Day) – 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 2nd 1921, to Mar 20 1921, that I last saw her alive on Mar 20 – 1921 – and that death occurred on the date stated above, at 5 P.M.
The CAUSE OF DEATH* was as follows:
Carcinoma of Cervix

Several (Duration) ... Yrs. ... mos. ... ds.
Contributory (Secondary)
(Duration) ... yrs. ... mos. ... ds.
(Signed) Thos. E. Mangum M. D.
19... (Address) Nampa Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Kohlerlawn Cem — DATE OF BURIAL: 3-22-1921

20. UNDERTAKER: F K Robinson — ADDRESS: Nampa Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33394
Registered No.

1. PLACE OF DEATH

County of Canyon

City of Nampa

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 7

Primary Registration District No. 1006

(No. ..... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

RECEIVED
APR 11 19
BUREAU OF VITAL STATISTICS

2. FULL NAME Celina Mary Harris

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married. (Write the word.)

6. DATE OF BIRTH: May, 24th, 1874 (Month, Day, Year)

7. AGE: 47 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day: how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Minnesota

10. NAME OF FATHER: Ben Bernard

11. BIRTHPLACE OF FATHER (State or Country): Canada.

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country): Canada.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Phil Harris

(Address) Homedale Ida

15. Filed April 9 1921 Pearle Dodds
Local Registrar

SUNSET-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April, 14, 1921 (Month, Day, Year)

17. I HEREBY CERTIFY, That ~~I attended deceased from~~ deceased died while being moved from Homedale, Idaho to Mercy Hospital at Nampa, 19 ..... to 19 ..... that I last saw h[illegible] alive on ..... 19 .....

and that death occurred on the date stated above, at 10:30 P.M.

The CAUSE OF DEATH* was as follows:

Acute dilitation of heart.

..... (Duration) — Yrs. — mos. — ds.

Contributory (Secondary) Chronic Brights

..... (Duration) 7 yrs. — mos. — ds.

(Signed) Geo. A. Kellogg M. D.

19..... (Address) Nampa, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Kohlerdown Cem	Apr 13 1921
20. UNDERTAKER	**ADDRESS**
Fred K. Robinson	Nampa Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33395
Registered No.

1. PLACE OF DEATH

County of Canyon
City of Nampa
If death occurs away from usual residence, give facts called for under special information.

RECEIVED
APR 11 1921
BUREAU OF VITAL STATISTICS

Registration District No. 7
Primary Registration District No. 1006
(No. ... St.)

2. FULL NAME Lewis Phillips Heatherwax

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH Apr (Month) 17 (Day) 1847 (Year)

7. AGE 73 Yrs. 11 Mos. 12 ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry, business or establishment in which employed (or employer) (Retired)

9. BIRTHPLACE (State or Country) New York

10. NAME OF FATHER Thomas Heatherwax

11. BIRTHPLACE OF FATHER (State or Country) U. S.

12. MAIDEN NAME OF MOTHER Jane Clark

13. BIRTHPLACE OF MOTHER (State or Country) U. S.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) L. P. Heatherwax
(Address) Minot, No. Dak.

15. Filed April 9 1921 Pearle Dodds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March (Month) 31 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sometime prior to death 19..., to ... 19...
that I last saw h... alive on ... 19...
and that death occurred on the date stated above at Died during afternoon of night P.M.
The CAUSE OF DEATH* was as follows:
Heart failure only cause known.

(Duration) ... Yrs. ... mos. ... ds.
Contributory (Secondary)
(Duration) ... yrs. ... mos. ... ds.

(Signed) J. H. Murray M. D.
April 1 1921 (Address) Nampa Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Rohlerdawn Cem	4/5 1921
20. UNDERTAKER H. T. Robinson	ADDRESS Nampa

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33396

Registration District No. 7

Primary Registration District No. 1022

Registered No.

RECEIVED APR 11 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Canyon

City of ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Verlin F Compton

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH: June (Month) 12 (Day) 1 (Year)

7. AGE: 3 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): ~~Ark~~ Idaho

10. NAME OF FATHER: E. C. Compton

11. BIRTHPLACE OF FATHER (State or Country): Ark

12. MAIDEN NAME OF MOTHER: Nora Edmundson

13. BIRTHPLACE OF MOTHER (State or Country): Ark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E. C. Compton

(Address) Nampa Ida

15.

Filed April 9 1921 Pearle Dodds Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 4 (Month) 2 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4 — 1 1921, to 4 — 2 1921, that I last saw him alive on 4 — 2 1921, and that death occurred on the date stated above, at 8 A.M.

The CAUSE OF DEATH* was as follows:

Shock

(Duration) 2½ hrs. ..... mos. ..... ds.

Contributory (Secondary) Burning of his clothing

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. C. Robinson M. D.

4-4 1921 (Address) Nampa

*State the *Disease Causing Death*; or in deaths from **Violent Causes**, state (1) **Means of Injury**; and (2) whether **Accidental, Suicidal or Homicidal.**

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Kohlerlawn Cem — DATE OF BURIAL: 4-3 1921

20. UNDERTAKER: F K Robinson — ADDRESS: Nampa

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 1006
File No. 33397
Registered No.

RECEIVED
APR 11 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Canyon
City of Nampa (If outside limits of city or village, write the name of township.) Mercy Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Leah Mae Chase

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Fem	white	single

6. DATE OF BIRTH May (Month) 11 (Day) 1919 (Year)

7. AGE 1 Yrs. 8 Mos. ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Utah

10. NAME OF FATHER Geo A Chase

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Susan Whitmore

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Geo A Chase
(Address) Nampa Ida

15. Filed April 9 1921 Pearle Dodds Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mar (Month) 13 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mch-12- 1921, to Mch-13- 1921, that I last saw her alive on Mch-13- 1921, and that death occurred on the date stated above, at 5 A. M.

The CAUSE OF DEATH* was as follows:

Septic peritonitis, following perforation of intestine by swallowed pin

(Duration) Yrs. mos. 2 ds.

Contributory (Secondary) Swallowed pin. E. D.

(Duration) yrs. mos. ds.

(Signed) F. B. Smith M. D.

4/9- 1921 (Address) Nampa Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Springville Utah | **DATE OF BURIAL** 19

20. UNDERTAKER F K Robinson | **ADDRESS** Nampa

Smith

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33398
Registered No.

1. PLACE OF DEATH

Registration District No. 7
Primary Registration District No. 1004
County of Canyon
City of Nampa (If outside limits, give township) 721 - 11th Ave N St.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
APR 11 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME Calvin H. Taylor

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Jan (Month) 4 (Day) 1836 (Year)

7. AGE: 86 Yrs. ... Mos. ... ds.

IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer): (Retired)

9. BIRTHPLACE (State or Country): N. Y

10. NAME OF FATHER: —

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Melissa Taylor
(Address) Nampa Ida

15.
Filed April 9 1921 Pearl Dodds
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 2 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 14 1921, to April 2 1921 that I last saw h.im alive on April 2 1921 and that death occurred on the date stated above, at 9-P. M.

The CAUSE OF DEATH* was as follows:

Senile Cirrhosis

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) J. P. Murray M. D.
April 3 1921 (Address) Nampa Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rohberlawn Cem — DATE OF BURIAL: 4-4 1921

20. UNDERTAKER: F. H. Robinson — ADDRESS: Nampa

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33399

Registered No.

1. PLACE OF DEATH

County of Canyon

City of Nampa

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No. 2554

(No. ..... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lewis W Corwin

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	white	married

6. DATE OF BIRTH: Mar (Month) 29 (Day) 1851 (Year)

7. AGE: 69 Yrs. ✓ Mos. ✓ ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Indiana

10. NAME OF FATHER: Jos Corwin

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs V C Perry
(Address) Nampa Ida

15. Filed March 10 1921 Pearl Dodds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 27 (Day) 21 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan Feb 3 1921, to Feb 27 1921, that I last saw him alive on Feb 27 1921, and that death occurred on the date stated above, at 7P M.

The CAUSE OF DEATH* was as follows:

Acute dilatation heart

(Duration) ..... Yrs. ..... mos. 3 ds.

Contributory (Secondary) Gall stones (Operation 2/3/21 (Duration) about 3 yrs. ..... mos. ..... ds.

(Signed) Horace C Belknap M. D.

3/10 1921 (Address) Nampa Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Nampa Ida	3-1 1921

20. UNDERTAKER	ADDRESS
Fred K. Robinson	Nampa Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 1116
File No. 3240
Registered No.

1. PLACE OF DEATH

County of Canyon
City of Nampa
(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William McAnally

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	

6. DATE OF BIRTH: April (Month) 21 (Day) 1852 (Year)

7. AGE: 70 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: Thomas McAnally

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Anne Sims

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. M. McAnally
(Address)

15. Filed March 10 1921 Pearle Dodds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 17 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 8 1921 to Feb 13 1921 that I last saw him alive on Feb 13 1921 and that death occurred on the date stated above, at 4 a. M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Bladder & metastasis.

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Leo N Chilton M. D.
2/10 1921 (Address) Nampa Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Nampa Idaho
DATE OF BURIAL: 2-15 1921

20. UNDERTAKER: None
ADDRESS: —

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CE[redacted] OF D[redacted]

[redacted]s of Idaho
BOA[redacted]D OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Canyon

City of Nampa

If death occurs away from usual residence, give facts called for under special information.

Registration Dis[redacted] No.

Primary Registration District No. 1006

(No. ..., ...St.)

File No. 33401

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Louisa J. Hazeltine

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: ... 1848
(Month) (Day) (Year)

7. AGE: 72 Yrs. ... Mos. ... ds.

IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer): ...

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: ...

11. BIRTHPLACE OF FATHER (State or Country): ...

12. MAIDEN NAME OF MOTHER: ...

13. BIRTHPLACE OF MOTHER (State or Country): ...

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs E. Hull

(Address) Boise Ida

15. Filed Mar. 10 1921 Pearle Dodds
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar 5 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3-5 1921, to 3-5 1921 that I last saw her alive on 3-4 1921, and that death occurred on the date stated above, at 1:30 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage Apoplexy

(Duration) instant mos. ... ds.

Contributory (Secondary) Arterio Sclerosis (Duration) ... yrs. ... mos. ... ds.

(Signed) H E Robinson M. D.

3-7 1921 (Address) Nampa

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death? ...

Former or usual residence ...

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Payette Ida	... 19...
20. UNDERTAKER	**ADDRESS**
Fred K. Robinson	Nampa Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED
APR 25 19[illegible]
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 1006
File No. 33409
Registered No. 3340[illegible]

1. PLACE OF DEATH
County of Canyon
City of Nampa (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Rudolph H. Hopper
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.):

6. DATE OF BIRTH: Feb (Month) 1 (Day) 1921 (Year)

7. AGE: ~ Yrs. ~ Mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: ✓
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Wm B. Hopper

11. BIRTHPLACE OF FATHER (State or Country): Mo.

12. MAIDEN NAME OF MOTHER: Mary Heibel

13. BIRTHPLACE OF MOTHER (State or Country): Switzerland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Wm B. Hopper
(Address): Nampa Ida

15. Filed March 10 1921 Pearle Dodds Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 11 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 1 1921 to Feb 11 1921, that I last saw him alive on Feb 11 1921, and that death occurred on the date stated above, at 8 A.M.

The CAUSE OF DEATH* was as follows:
Failure of pneumonia
bronchial Pleurisy

(Duration) ..... Yrs. ..... mos. 3 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Leo W Chilton M. D.
1921 (Address) Nampa Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Kohler Lawn
DATE OF BURIAL: 2-11 1921

20. UNDERTAKER: None
ADDRESS

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 1022
File No. 33403
Registered No.

1. PLACE OF DEATH

County of Canyon
City of Nampa
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elizabeth Mensing

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Fem	white	Married

6. DATE OF BIRTH

..... (Month) ..... (Day) 1877 (Year)

7. AGE

43 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Germany

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country) Germany

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER (State or Country) Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A C Mensing
(Address) Nampa Ida

15. Filed March 13 1921 Earle Dodds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb (Month) 11 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 8 1920, to Sept 22 1921 that I last saw her alive on Feb 1 1921 and that death occurred on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 1 Yrs. 6 mos. — ds.

Contributory (Secondary) Lobar Pneumonia

(Duration) — yrs. 1 mos. — ds.

3/10 1921 (Signed) Leon Chilton M. D. (Address) Nampa Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Nampa Ida — **DATE OF BURIAL** 3/13 1921

20. UNDERTAKER F. R. Robinson — **ADDRESS** Nampa Ida

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

E+B

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. ____
Primary Registration District No. 1004
File No. 33404
Registered No. ____

1. PLACE OF DEATH
County of Canyon
City of Nampa
(No. Mercy Hospital St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Infant Son of Mr. & Mrs. Messenger

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	

6. DATE OF BIRTH: March (Month) 6 (Day) 1921 (Year)

7. AGE: 0 Yrs. 0 Mos. 6 ds.
IF LESS than 1 day how many ____ hrs. or 36 min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ____
(b) General nature of industry, business or establishment in which employed (or employer) ____

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER C. H. Messenger

11. BIRTHPLACE OF FATHER (State or Country) Iowa

12. MAIDEN NAME OF MOTHER Meyers

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. H. Messenger
(Address) Nampa Ida

15. Filed March 16 1921 Pearle Dodds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 6 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ____ 19____, to March 6 1921
that I last saw h. im alive on March 6 1921,
and that death occurred on the date stated above, at 6 A.M.
The CAUSE OF DEATH* was as follows:
Premature birth, 6 months
Miscarriage

(Duration) 1 Yrs. 0 mos. 0 ds.
Contributory (Secondary) ____
(Duration) 0 yrs. 0 mos. 0 ds.
(Signed) Geo. D. Arthur M. D.
19____ (Address) Nampa, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days
Where was disease contracted if not at place of death? ____
Former or usual residence ____

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Nampa Ida	3-7 1921
20. UNDERTAKER	ADDRESS
J. R. Robinson	Nampa Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33405
Registered No.

1. PLACE OF DEATH

County of Canyon

City of Nampa

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 7

Primary Registration District No. 1004

(No. Mercy Hospital St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Infant Son of Mr + Mrs Messenger

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	

6. DATE OF BIRTH: March (Month) 6 (Day) 1921 (Year)

7. AGE: 0 Yrs. 0 Mos. 0 ds. IF LESS than 1 day how many 2 hrs. or 0 min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: ✓
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER C H Messenger

11. BIRTHPLACE OF FATHER (State or Country) Iowa

12. MAIDEN NAME OF MOTHER Meyers

13. BIRTHPLACE OF MOTHER (State or Country) Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C H Messenger
(Address) Nampa Ida

15. Filed March 10 1921 Pearle Dodds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 6 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ——— 19—, to March 6 1921 that I last saw h— alive on Mar. 6 1921 and that death occurred on the date stated above, at 1 A.M.

The CAUSE OF DEATH* was as follows:

Premature birth (6 mos.)

(Duration) ——— Yrs. ——— mos. ——— ds.

Contributory (Secondary)

(Duration) ——— yrs. ——— mos. ——— ds.

(Signed) Geo. A. Anderson M. D.

19— (Address) Nampa Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ——yrs.——mos.——days. In the State——yrs.——mos.——days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Nampa Idaho	3-7 1921
20. UNDERTAKER Fred K. Robinson	ADDRESS Nampa Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 9
Primary Registration District No. 1005
File No. 33406
Registered No.

1. PLACE OF DEATH
County of Canyon
City of Caldwell
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Wm Isaac

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
male	white	

6. DATE OF BIRTH: Oct (Month) 17 (Day) 1851 (Year)

7. AGE: 69 Yrs. 4 Mos. 23 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Stock Man
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New York State Orange Co.

10. NAME OF FATHER: James Isaac

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Mary Thorne

13. BIRTHPLACE OF MOTHER (State or Country): New York - Orange Co

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): [illegible]
(Address): Caldwell Idaho

15. Filed Mar. 13 - 1921 John B. Mayes
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 10 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 8 1921, to Mar 10 1921, that I last saw h[illegible] alive on Mar 10 1921, and that death occurred on the date stated above, at 1130 A.M.
The CAUSE OF DEATH* was as follows:
Pneumonia

(Duration) ..... Yrs. ..... mos. 3 ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C M Haley M. D.
3-12-1921 (Address) Caldwell Ida.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill — DATE OF BURIAL: 3/13 1921

20. UNDERTAKER: C. V. Peckham — ADDRESS: Caldwell Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

Registration District No. 3

Primary Registration District No. 2005

(No. ....., ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33407

Registered No. 33

1. **PLACE OF DEATH**

County of Canyon

City of Caldwell

If death occurs away from usual residence, give facts called for under special information.

2. **FULL NAME** Mrs Mary Olive Taylor

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. **SEX**: F

4. **COLOR OR RACE**: white

5. **SINGLE, MARRIED, WIDOWED OR DIVORCED** (Write the word.): widowed

6. **DATE OF BIRTH**: July (Month) 31 (Day) 1852 (Year)

7. **AGE**: 68 Yrs. 7 Mos. 9 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. **OCCUPATION**

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. **BIRTHPLACE** (State or Country): Miss.

10. **NAME OF FATHER**: Wm Ballard

11. **BIRTHPLACE OF FATHER** (State or Country): Pa

12. **MAIDEN NAME OF MOTHER**: Margaret ——

13. **BIRTHPLACE OF MOTHER** (State or Country): Pa

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**

(Informant) Mrs N. S. Shelley

(Address) Parma Idaho

15. Filed Mar. 12 1921

John C. Meyer
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH**: March (Month) 10 (Day) 1921 (Year)

17. **I HEREBY CERTIFY**, That I attended deceased from March 10 1921, to March 10 1921 that I last saw her alive on March 10, 1921, and that death occurred on the date stated above, at 7:30 P.M.

The **CAUSE OF DEATH*** was as follows:

Pneumonia

..... (Duration) ..... Yrs. ..... mos. 3 ds.

Contributory (Secondary) exposure, low resistance, age.

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) R. S. Skaden M.D. M. D.

1921 (Address) Caldwell, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. **PLACE OF BURIAL OR REMOVAL**: Canyon Hill.

DATE OF BURIAL: 3-13 1921

20. **UNDERTAKER**: CASE FURNITURE CO.

ADDRESS: Caldwell

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 2005
File No. 33408
Registered No. 34

1. PLACE OF DEATH
County of Canyon
City of Wilder
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mable E Geisler
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: ~~Write the words~~ M

6. DATE OF BIRTH: June 18 (Month) (Day) 1897 ~~1898~~ (Year)

7. AGE: 23 Yrs. 8 Mos. 22 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Home Wife.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ontario Canada

10. NAME OF FATHER: Wm. John Radley.

11. BIRTHPLACE OF FATHER (State or Country): Canada

12. MAIDEN NAME OF MOTHER: Margaret Ann White

13. BIRTHPLACE OF MOTHER (State or Country): Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Henry C. Riegler
(Address) Wilder Idaho.

15. Filed May 12 1921 John S. Irwin Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 10 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 10 1921, to Mar 19 21
that I last saw h.er alive on Mar 10 1921,
and that death occurred on the date stated above, at 12-15 P.M.,
The CAUSE OF DEATH* was as follows:
Shock or toxemia
as result of burn

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. V. Beckham M. D.
(Address) Wilder Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Wilder Cem. DATE OF BURIAL: 3-12-1921

20. UNDERTAKER: C. V. Beckham ADDRESS: Caldwell

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 9
Primary Registration District No. 2009
(No. ..... St.)

File No. 33409
Registered No. 38

1. PLACE OF DEATH

County of Canyon
City of Wilder.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Dorothy Marie Giesler

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
female	white.	

6. DATE OF BIRTH: Nov. (Month) 4 (Day) 1919 (Year)

7. AGE: 1 Yrs. 4 Mos. 6 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: Henry C. Giesler.

11. BIRTHPLACE OF FATHER (State or Country): Kansas.

12. MAIDEN NAME OF MOTHER: Mable E. Radley.

13. BIRTHPLACE OF MOTHER (State or Country): Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Henry C. Giesler
(Address) Wilder Idaho

15. Filed Mar. 12 1921 John S. Meyer. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 10 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....
and that death occurred on the date stated above, at 6:30 P.M.
The CAUSE OF DEATH* was as follows:

Burned to death

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

19..... (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Wilder Cem — DATE OF BURIAL: 3-12-1921

20. UNDERTAKER: C. V. Peckham — ADDRESS: Caldwell

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 1005
File No. 3340
Registered No. 32

1. PLACE OF DEATH
County of Canyon
City of Caldwell (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Flora Maria Cole
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: White

5. ~~SINGLE, MARRIED~~, WIDOWED ~~OR DIVORCED~~ (Write the word.): Widowed

6. DATE OF BIRTH: August (Month) 15 (Day) 1845 (Year)

7. AGE: 75 Yrs. 6 Mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Huron Co. Ill.

10. NAME OF FATHER: Wm Crowley

11. BIRTHPLACE OF FATHER (State or Country): Vermont

12. MAIDEN NAME OF MOTHER: Eliza Ann Campbell

13. BIRTHPLACE OF MOTHER (State or Country): Vermont

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. M. Cole
(Address) Caldwell Idaho

15. Filed Mar. 10 1921 John S. Meyer. Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 9 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1919 to March 9 1921 that I last saw h.e.r. alive on March 9 1921 and that death occurred on the date stated above, at 5-10 P.M.

The CAUSE OF DEATH* was as follows:
Pernicious Anemia

(Duration) 2 Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Cole M. D.
3/9 1921 (Address) Caldwell, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Salvador
DATE OF BURIAL ..... 19.....

20. UNDERTAKER: CASE FURNITURE CO.
ADDRESS: Caldwell

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 2005
File No. 33412
Registered No. 30

1. PLACE OF DEATH
County of Oyhee
City of Homedale
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Joel Hewitt

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widower

6. DATE OF BIRTH: Feb 1 1843 (Month) (Day) (Year)

7. AGE: 78 Yrs. 1 Mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Indiana

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wm Hogg
(Address) Homedale

15. Filed Mar. 4- 1921 John S. Meyer
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 4 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Heart failure
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) old age
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Paul L Bass M. D.
19..... (Address) Caldwell Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Robinette Oregon
DATE OF BURIAL: 3-6 1921

20. UNDERTAKER: CASE FURNITURE CO.
ADDRESS: Caldwell

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 8
Primary Registration District No. 2005
File No. 33413
Registered No. 29

1. **PLACE OF DEATH**
County of Canyon
City of Greenleaf
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. **FULL NAME** William Tasmant Dunbar
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
male	white	single

6. **DATE OF BIRTH** Dec (Month) 18 (Day) 1897 (Year)

7. **AGE** 23 Yrs. 2 Mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. **OCCUPATION**
(a) Trade, profession or particular kind of work Rancher
(b) General nature of industry, business or establishment in which employed (or employer)

9. **BIRTHPLACE** (State or Country) Kansas

10. **NAME OF FATHER** J. Allen Dunbar

11. **BIRTHPLACE OF FATHER** (State or Country) Kansas

12. **MAIDEN NAME OF MOTHER** Virginetta Haworth

13. **BIRTHPLACE OF MOTHER** (State or Country) Kansas

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**
(Informant) J. Allen Dunbar
(Address) Greenleaf Idaho

15. Filed Mar. 3 - 1921 John S. Meyer Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH** March 1 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 26 1921, to Feb 24 1921, that I last saw him alive on Feb 24 1921, and that death occurred on the date stated above, at 7-15 P.M.

The CAUSE OF DEATH* was as follows:
Tuberculosis

(Duration) ..... Yrs. ..... mos. 29 ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) R. E. Nida M.D.
19..... (Address) Caldwell Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. **PLACE OF BURIAL OR REMOVAL** Canyon Hill. **DATE OF BURIAL** 3-4 1921

20. **UNDERTAKER** O. V. Peckham **ADDRESS** Caldwell

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 2005
(No. ..... St.)

File No. 33414
Registered No. 28

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Canyon
City of Nampa

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Joseph W Hobson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Unknown (Month) (Day) 1 (Year)

7. AGE: 25 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): Section foreman 9-15

9. BIRTHPLACE (State or Country): Marysville Idaho

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) D O'Boyle
(Address) Nampa Idaho

15. Filed Mar. 1 1921 John L. Meyer Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feby (Month) 28 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to 2-28 1921, that I last saw him alive on Feby 28 1921, and that death occured on the date stated above, at 5-30 P.M.

The CAUSE OF DEATH* was as follows:
Accidentally Struck in temple by crow bar while unloading Boiler from R R Car Killing Instantly (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) D O'Boyle M. D.
2/28 1921 (Address) Nampa Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 2 yrs. 6 mos. ..... days. In the State Unknown ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence Marysville Idaho

19. PLACE OF BURIAL OR REMOVAL: Nampa Idaho — DATE OF BURIAL: ..... 191...

20. UNDERTAKER: CASE FURNITURE CO. — ADDRESS: Nampa Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

6V100 - YORK CO., PTRS. & 6085. 24653

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Canyon — Registration District No. 3

City of Caldwell — Primary Registration District No. 2005 — File No. 3415

(No. ..... St.) — Registered No. 27

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Owen Eugene Raymond

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH: 2 (Month) 24 (Day) 1921 (Year)

7. AGE: ..... Yrs. ..... Mos. 1 ds. — IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Justus R Raymond

11. BIRTHPLACE OF FATHER (State or Country) Colorado

12. MAIDEN NAME OF MOTHER Emma Crawford

13. BIRTHPLACE OF MOTHER (State or Country) Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J R Raymond
(Address) Caldwell Route 2

15. Filed Feb. 26 1921 — John A. Imeyer, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 24 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 24 1921, to Feb 24 1921
that I last saw him alive on Feb 24 1921
and that death occurred on the date stated above, at 2.30 P.M.

The CAUSE OF DEATH* was as follows:
Asphyxiation due to head lacerations during delivery
..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D. Montgomery M. D.
Feb 25 1921 (Address) Caldwell, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Canyon Int Cem	Feb 26 1921

20. UNDERTAKER CASE FURNITURE CO. — ADDRESS Caldwell

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Talley

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 5

Primary Registration District No. 2005

File No. 3316

Registered No. 26

County of Canyon

City of Caldwell (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James Harding Thompson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH: Oct. (Month) 24 (Day) 1920 (Year)

7. AGE: Yrs. 3 Mos. 27 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: J. A. Thompson

11. BIRTHPLACE OF FATHER (State or Country): Indiana

12. MAIDEN NAME OF MOTHER: Grace Robinson

13. BIRTHPLACE OF MOTHER (State or Country): Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. A. Thompson

Address Huston Idaho

15. Filed Feb. 22 - 1921 John L. Meyer - Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 21 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 12 1921 to Feb 12 1921 that I last saw h[illegible] alive on Jan 12 1921 and that death occurred on the date stated above, at 2-30 P.M.

The CAUSE OF DEATH* was as follows: Probably Pneumonia

I did not see after above date attended by phone

(Duration) once yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. M. Talley M. D.

2-22 1921 (Address) Caldwell Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Pleasant Ridge	2-22 1921
20. UNDERTAKER	ADDRESS
C. T. Peckham	Caldwell

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 1005
(No. ..... St.)

File No. 3417
Registered No. 23

1. **PLACE OF DEATH**

County of Canyon
City of Caldwell
If death occurs away from usual residence, give facts called for under special information.

2. **FULL NAME** Mrs Emily Page Hart

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Married

6. **DATE OF BIRTH** Dec. (Month) 26 (Day) 1841 (Year)

7. **AGE** 79 Yrs. 1 Mos. 23 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. **OCCUPATION**
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. **BIRTHPLACE** (State or Country) Ills

10. **NAME OF FATHER** Wm Page

11. **BIRTHPLACE OF FATHER** (State or Country) Virginia

12. **MAIDEN NAME OF MOTHER** Polly Edrington

13. **BIRTHPLACE OF MOTHER** (State or Country) Kentucky

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**
(Informant) E. Mae Hart
(Address) Caldwell, Idaho.

15. Filed Feb. 19 1921 John A. Meyer Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH** Feb (Month) 19 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 6 1921, to Feb. 19 1921, that I last saw h.. alive on Feb 19 1921, and that death occurred on the date stated above, at 7.45 A.M. The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... Yrs. ..... mos. 8 ds.
Contributory (Secondary) Cold
(Duration) ..... yrs. ..... mos. 10 ds.

(Signed) Sth. ... ey M. D.
19..... (Address) Caldwell Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. **PLACE OF BURIAL OR REMOVAL** Canyon Hill — **DATE OF BURIAL** 2-21-1921

20. **UNDERTAKER** CASE FURNITURE CO. — **ADDRESS** Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 2005
File No. 33418
Registered No. 24

1. PLACE OF DEATH
County of Canyon
City of Caldwell
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lea Riley Allen
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: ~~married~~ widowed

6. DATE OF BIRTH: July (Month) 12 (Day) 1861 (Year)

7. AGE: 59 Yrs. 7 Mos. 6 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Wm M Allen

11. BIRTHPLACE OF FATHER (State or Country): Indiana

12. MAIDEN NAME OF MOTHER: Eliza Holland

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Norman C Allen
(Address) Notus Ida #1

15. Filed Feb. 21 1921 — John L. Meyer — Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 18 (Day) 1921 (Year) — Feb.

17. I HEREBY CERTIFY, That I attended deceased from May 30 1920, to July 10 1920 — about 4 weeks
that I last saw h[illegible] alive on ..... 19..... before death.
and that death occurred on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:
Chronic Bright's Disease
..... (Duration) 2 Yrs. ..... mos. ..... ds. probably
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Henry M. D.
19..... (Address) Caldwell Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill. — DATE OF BURIAL: 2-21 1921

20. UNDERTAKER: [illegible] Peckham — ADDRESS: Caldwell

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 1005
(No. ..... St.)

File No. 33419
Registered No. 23

1. PLACE OF DEATH
County of Canyon
City of Caldwell
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William F. Small
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: (write the word) Divorced

6. DATE OF BIRTH: May (Month) 23 (Day) 1861 (Year)

7. AGE: 59 Yrs. 8 Mos. 24 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Carpenter
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wisconsin

10. NAME OF FATHER: Jim Small

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Elizabeth Herring

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) James Small
(Address) Caldwell, Ida.

15. Filed Feb. 18 1921 John L. Meyer
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 17 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 10 1920 to Feb 16 1921
that I last saw h.im alive on Feb 16 1921,
and that death occurred on the date stated above, at 7.2 M.
The CAUSE OF DEATH* was as follows:
Cancer of face.

(Duration) 4 Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) T. D. Frost M. D.
2/18 1921 (Address) Caldwell Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Canyon Hill	2-19 1921
20. UNDERTAKER	ADDRESS
V. Peckham	Caldwell

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3420
Registered No. 22

1. PLACE OF DEATH
County of Canyon
City of Caldwell
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 9
Primary Registration District No. 1005
(No. ..... St.)

2. FULL NAME Charles Henry Turner

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: January (Month) 30 (Day) 1861 (Year)

7. AGE: 60 Yrs. 0 Mos. 27 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Stockman
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Charles Turner

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Susan Bidwell

13. BIRTHPLACE OF MOTHER (State or Country): Rhode Island

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. J. Roth
(Address) Caldwell Ida.

15. Filed Feb. 19 1921 John L. Meyer
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 16 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH was as follows:*
Dr. Gilbreath with Ray Turner Stroke
Shortness of breath
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Paul L. Lamm M. D.
2-19-21 (Address) Caldwell Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill
DATE OF BURIAL: 2-20 1921

20. UNDERTAKER: CASE FURNITURE CO.
ADDRESS: Caldwell

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 2045
File No. 33421
Registered No. 27

1. PLACE OF DEATH
County of Canyon
City of Caldwell
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William H. H. Bellinger
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH: Jan. (Month) 14 (Day) 1846 (Year)

7. AGE: 75 Yrs. 0 Mos. 27 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Tennessee

10. NAME OF FATHER: Wm Bellinger

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: Mary Davis

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. M. Bellinger
(Address) Caldwell

15. Filed Feb. 11 1921 John L. Mayo
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: X 2 (Month) 11 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 7 1920, to Feb 10 1921, that I last saw h.. alive on Feb 10 1921, and that death occurred on the date stated above, at 6 A. M. 2-11-21

The CAUSE OF DEATH* was as follows:
Asthenia
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Ch. Myocarditis Age.
..... (Duration) 10+ yrs. ..... mos. ..... ds.
(Signed) J. B. Dudley M. D.
..... 19..... (Address) Caldwell Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence (Canyon Hill)

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill | DATE OF BURIAL: Feb 13 1921

20. UNDERTAKER: [illegible] FURNITURE CO. | ADDRESS: Caldwell

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 2005
File No. 33422
Registered No. 20

1. PLACE OF DEATH

County of Canyon
City of Middleton
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Maurice W. Hamer

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: 8 (Month) 11 (Day) 1917 (Year)

7. AGE: Yrs. 3 Mos. 5 ds. 29

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: (—)

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: J W Hamer

11. BIRTHPLACE OF FATHER (State or Country): Penna

12. MAIDEN NAME OF MOTHER: Helen R Clarke

13. BIRTHPLACE OF MOTHER (State or Country): Penna

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant): J W Hamer

(Address): Middleton Ida

15. Filed Feb. 11 1921 — John A Meyer — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 2 (Month) 10 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feby 3 1921, to Feby 10 1921, that I last saw him alive on Feby 10 1921, and that death occurred on the date stated above, at .....M.

The CAUSE OF DEATH* was as follows:

"Flu"

(Duration) ..... Yrs. ..... mos. 7 ds.

Contributory (Secondary) Frontal Sinus Abcess

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J W Hamer M. D.

19..... (Address) Middleton Ida

*State the **Disease Causing Death**; or in deaths from **Violent Causes**, state (1) **Means of Injury**; and (2) whether **Accidental, Suicidal or Homicidal.**

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Middleton — **DATE OF BURIAL:** 2-11 1921

20. UNDERTAKER: C. V. Peckham — **ADDRESS:** Caldwell

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 2005
File No. 33423
Registered No. 19

1. PLACE OF DEATH
County of Canyon
City of Caldwell
(No. ..... (St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Christopher (Kit Carson) Stover
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Apr (Month) 17 (Day) 1844 (Year)

7. AGE: 77 Yrs. 9 Mos. 14 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio.

10. NAME OF FATHER: Thomas Stover

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Caroline —

13. BIRTHPLACE OF MOTHER (State or Country): Ohio.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Bert Black
(Address) Caldwell Ida.

15. Filed Feb. 11th 1921 John S. Meyer Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 9 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I did not attend deceased, from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Examined deceased 1½ hours after death. From history of case believe death resulted from disease of Heart & Internal Injuries due to a fall.
(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Henry M. D.
19..... (Address) Caldwell Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill
DATE OF BURIAL: 2-11 1921

20. UNDERTAKER: CASE FURNITURE CO.
ADDRESS: Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 2007
File No. 33424
Registered No. 18

1. PLACE OF DEATH.
County of Canyon
City of Huston
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William Vantress

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower
6. DATE OF BIRTH. Dec. (Month) 22 (Day) 1837 (Year)
7. AGE: 83 Yrs. — Mos. 15 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher
(b) General nature of industry, business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Dont Know
10. NAME OF FATHER: Don't Know
11. BIRTHPLACE OF FATHER (State or Country): " "
12. MAIDEN NAME OF MOTHER: " "
13. BIRTHPLACE OF MOTHER (State or Country): " "
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Gilbert Vantress.
(Address) Huston Pct 2
15. Filed Feb. 9- 1921 John L. Meyer Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feby 7th (Month) (Day) 1921 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Jan, 1920, to Feby 4 1921, that I last saw him alive on Feby 4 1921, and that death occured on the date stated above, at 1 P.M.
The CAUSE OF DEATH* was as follows:
arterio sclerosis
5 years (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) J. L. Maxwell M. D.
2/8 1921 (Address) Wilder, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill. DATE OF BURIAL: 2-9 1921
20. UNDERTAKER: C. V. Peckham. ADDRESS: Caldwell Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SORS. 24853

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 2005
File No. 33425
Registered No. 99

1. PLACE OF DEATH
County of Canyon
City of Middleton
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Reynold Cox

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	white	Single

6. DATE OF BIRTH
Oct (Month) 7 (Day) 1903 (Year)

7. AGE
17 Yrs. 3 Mos. 29 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Oregon

10. NAME OF FATHER Ora A Cox

11. BIRTHPLACE OF FATHER (State or Country) Iowa

12. MAIDEN NAME OF MOTHER Savannah Canter

13. BIRTHPLACE OF MOTHER (State or Country) Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A. Cox
(Address) Middleton

15. Filed Feb. 7 1921 John L. Meyer
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Feb (Month) 6 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 5th 1921, to Feb 6 — 1921, that I last saw him alive on Feb 6th 1921, and that death occurred on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:
Valvular heart trouble, preceded by attack of Diphtheria

..... (Duration) ..... Yrs. 1 mos. 1 ds.
Contributory (Secondary) Dropsy set in two last week (Duration) ..... yrs. ..... mos. 8 ds.

(Signed) J. W. Hamer M. D.
2-7 1921 (Address) Middleton Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? Last Fall
Former or usual residence Usual Residence

19. PLACE OF BURIAL OR REMOVAL — DATE OF BURIAL
Middleton Ida 2-7 1921

20. UNDERTAKER — ADDRESS
CASH FURNITURE CO. Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 1005
File No. 33426
Registered No. 16

1. PLACE OF DEATH
County of Canyon
City of Caldwell
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John B. Ware
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): widower

6. DATE OF BIRTH: Sept (Month) 13 (Day) 1845 (Year)

7. AGE: 75 Yrs. 3 Mos. 27 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Carpenter.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio.

10. NAME OF FATHER:

11. BIRTHPLACE OF FATHER (State or Country): Ohio.

12. MAIDEN NAME OF MOTHER: Vernon

13. BIRTHPLACE OF MOTHER (State or Country): Ohio.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. D. Ware
(Address) Caldwell Idaho

15. Filed Feb. 11 1921
John S. Meyer
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 10 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 20 1920 to Jan 10 1921 that I last saw h. alive on Feb 1 1921 and that death occurred on the date stated above, at 7:30 P.M.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Arteria Sclerosis
(Duration) Several yrs. ..... mos. ..... ds.

(Signed) W. D. Ware M. D.
2/1 1921 (Address) Caldwell Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Canyon Hill	2-12-1921

20. UNDERTAKER	ADDRESS
W. Peckham	Caldwell

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho.
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 2007
File No. 33427
Registered No. 3

1. PLACE OF DEATH.
County of Canyon
City of Parma
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Minnie V Bonner

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): M

6. DATE OF BIRTH. Nov (Month) 16 (Day) 1874 (Year)

7. AGE: 46 Yrs. 22 Mos. 22 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer) Housewife

9. BIRTHPLACE (State or Country) Neb.

10. NAME OF FATHER: Oscar Ellicott

11. BIRTHPLACE OF FATHER (State or Country): Do not Know

12. MAIDEN NAME OF MOTHER: Do not Know

13. BIRTHPLACE OF MOTHER (State or Country): Do not Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Wm Bonner
(Address) .....

15. Filed 2-10 1921 Ruby Waldo Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 8 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1 1920, to Feb 8 1921, that I last saw h[er] alive on Feb 8 1921 and that death occured on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:

Cancer of the Stomach

(Duration) 1 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. M. Mitchell M. D.
2-10 1921 (Address) Parma.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL ~~OR REMOVAL~~: Parma cemetery — DATE OF BURIAL: Feb 10 1921

20. UNDERTAKER: Peckham Fun Co — ADDRESS: Parma

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 3

Primary Registration District No. 2007

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33428

Registered No. 2

1. PLACE OF DEATH.

County of Canyon

City of Parma

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Frank Ford

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. Sept (Month) ..... (Day) 1850 (Year)

7. AGE: 71 Yrs. 4 Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Georgia

10. NAME OF FATHER: Thomas c Ford

11. BIRTHPLACE OF FATHER (State or Country): N. C.

12. MAIDEN NAME OF MOTHER: Barbara a Tilla

13. BIRTHPLACE OF MOTHER (State or Country): N C

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edgar Ford

(Address) .....

15. Filed Feb-7 1921

Lulu Kaldy
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 4 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 25 1921, to Feb 2. 1921, that I last saw h.. alive on Jan 25 & Feb. 2 1921, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

.....

.....

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) General Debility

..... (Duration) 5 yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.

19.... (Address) Parma, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Parma Cemetary — DATE OF BURIAL: Feb 7

20. UNDERTAKER: Peckham Fun Co — ADDRESS: Parma Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

EVANS - YORK CO., PTRS. & BOOK. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33429
Registered No. 2

RECEIVED
APR 8 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH.
Registration District No. 82
Primary Registration District No. 216 9
County of Bonneyer
City of Sala Spring (St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Virginia Beck

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. July (Month) 10 (Day) 1883 (Year)

7. AGE: 28 Yrs. 8 Mos. 16 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Wife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mah

10. NAME OF FATHER: Andrew Brewer

11. BIRTHPLACE OF FATHER (State or Country): Penn.

12. MAIDEN NAME OF MOTHER: Nat Known

13. BIRTHPLACE OF MOTHER (State or Country): Not Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Chas K Beck Jr
(Address) Sala Spring Idah

15. Filed March 31 1921 Erik Ly Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 26 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 24 1921, to March 26 1921, that I last saw h[illegible] alive on March 26 1921, and that death occured on the date stated above, at 8:30 P M.

The CAUSE OF DEATH* was as follows:
Influenza Pulmonary Hemorrhage

(Duration) Yrs. mos. 15 ds.
Contributory (Secondary): None
(Duration) yrs. mos. ds.

(Signed) Erik Ly M. D.
March 26 1921 (Address) Sala Spring Idah

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Central Idah — DATE OF BURIAL: March 29 1921

20. UNDERTAKER: E D Whitman — ADDRESS: Sala Spr

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33430
Registered No. 479

Registration District No. 117
Primary Registration District No. 2196
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Cassia
City of Burley

2. FULL NAME Baby Breeze

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Feb. (Month) 20 (Day) 1921 (Year)

7. AGE ....Yrs....Mos....ds. IF LESS than 1 day how many .... hrs. or 30 min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At home
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: G.A. Breeze

11. BIRTHPLACE OF FATHER (State or Country): Illinois

12. MAIDEN NAME OF MOTHER: Ina Bundy

13. BIRTHPLACE OF MOTHER (State or Country): Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) G.B. Bundy
(Address) Burley Idaho

15. Filed Feb 23, 1921 Dr. J.C. Patterson M.D. Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. (Month) 20 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 1920 to Feb 20 1921
that I last saw him alive on Feb 20 1921
and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:
Premature Birth
.....
.....
.....(Duration) ..... Yrs..... mos. ½ hrs ds.

Contributory (Secondary) .....
.....(Duration) ..... Yrs..... mos..... ds.

(Signed) J.C. Patterson M. D.
2-21-1921 (Address) Burley Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Burley Ida — DATE OF BURIAL: Feb 24, 1921

20. UNDERTAKER — ADDRESS: Burley Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 117
Primary Registration District No. 2196
File No. 33431
Registered No. 4372

1. PLACE OF DEATH
County of Cassia
City of Burley
If death occurs away from usual residence, give facts called for under special information.

(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Woodrow Jolley

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Jan. (Month) 25 (Day) 1921 (Year)

7. AGE ..... Yrs. ..... Mos. 20 ds.
IF LESS than 1 day how many .... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) none

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER R.J. Jolley

11. BIRTHPLACE OF FATHER Washington Co Utah (State or Country)

12. MAIDEN NAME OF MOTHER Ezra Conger

13. BIRTHPLACE OF MOTHER Alabama (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R. J. Jolley
(Address) Burley

15. Filed 2-16-21. 191.... W. J. Pattison Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. (Month) 14 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 7 1921 to Feb 14 1921 that I last saw h.m. alive on Feb. 14 1921 and that death occurred on the date stated above, at 12:30 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia

.....(Duration) ..... Yrs. ..... mos. 7 ..... ds.

Contributory (Secondary) .....

.....(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) R.J. Jolley M. D.

.....19.... (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs.....mos....days. In the ,State....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Burley Idaho — DATE OF BURIAL 2-15-... 1921

20. UNDERTAKER R. J. Jolley — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

Form V. S. No. 5) 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33432
Registered No. 483

1. PLACE OF DEATH.
County of Cassia
City of Burley

Registration District No. 17
Primary Registration District No. 2196
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Geo. Henry

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Jan. 31 1921 (Month) (Day) (Year)

7. AGE: ..... yrs. ..... mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Burley Ida

10. NAME OF FATHER: John Henry

11. BIRTHPLACE OF FATHER (State or Country): Payson Utah

12. MAIDEN NAME OF MOTHER: Martha Prichett

13. BIRTHPLACE OF MOTHER (State or Country): Fairview Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Henry
(Address) Burley Ida

15. Filed Feb 15 1921 Dr. J. C. Patterson
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb 3 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 31 1921 to Feb 3 1921 that I last saw h[illegible] alive on Feb 3 1921 and that death occurred on the date stated above, at 5 P M.

The CAUSE OF DEATH* was as follows:

Apnoea
Congenital absence of Rectum & part of Ileum.

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. H. Cooper M. D.

19 ..... (Address) Burley Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL ..... 191...

20. UNDERTAKER | ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 317
Primary Registration District No. 2196
File No. 33435
Registered No. 486

1. PLACE OF DEATH
County of Cassia
City of Burley
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Henry W Hammock.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Unknown. (Month) (Day) 1 (Year)

7. AGE: 37 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: R.R. Section Hand.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kentucky.

10. NAME OF FATHER: John A. Hammock.

11. BIRTHPLACE OF FATHER (State or Country): Tenn.

12. MAIDEN NAME OF MOTHER: Milinda Macey.

13. BIRTHPLACE OF MOTHER (State or Country): Kentucky.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chas. Hammock.
(Address) Rupert, Idaho.

15. Filed Mar 12, 1921 Dr. J. C. Patterson
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 10 (Day) — 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Fracture of Skull.
Last By moving train.
Accidental.
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) L. B. Tellegy (Coroner) M. D.
2/10/1921. (Address) Burley, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Burley Ida. DATE OF BURIAL: Feb. 12 1921.

20. UNDERTAKER: L. B. Tellegy ADDRESS: Burley Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 17
Primary Registration District No. 2196
(No. ..... St.)

File No. 33436
Registered No. 487

1. PLACE OF DEATH.
County of Cassia
City of Marion
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Myrle Webb Pope

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. December (Month) 14 (Day) 1919 (Year)

7. AGE: 1 Yrs. 1 Mos. 16 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): None

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: William Pope [Merrill]

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Esther Elizabeth Webb

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) William Pope Merrill
(Address) .....

15. Filed Mar. 12, 1921 Dr. J. C. Patterson Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24853

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: January (Month) 30 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jany 30 1921, to Jany 30 1921, that I last saw h.im alive on Jany 30 1921, and that death occured on the date stated above, at 9:45 P M.

The CAUSE OF DEATH* was as follows:
Broncho. pneumonia
.....
.....
(Duration) 2 Yrs. mos. 6 ds.
Contributory (Secondary) Enteritis
(Duration 2 yrs. mos. 1 ds.

(Signed) Jesse L Rains M. D.
1/31 1921 (Address) Oakley Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Richmond Utah — DATE OF BURIAL: Feb 3 1921

20. UNDERTAKER: L. B. Talloogy — ADDRESS: Burley Ida.

Smith.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Cassia

City of Declo

(No. ..... St.)

Registration District No. 117

Primary Registration District No. 2196

File No. 3343

Registered No. 489

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mac C. Sugenobu.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: Japs.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: March (Month) 25 (Day) 1920. (Year)

7. AGE: # Yrs. 10 Mos. 28 ds.

IF LESS than 1 day: how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Burley Ida

10. NAME OF FATHER: J. Sugenobu.

11. BIRTHPLACE OF FATHER (State or Country): Japan.

12. MAIDEN NAME OF MOTHER: M. Sugenobu.

13. BIRTHPLACE OF MOTHER (State or Country): Japan.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): J. Sugenobu.
(Address): Declo Idaho.

15. Filed Mar 12, 1921 D. J. Patterson Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feby. (Month) 20 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h-er alive on Feb. 20 1921
and that death occurred on the date stated above, at 7. P. M.
The CAUSE OF DEATH* was as follows:

Measles

(Duration) ..... Yrs. ..... mos. 5 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G. W. Smith M. D.

3/1 1921 (Address) Burley Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Burley Ida. DATE OF BURIAL: Feby 19.....

20. UNDERTAKER Home ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

Fremstad.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 117
Primary Registration District No. 2196
File No. 33438
Registered No. 289

1. PLACE OF DEATH
County of Cassia
City of Burley
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Thomas D. Enough

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.
4. COLOR OR RACE: White.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Sept (Month) 14. (Day) 1920. (Year)

7. AGE: # Yrs. 4 Mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Burley Ida.

10. NAME OF FATHER: Roy Enough.

11. BIRTHPLACE OF FATHER (State or Country): Pennsylvania.

12. MAIDEN NAME OF MOTHER: Ethel Rice.

13. BIRTHPLACE OF MOTHER (State or Country): Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Roy Enough.
(Address) Burley Ida.

15. Filed Mar. 12 1921 Dr. J. C. Patterson
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feby. (Month) 9. (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 9 1921, to Feb 9 - 1921, that I last saw him alive on Feb 9 - 1921, and that death occurred on the date stated above, at 7 A M.

The CAUSE OF DEATH* was as follows:

Spinal Meningitis

(Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary) Pneumonia

(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) Joseph Fremstad M. D.

19 ..... (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Burley Ida. DATE OF BURIAL: Feby. 9 1921.

20. UNDERTAKER: L. B. Talloyd. ADDRESS: Burley Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 117
Primary Registration District No. 2196
File No. 33439
Registered No. 490

1. PLACE OF DEATH
County of Cassia
City of Burley
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Effie Lee

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: October (Month) 27. (Day) 1876. (Year)

7. AGE: 45 Yrs. 3 Mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Arizona

10. NAME OF FATHER: Maronia Savage

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Charity E. Kniden

13. BIRTHPLACE OF MOTHER (State or Country): Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) S. J. Lee
(Address) Burley Ida.

15. Filed Mar. 12 1921 D. J. Patterson Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feby. (Month) 7- th. (Day) 1921. (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 20 1920, to Feb 7 1921, that I last saw h.. alive on Feb 7 1921, and that death occurred on the date stated above, at 1 P. M.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency of Heart

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F. P. Cutler M. D.

19..... (Address) Burley

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Burley Ida — DATE OF BURIAL: Feb. 12 1921

20. UNDERTAKER: L. B. Gallogley — ADDRESS: Burley Ida

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 117
Primary Registration District No. 2196
File No. 33440
Registered No. 491

1. **PLACE OF DEATH**
County of Cassia
City of Burley
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. **FULL NAME** Anna Fay Heymas.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. **SEX**: Female
4. **COLOR OR RACE**: White.
5. **SINGLE, MARRIED, WIDOWED OR DIVORCED** (Write the word.): Single

6. **DATE OF BIRTH**: Jan. (Month) 28 (Day) 1921. (Year)

7. **AGE**: ## Yrs. # Mos. 21 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. **OCCUPATION**
(a) Trade, profession or particular kind of work: At Home.
(b) General nature of industry, business or establishment in which employed (or employer):

9. **BIRTHPLACE** (State or Country): Burley Ida.

10. **NAME OF FATHER**: George A. Heymas.

11. **BIRTHPLACE OF FATHER** (State or Country): Liberty Ida.

12. **MAIDEN NAME OF MOTHER**: Emma J. Johnson.

13. **BIRTHPLACE OF MOTHER** (State or Country): Idaho.

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**
(Informant) George A. Heymas.
(Address) Burley Ida. R.F.D.

15. Filed Mar. 12, 1921 Dr. J. C. Patterson
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH**: Feby. (Month) 18 (Day) 1921. (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 17 1921, to Feb. 18 1921
that I last saw her alive on Feb. 17 1921,
and that death occurred on the date stated above, at 4 P. M.
The CAUSE OF DEATH* was as follows:
Bronchio Pneumonia

(Duration) ..... Yrs. ..... mos. 2 ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. C. Patterson M. D.
2-19 1921. (Address) Burley Ida

*State the **Disease Causing Death**; or in deaths from **Violent Causes**, state (1) **Means of Injury**; and (2) whether **Accidental, Suicidal or Homicidal.**

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Liberty Ida,	Feby 22 1921.
20. UNDERTAKER	**ADDRESS**
L. B. Bellozzy.	Burley Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

Patterson

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33441

Registered No. 492

1. PLACE OF DEATH

County of Cassia

City of Declo.

(No. ..... St.)

Registration District No. 117

Primary Registration District No. 2196

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Robert Clifford Alexander.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH: June 15 (Month) (Day) 1921. (Year)

7. AGE: ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: At Home.

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Burley Ida.

10. NAME OF FATHER: James A. Alexander.

11. BIRTHPLACE OF FATHER (State or Country): Missouri.

12. MAIDEN NAME OF MOTHER: Mary L. Moffitt.

13. BIRTHPLACE OF MOTHER (State or Country): Missouri.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. A. Alexander.

(Address) Declo Ida.

15. Filed Mar. 12, 1921 Dr. J. C. Patterson, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feby. (Month) 23rd. (Day) 1921. (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 15 1921, to Feb. 23 1921, that I last saw h[illegible] alive on Feb 22 1921, and that death occurred on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) ..... Yrs. ..... mos. 10 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. C. Patterson M. D.

2-24 1921 (Address) Burley, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Burley Ida. DATE OF BURIAL: Feb. 24, 1921

20. UNDERTAKER: None ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

RECEIVED APR 6 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33442
Registered No.

1. PLACE OF DEATH. Registration District No. 125
County of Clark Primary Registration District No. 2203
City of Dubois, St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Wayne Earl Robertson.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH: 1 (Month) 25 (Day) 1921 (Year)

7. AGE: yrs. 2 mos. 3 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ~
(b) General nature of industry business, or dstablishment in which employed (or employer) ~

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Earl J. Robertson.

11. BIRTHPLACE OF FATHER (State or Country) Washington

12. MAIDEN NAME OF MOTHER Blanche M. Miller

13. BIRTHPLACE OF MOTHER (State or Country) Washington.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Earl J. Robertson
(Address) Dubois, Idaho.

15. Filed March 29 1921 C E Jones M D Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 3 (Month) 28 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Natal all 191, to — — 191, that I last saw h alive on March 27 1921, and that death occurred on the date stated above, at 5:30 A. M.

The CAUSE OF DEATH* was as follows:
Fatal Nutrition and Gastritis

(Duration) — yrs. — mos. — ds.
Contributory (Secondary) Lack of proper food.
(Duration) — yrs. — mos. — ds.

(Signed) A. Howard Young M.D.
3-30 1921 (Address) Dubois, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Dubois. DATE OF BURIAL: 3-29-1921

20. UNDERTAKER: Nour. ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 36
Primary Registration District No. 2020
File No. 33444
Registered No. 2

1. PLACE OF DEATH

County of Elmore
City of Mtn Home (or Village) (St.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED APR 8 1921 BUREAU OF VITAL STATISTICS

2. FULL NAME Laura Virginia Callaway

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widowed (Write the word.)

6. DATE OF BIRTH: Nov. 13 [illegible] (Month) (Day) (Year)

7. AGE: 77 Yrs. 4 Mos. 15 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Clark Co. Ga.

10. NAME OF FATHER: Dr. [illegible] Lindsey Durham

11. BIRTHPLACE OF FATHER (State or Country): Va.

12. MAIDEN NAME OF MOTHER: Lindsey

13. BIRTHPLACE OF MOTHER (State or Country): [illegible]

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Layne Callaway

(Address) Mtn Home Ida

15.

Filed 4-1-1921

J E Evans
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March [illegible] 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3-24-1921 to 3-28-1921 that I last saw h[illegible] alive on 3-27-1921, and that death occurred on the date stated above, at [illegible] M.

The CAUSE OF DEATH* was as follows:

Senility & Obstruction of Bowels

(Duration) ..... Yrs. ..... mos. 8 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J E Evans M. D.

3-29-1921 (Address) Mtn Home Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cem. Boise — DATE OF BURIAL: 3-29-1921

20. UNDERTAKER: A M Conover — ADDRESS: Mtn Home Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
APR 11 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 2119

County of Franklin Primary Registration District No. 27

City of Treasureton (No. ..... St.)

File No. 33445

Registered No. 24

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Carlos Leroy Williams.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
male	white	single

6. DATE OF BIRTH Nov (Month) 12 (Day) 1899 (Year)

7. AGE 1 Yrs. 4 Mos. 9 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Child
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Charles Albert Williams

11. BIRTHPLACE OF FATHER (State or Country) Idaho

12. MAIDEN NAME OF MOTHER Florence Hunt

13. BIRTHPLACE OF MOTHER (State or Country) Salt Lake City

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Father
(Address) Treasureton Ida

15. Filed April 7 1921. Dr. A R Cutler
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March (Month) 14 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 21 1921, to March 14 1921
that I last saw h. in alive on March 14 1921,
and that death occurred on the date stated above, at 9 AM.
The CAUSE OF DEATH* was as follows:
Cerebrospinal Meningitis
Meningococcus.

(Duration) Yrs. 1 mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) A R Cutler M. D.

3-15 1921 (Address) Preston Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Treasureton Ida.	4-16 1921

20. UNDERTAKER	ADDRESS
W A Skidmore	Preston Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED APR 8 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33446
Registered No. [illegible]

1. PLACE OF DEATH

Registration District No. 80

County of Bonner Primary Registration District No. 267

City of ..... Port Rock ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Seward M Corl

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Jan (Month) 22 (Day) 1872 (Year)

7. AGE: 47 Yrs. 8 Mos. 10 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Steam Shovel Craneman

(b) General nature of industry, business, or establishment in which employed (or employer)..... Cement Plant

9. BIRTHPLACE (State or Country) Corry Penn

10. NAME OF FATHER: Unobtainable

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Spokane Lodge #228 B. P. O. Elks

(Address) Spokane Wash

15. Filed March 10th 1921 John Lawson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 4 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ~~[illegible]~~ 191 ; that I last saw ~~deceased~~ alive on ~~[illegible]~~ 191 ; and that death occured on the date stated above at ~~[illegible]~~ M.

The CAUSE OF DEATH* was as follows:

Accident. Crushed by steam Shovel.

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) W. M. Kinyon M. D.

19 (Address) Corr Bonner Co. Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos. 5 ...days. In the State.....yrs.....mos. 5 ...days

Where was disease contracted if not at place of death?.....

Former or usual residence Spokane Wash

19. PLACE OF BURIAL OR REMOVAL: Corry Penn — DATE OF BURIAL: ..... 191.....

20. UNDERTAKER: Hazen & Jaeger — ADDRESS: Spokane Wash

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STNRS. 24658

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33447
Registered No. 20

1. PLACE OF DEATH

County of Franklin
City of Preston (No. ..... St.)
Registration District No. 219
Primary Registration District No. 27

RECEIVED
APR 11 1921
BUREAU OF VITAL STATISTICS

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Wm Edgar Godderidge

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.):

6. DATE OF BIRTH: Jan. (Month) 17 (Day) 1921 (Year)

7. AGE: ..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or 20 min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Franklin

10. NAME OF FATHER: Wm Godderidge

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Alice Effie Garnett

13. BIRTHPLACE OF MOTHER (State or Country): Smithfield Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) William Godderidge
(Address) Preston Ida

15. Filed April 7 1921. D A Russell Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. (Month) 17 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 27 1921, to Jan 17 1921 that I last saw h.. alive on Jan 16 1921, and that death occurred on the date stated above, at 7.30 M.

The CAUSE OF DEATH* was as follows:
Ill bef. Premature birth
age about 7 months gestation

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary): Not known

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Allen P Russell M. D.
Jan 17 1921 (Address) Preston

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Treasureton Ida. | DATE OF BURIAL: Jan. 19 1921

20. UNDERTAKER | ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33448

Registered No. 27

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

RECEIVED APR 1 1921 BUREAU OF VITAL STATISTICS

Registration District No. 2119

Primary Registration District No. 27

1. PLACE OF DEATH.

County of Franklin

City of Weston Ada St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elsa Lacresia Kofoed

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. Dec (Month) 14 (Day) 1920 (Year)

7. AGE: Yrs. 1 Mos. 22 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Franklin Co Idaho

10. NAME OF FATHER: Charles A Kofoed

11. BIRTHPLACE OF FATHER (State or Country): Weston Idaho

12. MAIDEN NAME OF MOTHER: Sarah H Williams

13. BIRTHPLACE OF MOTHER (State or Country): Richmond Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C Thos A Kofoed

(Address) Weston Idaho

15. Filed April 7 1921

D A Rulon
Local Registrar

SYMS - YORK CO., PTRS. & BOBS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 7 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 4 1921, to Feb 7 1921, that I last saw her alive on Feb 7 1921 and that death occured on the date stated above, at 10:30 P.M.

The CAUSE OF DEATH* was as follows:

Double Pneumonia

(Duration) Yrs. mos. 3 ds.

Contributory (Secondary)

(Duration yrs. mos. ds.

(Signed) Thos B Holden M. D.

19..... (Address) Weston, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Weston, Ida. — DATE OF BURIAL: Feb 11 1921

20. UNDERTAKER: none — ADDRESS: —

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3349

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APR 11 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Franklin Registration District No. 2117
City of Preston Primary Registration District No. 27 St.)
Registered No. 22

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Raymond Gedder Merrill

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M.	W.	

6. DATE OF BIRTH: Mar. (Month) 30 (Day) 1921 (Year)

7. AGE: ....Yrs. ....Mos. 1 ds. IF LESS than 1 day how many 6 hrs. or ....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Preston Idaho

10. NAME OF FATHER Elmer Raymond Merrill

11. BIRTHPLACE OF FATHER (State or Country) Mapleton Franklin Co.

12. MAIDEN NAME OF MOTHER Vera E. Geddes

13. BIRTHPLACE OF MOTHER (State or Country) Preston Ida.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Elmer Raymond Merrill
(Address) Preston Ida.

15. Filed April 7 1921. Dr. A.R. Cutler
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 3 (Month) 31 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3-30 1921, to 3-31 1921 that I last saw h.... alive on 3-31 1921, and that death occurred on the date stated above, at 3:00 P.M.

The CAUSE OF DEATH* was as follows:
Status Lymphaticus
enlarged thymus causing asphyxia
(Duration) Yrs. .... mos. 1 ds.
Contributory (Secondary) Premature
(Duration) .... yrs. .... mos. .... ds.

(Signed) A. R. Cutler M. D.
4-1 1921 (Address) Preston Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients or Recent Residents.)
At place of death ....yrs. ....mos. ....days. In the State ....yrs. ....mos. ....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Preston	Apr 1 1921
20. UNDERTAKER W. A. Skidmore	ADDRESS Preston Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 3-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 2119

County of Franklin

Primary Registration District No. 27

File No. 33450

City of Preston (No. ..... St.)

Registered No. 23

If death occurs away from usual residence, give facts called for under special information.

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APR 11 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME Eugene J. Stewart

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	W.	Single

6. DATE OF BIRTH: March (Month) 6 (Day) 1921 (Year)

7. AGE: 0 Yrs. 0 Mos. 14 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Preston Idaho

10. NAME OF FATHER: J B Stewart

11. BIRTHPLACE OF FATHER (State or Country): Lehi Utah

12. MAIDEN NAME OF MOTHER: Elva M Wright

13. BIRTHPLACE OF MOTHER (State or Country): America Fork Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J B Stewart
(Address) Preston Idaho

15. Filed April 7 1921 Dr A R Curtis Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 20 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 6 1921, to March 20 1921, that I last saw h[illegible] alive on Mar 20 1921, and that death occurred on the date stated above, at 10:15 P M.

The CAUSE OF DEATH* was as follows:
Atelectasis — premature labor 7 mos.

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Curtis Hart M. D.
(Address) Preston, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
American Fork Utah	Apr. 2 1921

20. UNDERTAKER	ADDRESS
W. A. Skidmore	Preston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33451
Registered No. 24

1. PLACE OF DEATH.
County of Franklin
City of Weston Idaho (If not in incorporated limits, give township or other subdivision.) St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 219
Primary Registration District No. 27

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APR 11 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME Ellen Anderson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	white	

6. DATE OF BIRTH.
Aug (Month) 11 (Day) 1920 (Year)

7. AGE
Yrs. 7 Mos. 6 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE
(State or Country) Franklin Co. Idaho

10. NAME OF FATHER Adolph Anderson

11. BIRTHPLACE OF FATHER
(State or Country) Midvale Utah

12. MAIDEN NAME OF MOTHER Clara Fredricksen

13. BIRTHPLACE OF MOTHER
(State or Country) Franklin Co Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Adolph Anderson
(Address) Weston, Idaho

15.
Filed April 7 1921
Dr A R Rutter
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
March (Month) 17 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 14 1921, to March 17 1921, that I last saw him alive on March 16 1921, and that death occured on the date stated above, at 2 A M.

The CAUSE OF DEATH* was as follows:
Whooping Cough

(Duration) ..... Yrs. ..... mos. 10 ds.
Contributory (Secondary) Pneumonia
(Duration ..... yrs. ..... mos. 3 ds.
(Signed) Thos. B. Holden M. D.
19..... (Address) Weston

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Weston, Ida. DATE OF BURIAL: Mar. 19 1921
20. UNDERTAKER: ADDRESS:

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & ENGS. 24653

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED
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BUREAU OF STATISTICS

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33452
Registered No. .....

1. PLACE OF DEATH.
County of Fremont
City of Ashton Idaho
(No. ..... St.)
Registration District No. .....
Primary Registration District No. .....
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Melvina Fessela Baker

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Sept. (Month) 9 (Day) 1893 (Year)

7. AGE: 27 Yrs. 6 Mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Helena Montana

10. NAME OF FATHER: Phillip Lyons

11. BIRTHPLACE OF FATHER (State or Country): Don't Know

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE [illegible] TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Robert Baker
(Address) Ashton Idaho

15. Filed 3/23 1921 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 3 (Month) 22 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1916, to June 29 1921, that I last saw her alive on 3/16 1921, and that death occured on the date stated above, at 2 P M.

The CAUSE OF DEATH* was as follows:
Epilepsy
(Duration) One Yrs. mos. ds.
Contributory (Secondary) Inflammatory Rheumatism
(Duration) yrs. mos. 9 ds.

(Signed) [signature] M. D.
June 1921 (Address) Ashton Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Ashton Idaho
DATE OF BURIAL: 3/24 1921

20. UNDERTAKER: Lewis Kerr
ADDRESS: Ashton Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24654

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 32454
Registered No.

1. PLACE OF DEATH
County of Fremont
City of St Anthony
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No.
(No. , St.)

2. FULL NAME Delmar D. Rawson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
male	white	single

6. DATE OF BIRTH: 7 (Month) 28 (Day) 1920 (Year)

7. AGE: 0 Yrs. 7 Mos. 17 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Ida

10. NAME OF FATHER Geo. Rawson

11. BIRTHPLACE OF FATHER (State or Country) Ida

12. MAIDEN NAME OF MOTHER Edith Davis

13. BIRTHPLACE OF MOTHER (State or Country) Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Geo Rawson
(Address) St Anthony Ida

15. Filed 3-17-1921
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 3 (Month) 17 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3-8 1921, to 3-17 1921, that I last saw him alive on 3-8 1921, and that death occurred on the date stated above, at 5 am M.

The CAUSE OF DEATH* was as follows:
whooping Cough
(Duration) Yrs. mos. ds.
Contributory (Secondary) none
(Duration) yrs. mos. ds.

(Signed) J. M. Gray M. D.
3-17 1921 (Address) St Anthony Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Parker Ida	3/19/1921
20. UNDERTAKER	ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 99
Primary Registration District No. 2177
File No. 33455
Registered No.

1. PLACE OF DEATH
County of Fremont
City of Teton
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Alphonzo Willey
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Sept (Month) 30 (Day) 1842 (Year)

7. AGE: 78 Yrs. 4 Mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ill.

10. NAME OF FATHER: Willey

11. BIRTHPLACE OF FATHER (State or Country): Dont Know

12. MAIDEN NAME OF MOTHER: Sarah Ann Ward

13. BIRTHPLACE OF MOTHER (State or Country): Dont Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Willey
(Address)

15. Filed Feby 10 19 21 — W D Wurst, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 14 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from at no time to ..... 19....., that I last saw h..... alive on ..... 19....., and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Old Age

(Duration) ..... Yrs. ..... mos. 2 ds.
Contributory (Secondary): little Cold.
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W D Wurst Local Reg. M. D.
19..... (Address) St Anthony

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Teton Idy — DATE OF BURIAL: 1/19/1921

20. UNDERTAKER: None — ADDRESS: —

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

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Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

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APR - 4 1921
BUREAU OF VITAL STATISTICS

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 104
Primary Registration District No.

File No. 33464
Registered No.

1. PLACE OF DEATH.
County of Idaho
City of White Bird (No. St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Powell Gibson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, ~~MARRIED, WIDOWED OR DIVORCED~~. (*Write* the word.)

6. DATE OF BIRTH: Don't Know (Month) 1 (Day) (Year)

7. AGE: 63 yrs. mos. ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work: Jeweller
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Georgia

10. NAME OF FATHER: ~~Gibson~~

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chas - Wilson
(Address) White Bird - Ida

15.
Filed ..... 191 .....
W. A. Foskett
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan (Month) 31 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1918, to Jan 1921 that I last saw him alive on Jan 31 1921 and that death occurred on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:
Cancer of Bowels

(Duration) 2 7 yrs. mos. ds.

Contributory (Secondary)
(Duration) 5 yrs. mos. ds.

(Signed) W A Foskett M. D.
Feb 2 1921 (Address) White Bird Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: White Bird — DATE OF BURIAL: Feb 1 1921

20. UNDERTAKER: Hancock — ADDRESS: Grangeville

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

RECEIVED

APR 4 1921

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33465
Registered No.

1. PLACE OF DEATH.
Registration District No. 104
County of Idaho
City of White Bird (No. , St.)
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Herbert M. King

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	married

6. DATE OF BIRTH
Jan (Month) 1 (Day) 1853 (Year)

7. AGE
68 yrs. — mos. — ds.
IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Rancher
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Indiana

10. NAME OF FATHER James King

11. BIRTHPLACE OF FATHER (State or Country) —

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER (State or Country) —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Herbert King
(Address) Lucile Ida

15.
Filed 191
W. A. Foskett
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Jan 16 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 9 1921, to Jan 16 1921, that I last saw him alive on Jan 16 1921 and that death occurred on the date stated above, at 9:35 P.M.

The CAUSE OF DEATH* was as follows:
Chronic Nephritis
Aortic Stenosis

(Duration) 6 yrs. mos. ds.
Contributory (Secondary) Arterial Sclerosis
(Duration) 6 yrs. mos. ds.

(Signed) W A Foskett M. D.
19 (Address) White Bird

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
White Bird	Jan 18 1921
20. UNDERTAKER	ADDRESS
Hancock	Gr.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

GYMS - YORK CO., PTRS. & SDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Idaho

City of Kooskia

Registration District No. 106

Primary Registration District No. 2124

(No. ..... St.)

File No. 33468

Registered No. 103

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lila Marie Rankin

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: Indian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. July (Month) 13 (Day) 1920 (Year)

7. AGE: ..... Yrs. 7 Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Wm Rankin

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Ivy Lawrence

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William Rankin

(Address) Kooskia, Idaho.

15.

Filed Feb 22 1921

J. W. Weikert Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 21 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 14 1921, to Feb 21 1921, that I last saw h[illegible] alive on Feb 21 1921, and that death occured on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. W. Weikert M. D.

Feb 22 1921 (Address) Kooskia - Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Kooskia. Corbett Cemetery

DATE OF BURIAL: 2/23 1921

20. UNDERTAKER

ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Idaho

City of Kooskia

Registration District No. 106

Primary Registration District No. 2184

(No. ....., ... St.)

File No. 33469

Registered No. 102

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lulu Samuels

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: Indian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. — (Month) (Day) 1 (Year)

7. AGE: 55 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: housewife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Dave Kuns

11. BIRTHPLACE OF FATHER (State or Country): .....

12. MAIDEN NAME OF MOTHER: Sallie Wilbur

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George Samuels

(Address) Kooskia Idaho

15. Filed Feb 18 1921 J. M. Tuberkuns Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: February (Month) 17 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 12 1921, to Feb 17 1921, that I last saw h[illegible] alive on Feb 16 1921, and that death occured on the date stated above, at 5:35 a. M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Tuberkuns M. D.

Feb 17 1921 (Address) Kooskia - Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Fortman Cem. Ohara Mortuary — DATE OF BURIAL: Feb 18 1921

20. UNDERTAKER ..... ADDRESS .....

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 98
Primary Registration District No. 2176
File No. 23470
Registered No. 17

1. PLACE OF DEATH
County of Jefferson
City of Rigby (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Orson Grover Hoggan

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): single

6. DATE OF BIRTH: Dec (Month) 8 (Day) 1919 (Year)

7. AGE: 1 Yrs. 2 Mos. 26 Ds.
IF LESS than 1 day: how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: W. W. Hoggan

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Elizabeth Grover

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. W. Hoggan
(Address) Rigby Ida.

15. Filed Mch 10 19 21 Ray H. Fisher Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mch (Month) 6 (Day) 19 21 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mch 5 19 21 to Mch 6 19 21
that I last saw h~~e~~ alive on Mch 6 19 21
and that death occurred on the date stated above, at 8 a M.
The CAUSE OF DEATH* was as follows:
acute intestinal intoxication

..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) O. F. Call M. D.
3-9 19 21 (Address) Rigby Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rigby
DATE OF BURIAL: 3-8 19 21

20. UNDERTAKER: W. A. Young
ADDRESS: Rigby

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 98
Primary Registration District No. 2176
(No. ..... St.)

File No. 23471
Registered No. 16

1. **PLACE OF DEATH**
County of Jefferson
City of Mclean
If death occurs away from usual residence, give facts called for under special information.

2. **FULL NAME** Ruth Gibson
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. **SEX** F
4. **COLOR OR RACE** White
5. **SINGLE, MARRIED, WIDOWED OR DIVORCED** (Write the word) single

6. **DATE OF BIRTH** Oct (Month) 30 (Day) 1919 (Year)

7. **AGE** 1 Yrs. 3 Mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. **OCCUPATION**
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business or establishment in which employed (or employer):

9. **BIRTHPLACE** (State or Country) Ida

10. **NAME OF FATHER** Geo. D. Gibson

11. **BIRTHPLACE OF FATHER** (State or Country) Utah

12. **MAIDEN NAME OF MOTHER** Nettie Richardson

13. **BIRTHPLACE OF MOTHER** (State or Country) Idaho

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**
(Informant) George D. Gibson
(Address) Mclean, Ida

15. Filed Mch 1921 Ray H. Fisher
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH** Feb (Month) 3 (Day) 1921 (Year)

17. **I HEREBY CERTIFY**, That I attended deceased from Jan 29 1921 to Feb 3 1921
that I last saw h. liv alive on Feb 3 1921
and that death occurred on the date stated above, at 1130 P.M.
The **CAUSE OF DEATH*** was as follows:

Broncho - pneumonia

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. 10 ds.

(Signed) Earl D. Jones M. D.
2-5 1921 (Address) Roberts, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. **PLACE OF BURIAL OR REMOVAL** Annis
DATE OF BURIAL 2-6 1921

20. **UNDERTAKER** W. L. Young
ADDRESS Rigby

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 98
Primary Registration District No. 2176
File No. 33472
Registered No. 15

1. PLACE OF DEATH
County of Jefferson
City of Rigby
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ingra P. Carlson
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widowed (Write the word.)

6. DATE OF BIRTH: June (Month) 11 (Day) 1829 (Year)

7. AGE: 91 Yrs. 8 Mos. 25 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER: unknown

11. BIRTHPLACE OF FATHER (State or Country): "

12. MAIDEN NAME OF MOTHER: "

13. BIRTHPLACE OF MOTHER (State or Country): "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Carlson
(Address) Rigby, Ida

15. Filed Mch 10 1921 Ray H Fisher Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 5 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 1 1921 to Feb 5 1921
that I last saw her alive on Feb 5 1921
and that death occurred on the date stated above, at 1P. M.
The CAUSE OF DEATH* was as follows:
Senility
(Duration) 2 Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) A. M. Palmer M. D.
2-6 1921 (Address) Rigby

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Orford Ida — DATE OF BURIAL: 2-7 1921

20. UNDERTAKER: W. L. Young — ADDRESS: Rigby

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 98
Primary Registration District No. 2176
File No. 5348
Registered No. 14

1. PLACE OF DEATH
County of Jefferson
City of Monteview
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Andrew Keith Nielson
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Jan (Month) 2 (Day) 1921 (Year)

7. AGE: ..... Yrs. ..... Mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ida

10. NAME OF FATHER: Anders Nielson

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Alice R. Taylor

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Anders Nielson
(Address) Monteview Ida

15. Filed Mch 10 1921 Ralph Fish Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 17 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....
and that death occurred on the date stated above, at 9:30 P. M.
The CAUSE OF DEATH* was as follows:
Convulsions
Never saw patient alive.
..... (Duration) ..... Yrs. ..... mos. 8 hrs ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Earl D. Jones M. D.
1-19 1921 (Address) Roberts Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Roberts — DATE OF BURIAL: 1-19 1921

20. UNDERTAKER: Friends — ADDRESS: .....

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 98
Primary Registration District No. 2176
(No. ..... St.)

File No. 33474
Registered No. 13

1. PLACE OF DEATH

County of Jefferson

City of Ryegley

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Maryetta S. Oakden

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F	White	married

6. DATE OF BIRTH: Jan (Month) 27 (Day) 190 (Year)

7. AGE: 20 Yrs. 1 Mos. 15 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Arthur Sapton

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Manetta Jones

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Arthur Sapton
(Address) Ryegley Ida

15. Filed Mch 12 19 21 Ray H Fisher Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 11 (Day) 19 21 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 7 19 21 to Mch 11 19 21
that I last saw her alive on Mch 11 19 21
and that death occurred on the date stated above, at 5 20 P. M.
The CAUSE OF DEATH* was as follows:
Internal Haemorrhage
(Intra Abdominal)
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Parturition
(Duration) ..... yrs. ..... mos. 1 ds.
(Signed) H. A. Anderson M. D.
3-12 19 21 (Address) Ryegley Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Ryegley	3-14 19 21
20. UNDERTAKER D. A. Harris	ADDRESS Ryegley

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 98
Primary Registration District No. 2176
File No. 33475
Registered No. 42

1. PLACE OF DEATH
County of Jefferson
City of Rigby R 3
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sadie Anderson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Infant

6. DATE OF BIRTH: Jan 4 - 21 1
(Month) (Day) (Year)

7. AGE: ..... Yrs. 10 Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ida

10. NAME OF FATHER: Albert Anderson

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Vida Waters

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) James Anderson
(Address) Rigby R 3

15. Filed Mch 10 19 21 Ray H Fisher
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan 14 19 21
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 4 19 21 to Jan 14 19 21
that I last saw h.. alive on Jan 12 19 21
and that death occurred on the date stated above, at 9 P.M.
The CAUSE OF DEATH* was as follows:
Non closure heart valves
(Bleu Baby)
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) J. A Anderson
1-15 19 21 (Address) Rigby Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rigby — DATE OF BURIAL: 1-16 19 21

20. UNDERTAKER: Friends — ADDRESS: Rigby

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33476

Registration District No. 8
Primary Registration District No. 2176

1. **PLACE OF DEATH**
County of Jefferson
City of Rigby R.D. (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. **FULL NAME** Richard Afton Robinson
Registered No. 11
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. **SEX** M
4. **COLOR OR RACE** White
5. **SINGLE, MARRIED, WIDOWED OR DIVORCED** Child (Write the word.)

6. **DATE OF BIRTH** Jan (Month) 30 (Day) 1920 (Year)

7. **AGE** 1 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. **OCCUPATION**
(a) Trade, profession or particular kind of work Child
(b) General nature of industry, business or establishment in which employed (or employer)

9. **BIRTHPLACE** (State or Country) Ida

10. **NAME OF FATHER** J. W. Robinson

11. **BIRTHPLACE OF FATHER** (State or Country) Utah

12. **MAIDEN NAME OF MOTHER** Ella M Silcock

13. **BIRTHPLACE OF MOTHER** (State or Country) Utah

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**
(Informant) J. W. Robinson
(Address) Rigby R.D. 1

15. Filed Feb 10 1921 Ray H Fisher Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH** Jan (Month) 31 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from did not attend 19 ... to 19 ..., that I last saw h. alive dead on Jan 31 1921 and that death occurred on the date stated above, at 7 1/5 P.M.
The CAUSE OF DEATH* was as follows:

Pneumonia

..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Failing circulation
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) O. J. Call M. D.
2-1 1921 (Address) Rigby Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. **PLACE OF BURIAL OR REMOVAL** Grant — **DATE OF BURIAL** 2-1 1921

20. **UNDERTAKER** Friends — **ADDRESS** Rigby Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 98
Primary Registration District No. 2176
File No. 33478
Registered No. 10

1. PLACE OF DEATH
County of Jefferson
City of Ririe
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Heck
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widow (Write the word.)

6. DATE OF BIRTH: Jan 2 (Month) 23 (Day) 92 (Year)

7. AGE: Yrs. 1 Mos. 21 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Ida

10. NAME OF FATHER: George Heck

11. BIRTHPLACE OF FATHER (State or Country): Penn.

12. MAIDEN NAME OF MOTHER: Sarah Bowen

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Geo. Heck
(Address) Ririe Ida

15. Filed Mch 10 1921 Ray H Fisher Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 23 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2-22 1921 to 2-23 1921
that I last saw h..... alive on 2-22 1921
and that death occurred on the date stated above, at 1 P. M.
The CAUSE OF DEATH* was as follows:

Broncho - Pneumonia

(Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Jany F. Price M. D.
2-24 1921 (Address) Ririe Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rigby — DATE OF BURIAL: 2-25 1921

20. UNDERTAKER: D. A. Harris — ADDRESS: Rexburg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 98
Primary Registration District No. 2176
File No. 33479
Registered No. 9

1. PLACE OF DEATH
County of Jefferson
City of Rigby
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Washington Goodrich
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): married

6. DATE OF BIRTH: Apr (Month) 16 (Day) 1838 (Year)

7. AGE: 82 Yrs. 10 Mos. 15 ds.
IF LESS than 1 day: how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): N. Y.

10. NAME OF FATHER: E. Goodrich

11. BIRTHPLACE OF FATHER (State or Country): N. Y.

12. MAIDEN NAME OF MOTHER: Elizabeth Reury

13. BIRTHPLACE OF MOTHER (State or Country): N. Y.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Frank G. Woods
(Address) Rigby, Ida

15. Filed Mch 10 19 21 Ray H Fisher, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 21 (Day) 19 21 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 20 19 21 to Feb 21 19 21
that I last saw h[illegible] alive on Feb 21 19 21
and that death occurred on the date stated above, at 8" P.M.
The CAUSE OF DEATH* was as follows:
Uremic Intoxication
Resp. Depression
(Duration) ..... Yrs. ..... mos. 12 ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) O. F. Call M. D.
2-22 19 21 (Address) Rigby

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence: Iowa

19. PLACE OF BURIAL OR REMOVAL: Iowa
DATE OF BURIAL 19

20. UNDERTAKER: Jay [illegible] Edelson Co
ADDRESS: Rigby

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 98
Primary Registration District No. 2176
File No. 33481
Registered No. 5

1. PLACE OF DEATH
County of Jefferson
City of Rigby
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Wm Walter Bowles

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: m
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Feb (Month) 26 (Day) 1917 (Year)

7. AGE: 3 Yrs. 11 Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: W. J. Bowles

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Elizabeth Pitman

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. J. Bowles
(Address) Rigby R#2 Ida

15. Filed Mch 10 21 Ray H. Fisher Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 26 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 25 1921 to Jan 27 1921
that I last saw h~~im~~ alive on Jan 25 1921
and that death occurred on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia
Mycarditis

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. 9 ds.

(Signed) Ray H. Fisher M. D.
1-27 1921 (Address) Rigby

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Milo, Idaho — DATE OF BURIAL: 1-28 1921

20. UNDERTAKER: W. L. Young — ADDRESS: Rigby

FORM V. S. No. 6-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 98
Primary Registration District No. 2176
(No. ..... St.)

File No. 33482
Registered No. 6

1. **PLACE OF DEATH**

County of Jefferson
City of Rigby

If death occurs away from usual residence, give facts called for under special information.

2. **FULL NAME** Daniel J. Wearsling.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. **SEX** M

4. **COLOR OR RACE** W

5. **SINGLE, MARRIED, WIDOWED OR DIVORCED** (Write the word.) Widowed.

6. **DATE OF BIRTH** Mar 30 1846
(Month) (Day) (Year)

7. **AGE** 74 Yrs. 9 Mos. 26 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. **OCCUPATION**
(a) Trade, profession or particular kind of work: Old gentleman at home.
(b) General nature of industry, business or establishment in which employed (or employer):

9. **BIRTHPLACE** (State or Country) Penn.

10. **NAME OF FATHER** John Wearsling.

11. **BIRTHPLACE OF FATHER** (State or Country) Don't Know.

12. **MAIDEN NAME OF MOTHER** Lucy J. Bartlett.

13. **BIRTHPLACE OF MOTHER** (State or Country) Don't Know.

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**
(Informant) Mrs. Lula E. Dutson
(Address) Rigby, Ida.

15. Filed Feb 10 1921 Roy Fisher
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH** Jan 24 1921
(Month) (Day) 19 (Year)

17. **I HEREBY CERTIFY**, That I attended deceased from Jan 18 1919 to Jan 24 1921 that I last saw h.im alive on Jan 23 1921 and that death occurred on the date stated above, at 9 A. M.

The CAUSE OF DEATH* was as follows:

Senility & Cystitis

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Dr. Sam F. Price M. D.

Jan 24 1921 (Address) Rigby

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. **PLACE OF BURIAL OR REMOVAL** Shelton — **DATE OF BURIAL** Jan 26 1921

20. **UNDERTAKER** Friends — **ADDRESS** Rigby, Ida

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 98
Primary Registration District No. 2176
File No. 33483
Registered No. 4

1. **PLACE OF DEATH**
County of Jefferson
City of Lewisville (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. **FULL NAME** Lelia Josephine Erickson
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. **SEX** F
4. **COLOR OR RACE** W
5. **SINGLE, MARRIED, WIDOWED OR DIVORCED** Infant (Write the word.)

6. **DATE OF BIRTH** Nov 11 1919 (Month) (Day) (Year)

7. **AGE** 1 Yrs. 4 Mos. 9 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. **OCCUPATION**
(a) Trade, profession or particular kind of work Infant
(b) General nature of industry, business or establishment in which employed (or employer)

9. **BIRTHPLACE** (State or Country) Ida

10. **NAME OF FATHER** Joseph E. Erickson

11. **BIRTHPLACE OF FATHER** (State or Country) Idaho.

12. **MAIDEN NAME OF MOTHER** Dora M. Goody

13. **BIRTHPLACE OF MOTHER** (State or Country) Idaho.

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**
(Informant) Joseph E Erickson
(Address) Lewisville Ida

15. Filed Mch 10 1921 Ray K. Fisher Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH** Jan 19 1921 (Month) (Day) (Year)

17. **I HEREBY CERTIFY**, That I attended deceased from Jan 17 1921 to Jan 19 1921
that I last saw h.er alive on Jan 19 1921
and that death occurred on the date stated above, at 12 M.
The **CAUSE OF DEATH*** was as follows:
Intestinal Intoxication
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Resp. depression
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) O. J. Call M. D.
1-19 1921 (Address) Rigby

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. **PLACE OF BURIAL OR REMOVAL** Lewisville Ida — **DATE OF BURIAL** 1-21 1921

20. **UNDERTAKER** W. L. Young — **ADDRESS** Rigby

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Jefferson
City of Rigby

Registration District No. 98
Primary Registration District No. 2176
(No. ....., ... St.)

File No. 33484
Registered No. 3

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Wanda Copeland

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
F	White	Infant

6. DATE OF BIRTH: Jan (Month) 2 (Day) 1921 (Year)

7. AGE: ..... yrs. ..... mos. 23 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho.

10. NAME OF FATHER D.V. Copeland

11. BIRTHPLACE OF FATHER (State or Country) Kansas

12. MAIDEN NAME OF MOTHER Gertrude Antrum

13. BIRTHPLACE OF MOTHER (State or Country) Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) D.V. Copeland
(Address) Rigby #2

15. Filed 2-10 1921 Ray Fisher Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan (Month) 25 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at 9a M.
The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory .....
(Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Sam L. Bruce M. D.
1-26 1921 (Address) Rigby, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Shelton	1-26 1921

20. UNDERTAKER	ADDRESS
C.E. Drinkwater	Ida Falls.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 98
Primary Registration District No. 2176
File No. 33487
Registered No. 18

1. PLACE OF DEATH
County of Jefferson
City of Lewisville (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Steve Ellsworth
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Feb. (Month) 18 (Day) 1 (Year)

7. AGE: ..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: Preston B. Ellsworth

11. BIRTHPLACE OF FATHER (State or Country): Idaho.

12. MAIDEN NAME OF MOTHER: Edna Walker

13. BIRTHPLACE OF MOTHER (State or Country): Ida.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) P. B. Ellsworth
(Address) Lewisville

15. Filed Mch 10 1921 Ray H. Fisher Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 20th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 18 1921, to Feb. 20 1921
that I last saw h~~im~~ alive on Feb 20 1921,
and that death occurred on the date stated above, at 12:40 P. M.
The CAUSE OF DEATH* was as follows:

Oedema of Lungs

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Laryngitis.
(Duration) ..... yrs. ..... mos. 4 ds.

(Signed) Ray H. Fisher. M. D.
Feb 22 1921 (Address) Rigby - Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewisville — DATE OF BURIAL: Feb 22 1921

20. UNDERTAKER: Rigby Fur. Co. — ADDRESS: Rigby, Ida

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
APR 7 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 3348

Registered No. 901

1. PLACE OF DEATH

Registration District No.

Primary Registration District No.

County of Kootenai

City of Coeur d'Alene (If not in incorporated city or village give township) (If in hospital or institution give its name instead of street and No.) Red Cross Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William Nicholls

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: (Month) (Day) 1864 (Year)

7. AGE: 57 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Millwright

(b) General nature of industry, business or establishment in which employed (or employer): D'd Lumber Co

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: Henry Nicholls

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Ann Thomas

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) James Nichols

(Address) Wallace Ida

15. Filed April 4 1921 D D Drenna Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 16 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 12 1921 to March 16 1921 that I last saw h.im alive on March 16 1921, and that death occurred on the date stated above, at 9:15 P. M.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(Duration) Yrs. mos. 14 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Alexander Barclay M. D.

3-17 1921 (Address) Coeur d Alene

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State 72 yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence 121 Coeur d'Alene ave. Coeur d'Alene

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetery

DATE OF BURIAL: 3/18 1921

20. UNDERTAKER: E B Mooney

ADDRESS: Coeur d'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
APR 7 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 30
Primary Registration District No. 1051
File No. 33490
Registered No. 900

1. PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene (No. 335 3rd St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Morgaret-Ellen Biggs

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: single (Write the word.)

6. DATE OF BIRTH: March 22 1921 (Month) (Day) (Year)

7. AGE: — Yrs. — Mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: Orville Biggs

11. BIRTHPLACE OF FATHER (State or Country): Okla.

12. MAIDEN NAME OF MOTHER: Goshie Laglaie

13. BIRTHPLACE OF MOTHER (State or Country): Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. L. Biggs
(Address) 1035-3rd City

15. Filed April 4 1921 D. D. Brennan, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 25 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mch 22 1921 to Mch 25 1921 that I last saw h— alive on Mch 24 1921, and that death occurred on the date stated above, at 9:30 A. M.

The CAUSE OF DEATH* was as follows:
Pneumonia Lobar —

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. W. Holden M. D.
3/25 1921 (Address) Coeur d'Alene Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Forest Cem. C. D. A. | DATE OF BURIAL: 3-26 1921

20. UNDERTAKER: C Carrey | ADDRESS: C'dalene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
APR 7 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 30

Primary Registration District No. 1051

File No. 33491

Registered No. 888

County of Kootenai

City of Rathdrum (If outside limits of city or village, give township.) St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Elsie Hendrich Seeley

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Sept (Month) 5 (Day) 1879 (Year)

7. AGE: 42 Yrs. 6 Mos. 8 ds.

IF LESS than 1 day how many.....hrs. or.....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Home Wife

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ida.

10. NAME OF FATHER: D. S. Hendricks

11. BIRTHPLACE OF FATHER (State or Country): Wis.

12. MAIDEN NAME OF MOTHER: Ella Brosnan.

13. BIRTHPLACE OF MOTHER (State or Country): U. S.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) James T. Seeley

(Address) Rathdrum Ida

15. Filed Apr. 4, 1921 D D Dremark Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 14 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....

that I last saw he alive on Mch. 14, 1921,

and that death occurred on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Uremia, Convulsions

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Try pregnancy 8 hrs.

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D. D. Dremark M. D.

3/14 1921 (Address) Coeur d Alene Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State 17 yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetery — DATE OF BURIAL: 3/14 1921

20. UNDERTAKER: R B Mooney — ADDRESS: C d A Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
APR 1 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 30
Primary Registration District No. 1051
File No. 33492
Registered No. 891

1. PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene (If outside limits of city or village, give township) 5th St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ralph Phelps

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Feb (Month) 26 (Day) 1841 (Year)

7. AGE: 80 Yrs. 0 Mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): N. Y.

10. NAME OF FATHER: Clark Phelps

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: Laura Keeler

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Lauretta G. Brush
(Address) 1204 - 5 - St.

15. Filed Apr. 4 1921 D D Drennan Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 8 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 3 1921 to Feb. 3. 1921
that I last saw him alive on Feb. 3. 1921
and that death occurred on the date stated above, at 8 A M.
The CAUSE OF DEATH* was as follows:
Chronic interstitial Nephritis.

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John O Wood M. D.
Mar. 10 1921 (Address) Coeur d'Alene. Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Forest Cem. C'dAlene — DATE OF BURIAL: 3-10 1921

20. UNDERTAKER: Casseday — ADDRESS: C'dAlene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

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FORM V. S. No. 5-25 M. 1-19.

RECEIVED
APR 7 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 30

County of Kootenai

Primary Registration District No. 1051

File No. 33402

City of Coeur d Alene (No. ..... St.)

Registered No. 8496

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Gene Study.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH: Nov. (Month) 21 (Day) 1856 (Year)

7. AGE: 65 Yrs. 3 Mos. 15 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Druggist
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ind.

10. NAME OF FATHER: Martin Study

11. BIRTHPLACE OF FATHER (State or Country): South Kans

12. MAIDEN NAME OF MOTHER: Elizabeth Overstreet

13. BIRTHPLACE OF MOTHER (State or Country): Dont Kno

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Fred Crandall
(Address): Genesee Ida

15. Filed Apr 4 1921 D D Drenna
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March. (Month) 7 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5 Yrs. 19..... to ..... 19.....
that I last saw h..... alive on 7- Mar 1921
and that death occurred on the date stated above, at 11 A M.
The CAUSE OF DEATH* was as follows:

Carcinoma of Left Breast

(Duration) 4 Yrs. mos. ds.

Contributory (Secondary) Exhaustion

(Duration) yrs. mos. ds.

(Signed) D D Drennan M. D.

3/8 1921 (Address) Coeur d'Alene

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetery — DATE OF BURIAL: 3/9 1921

20. UNDERTAKER: R B Mooney — ADDRESS: C d A

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
APR 7 1921
BUREAU OF VITAL STATISTICS
STATE OF IDAHO

1. PLACE OF DEATH

Registration District No. 30
Primary Registration District No. 1051
File No. 32404
Registered No. 895

County of Kootenai
City of Coeur d'Alene (If outside city limits, give township) No. 1036 2nd St. (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lewis McKeen Dennis

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: June (Month) 9 (Day) 1851 (Year)

7. AGE: 69 Yrs. 8 Mos. 27 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Barber
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Penn.

10. NAME OF FATHER: Dennis

11. BIRTHPLACE OF FATHER (State or Country): Penn.

12. MAIDEN NAME OF MOTHER: Smith

13. BIRTHPLACE OF MOTHER (State or Country): Penn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) B. J. Dennis
(Address)

15. Filed April 4 1921 D. D. Tresemer, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 6th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 4 1921, to March 6 1921, that I last saw him alive on March 6 1921, and that death occurred on the date stated above, at 7 P. M.
The CAUSE OF DEATH* was as follows:

Dilitation of Heart

(Duration) 1 Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

3/7 1921 (Signed) Louis D Mast M. D.
(Address) Coeur d'Alene, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Forest Cem.	3-8 1921

20. UNDERTAKER	ADDRESS
C. Cassedy	C D Alene

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
APR 7 1921
BUREAU OF STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 30

Registration District No. 1051

File No. 33495

Registered No. 899

1. PLACE OF DEATH

County of Kootenai

City of Coeur d'Alene (No. 1029 Wallace St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Eldor Prosser

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Feb (Month) 24 (Day) 1920 (Year)

7. AGE: 0 Yrs. 0 Mos. 6 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Earl Prosser

11. BIRTHPLACE OF FATHER (State or Country): Ills

12. MAIDEN NAME OF MOTHER: Elizabeth Heldstead

13. BIRTHPLACE OF MOTHER (State or Country): Ills

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Earl Prosser

(Address) Coeur d'Alene, Ida.

15. Filed Apr. 7, 1921 D D Brennan Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mch (Month) 2 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 24, 1921, to Mch 2 1921, that I last saw h[im] alive on Mch 1 1921 and that death occurred on the date stated above, at 7:30 P. M.

The CAUSE OF DEATH* was as follows:

Premature birth

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Flynn M. D.

3/2 1921 (Address) Coeur d'Alene Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. 6 days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetery — DATE OF BURIAL: Mch 3 1921

20. UNDERTAKER: R B Mooney — ADDRESS: Coeur d'Alene Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
APR 7 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Kootenai — Registration District No. 30

City of Coeur d'Alene — Primary Registration District No. 1051 — (No. Indiana ave. St.)

File No. 33496

Registered No. 893

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Joseph Mainville

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	White	Married

6. DATE OF BIRTH: Jan (Month) 12 (Day) 1854 (Year)

7. AGE: 67 Yrs. 1 Mos. 4 ds. — IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Canada

10. NAME OF FATHER:

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Joseph Mainville
(Address) Portland Oregon

15. Filed April 4 1921 — D D Drennan, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar (Month) 1 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Myocarditis Chronic Dilated Heart
3 Days Visiting Not Long Sick
For 2 Days (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Nephritis Chronic Interstitial
Heart Decrease
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) D. D. Drennan M. D.
3/3 1921 (Address) Coeur d'Alene

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State 24 yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Kootenai County	March 1921
20. UNDERTAKER: R B Mooney	ADDRESS: Coeur d'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

Registration District No. 126

Primary Registration District No. 2204

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33497

Registered No. 77

1. PLACE OF DEATH

County of Kootenai

City of Kearnan (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Dominic Dire

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: Italian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married (in Italy)

6. DATE OF BIRTH: ✓ (Month) ✓ (Day) 1856 (Year)

7. AGE: 65 Yrs. — Mos. — ds.

IF LESS than 1 day how many — hrs. or — min.? —

8. OCCUPATION

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Italy

10. NAME OF FATHER: Jimy Dire

11. BIRTHPLACE OF FATHER (State or Country): Italy

12. MAIDEN NAME OF MOTHER: Mary —

13. BIRTHPLACE OF MOTHER (State or Country): Italy

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Dire

(Address) Wallace Ida

15. Filed 2-1 1921

J. M. Fanning
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jany (Month) 4 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jany 1st 1921 to Jany 4 1921 that I last saw h.. alive on Jany 4 1921 and that death occurred on the date stated above, at 3 A.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemmorhage

(Duration) ..... Yrs. ..... mos. 3 ds.

Contributory (Secondary) ✓

(Duration) ✓ yrs. ✓ mos. ✓ ds.

(Signed) C. E. Montemply M. D.

1/5 1921 (Address) Kearnan

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Kearnan

DATE OF BURIAL: 1/5 1921

20. UNDERTAKER: Cassidy

ADDRESS: Coeur d'Alene

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24 RECEIVED CERTIFICATE OF DEATH

APR 8 1924

BUREAU OF VITAL STATISTICS

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33498
Registered No.

1. PLACE OF DEATH. Registration District No. 64
County of Latah Registration District No. 2144
City of Troy (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Kermit Bovencamp

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH: March (Month) 8 (Day) 1921 (Year)
7. AGE: ~ yrs. ~ mos. 1 ds. IF LESS than 1 day how many ..... hrs. or ..... min?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry business or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Latah Idaho
10. NAME OF FATHER: E. M. Bovencamp
11. BIRTHPLACE OF FATHER (State or Country): Troy Latah "
12. MAIDEN NAME OF MOTHER: Anna Johnson
13. BIRTHPLACE OF MOTHER (State or Country): South Dakota "
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Dr J. H. Kelly
(Address) Kendrick Idaho.
15. Filed Mar 9 1924 J. E. Pickard Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March (Month) 9 (Day) 1921 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Mar 8 1921, to March 9 1921 that I last saw him alive on March 8 1921 and that death occurred on the date stated above, at 2 P.M.
The CAUSE OF DEATH* was as follows:
Infant
..... (Duration) ~ yrs. ~ mos. ~ ds.
Contributory (Secondary)
..... (Duration) ~ yrs. ~ mos. ..... ds.
(Signed) J. H. Kelly M. D.
3-9 1924 (Address) Kendrick Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL / DATE OF BURIAL
Little Bear Ridge Mar 9 1921

20. UNDERTAKER / ADDRESS
J. E. Pickard Troy

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED APR 8 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Latah — Registration District No. 61
City of Moscow — Primary Registration District No. 10 11 — St.)
File No. 33499
Registered No. 1
If death occurs away from usual residence, give facts called for under special information.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Julia Helen Fiscus

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	

6. DATE OF BIRTH December (Month) 5th (Day) 1913 (Year)

7. AGE 7 Yrs. 7 Mos. 25 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Schoolgirl
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Potlatch, Idaho

10. NAME OF FATHER Walter Allen Fiscus

11. BIRTHPLACE OF FATHER (State or Country) Kansas

12. MAIDEN NAME OF MOTHER Susie Vogel

13. BIRTHPLACE OF MOTHER (State or Country) Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Julia Vogel
(Address) Moscow, Idaho.

15. Filed 3/7 1921 N H Carruthers Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March (Month) 2 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feby 13 1921, to Mch 2, 1921, that I last saw h[er] alive on Mch 2 1921, and that death occurred on the date stated above, at 3:00 P.M.
The CAUSE OF DEATH* was as follows:

Pyemia

(Duration) ..... Yrs. ..... mos. 2 ds.
Contributory (Secondary) Abcessed tooth
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Chas. L. Pitman M. D.
3/7 1921 (Address) Moscow Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. 17 days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence Potlatch Idaho

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Potlatch Idaho	3/4 1921

20. UNDERTAKER Glen Price — ADDRESS Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33500
Registered No. 8

1. PLACE OF DEATH
County of Latah
City of Moscow (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

RECEIVED APR 8 1921 BUREAU OF VITAL STATISTICS

Registration District No. 61
Primary Registration District No. 1011

2. FULL NAME Mamie E Helfert

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Fem	white	Widowed

6. DATE OF BIRTH: July (Month) 19 (Day) 1877 (Year)

7. AGE: 49 Yrs. 7 Mos. 19 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): North Carolina

10. NAME OF FATHER: B F Jones

11. BIRTHPLACE OF FATHER (State or Country): North Carolina

12. MAIDEN NAME OF MOTHER: Mary A Hauser

13. BIRTHPLACE OF MOTHER (State or Country): North Carolina

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) B F Jones
(Address) Moscow Ida

15. Filed 3/11 19 21 M Mcarthers
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mch (Month) 16 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mch 6 1921, to Mch 6 1921, that I last saw h[illegible] alive on Mch 6 19..., and that death occurred on the date stated above, at 5[illegible] M.

The CAUSE OF DEATH* was as follows:

Aortic insufficiency

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas. L. Gritman M. D.

3/11 1921 (Address) Moscow

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Moscow — DATE OF BURIAL: 3/13 1921

20. UNDERTAKER: Glenn Funeral Home — ADDRESS: Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

No. 5-A—25 M. 1-19.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33501

Registered No. 9

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Latah

City of Moscow (If outside limits, give township) St.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED Registration District No. 1011
APR 8 Primary Registration District No.
BUREAU OF VITAL STATISTICS

DATE OF DEATH 61

2. FULL NAME Emma M. Eggan.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Fem	White	Married

6. DATE OF BIRTH: Mch (Month) 3 (Day) 1872 (Year)

7. AGE: 49 Yrs. Mos. 2 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER: ?

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: ?

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) James Eggan.
(Address) Moscow

15. Filed 3/11 1921 N. H. Carithers Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mch (Month) 19 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 1 1921, to March 10 1921, that I last saw her alive on Mch 10 1921, and that death occurred on the date stated above, at 10:20 P.M.

The CAUSE OF DEATH* was as follows:

Peritonitis

(Duration) Yrs. mos. ds.

Contributory (Secondary): Gastric perforation

(Duration) yrs. mos. ds.

(Signed) Chas. L. Fitzman M. D.

3/11 1921 (Address) Moscow

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. 3 days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Moscow — DATE OF BURIAL: 3/13 1921

20. UNDERTAKER: Gem City — ADDRESS: Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Latah — Registration District No. 101

City of Moscow — Primary Registration District No. 1011 — St.)

RECEIVED APR 8 1921 BUREAU OF VITAL STATISTICS

File No. 33502

Registered No. 10

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Doris Leith.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widowed

6. DATE OF BIRTH: May (Month) 16 (Day) 1845 (Year)

7. AGE: 75 Yrs. 10 Mos. 1 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: ?

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: ?

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs W J Leith

(Address) Moscow

15. Filed 3/18 1921 W. H. Carruthers Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 17 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 16th 1921, to March 16th 1921, that I last saw her alive on March 16 1921, and that death occurred on the date stated above, at 11 A M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... Yrs. ..... mos. 3 ds.

Contributory (Secondary) Paralysis

(Duration) ..... yrs. 6 mos. ..... ds.

(Signed) W. A. Adair M. D.

March 18 1921 (Address) Moscow Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Cameron Idaho — DATE OF BURIAL ..... 19.....

20. UNDERTAKER — ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED
APR 8 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Latah Registration District No. 61
City of Moscow Primary Registration District No. 1011
If death occurs away from usual residence, give facts called for under special information.

File No. 33503
Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Emma Berglund

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Fem	white	widowed

6. DATE OF BIRTH Feb 24 1848
(Month) (Day) (Year)

7. AGE 73 Yrs. 1 Mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work At Home
(b) General nature of industry, business or establishment in which employed (or employer) with children

9. BIRTHPLACE (State or Country) Sweden

10. NAME OF FATHER Nels Peterson

11. BIRTHPLACE OF FATHER (State or Country) Sweden

12. MAIDEN NAME OF MOTHER ?

13. BIRTHPLACE OF MOTHER (State or Country) ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J A Berglund
(Address) Moscow

15. Filed 3/30 1921 M M Carithers
Local Registrar

SUNS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 27 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 13, 1921 to March 27, 1921
that I last saw her alive on March 27, 1921
and that death occurred on the date stated above, at 10:30 P.M.
The CAUSE OF DEATH* was as follows:

La Grippe

(Duration) ..... Yrs. ..... mos. 2 weeks

Contributory (Secondary) Mitral Regurgitation

(Duration) 4 yrs. — mos. — ds.

(Signed) J. Curtis M. D.
3/30 1921 (Address) Moscow

*State the ~~Disease~~ Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Moscow	4/3 1921
20. UNDERTAKER	ADDRESS
Gilbert Rice	Moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 61

Primary Registration District No. 10 11

File No. 33504

County of Latah

City of Moscow (No.) ..... St.)

Registered No. 12

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its name instead of street and number.

RECEIVED
APR 8 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME William Willard Edwin Layton

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE:

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.):

6. DATE OF BIRTH: July (Month) 18 (Day) 1913 (Year)

7. AGE: 8 Yrs. 7 Mos. 10 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Elko Nev.

10. NAME OF FATHER: Joseph Layton.

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Rose Jordan.

13. BIRTHPLACE OF MOTHER (State or Country): Oregon.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Rose Moorhead

(Address) Pierce Ida.

15. Filed 3/2 1921 M Hamilton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 17 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 25 th 1921, to March 17 1921 that I last saw him alive on March 17 1921 and that death occurred on the date stated above, at 1.30 P.M.

The CAUSE OF DEATH* was as follows:

Acute Pneumonia

(Duration) ..... Yrs. ..... mos. 6 ds.

Contributory (Secondary) Tuberculosis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. W. Stevenson M. D.

3/2 1921 (Address) Moscow Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Pierce Idaho — DATE OF BURIAL ..... 19.....

20. UNDERTAKER: Glen Rice — ADDRESS Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33505
Registered No. 13

1. PLACE OF DEATH
County of Latah
City of Moscow (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

RECEIVED
APR 8 1921
BUREAU OF VITAL STATISTICS

Registration District No. 101
Primary Registration District No. 1011

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Nettie L Branson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: March 4 1891 (Month) (Day) (Year)

7. AGE: 30 Yrs. 25 Mos. ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Home wife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Colorado

10. NAME OF FATHER: Wm H Spangler

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Laura E. Drew

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): W E Branson
(Address): Moscow

15. Filed 3/30 1921 D H Boarthers Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 29 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 1 1920, to March 29 1921 that I last saw h.r alive on March 24 1921 and that death occurred on the date stated above, at 10 A.M.
The CAUSE OF DEATH* was as follows:
Pulmonary tuberculosis
(Duration) 10 about Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) J. N. Clarke M. D.
3/30 1921 (Address) Moscow

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Moscow | DATE OF BURIAL: 4/1 1921

20. UNDERTAKER: Gillis Bros | ADDRESS: Moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33506
Registered No. 14

1. PLACE OF DEATH
County of Latah
City of Moscow (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

RECEIVED
APR 8 1921
BUREAU OF VITAL STATISTICS

Registration District No. 61
Primary Registration District No. 1011

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Dorthy E. Hurley

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F	White	

6. DATE OF BIRTH: March (Month) 16 (Day) 1921 (Year)

7. AGE: ..... Yrs. ..... Mos. 11 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho.

10. NAME OF FATHER Lorenzo A. Hurley

11. BIRTHPLACE OF FATHER (State or Country) Iowa.

12. MAIDEN NAME OF MOTHER Mary A. Woodside

13. BIRTHPLACE OF MOTHER (State or Country) Penn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Lorenzo A. Hurley
(Address) Moscow Ida

15. Filed 3/21 1921 W. H. Carithers Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mch (Month) 27 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mch 14 1921 to Mch 27 1921 that I last saw h..... alive on ..... 19..... and that death occurred on the date stated above, at 3304 M.

The CAUSE OF DEATH* was as follows:
Premature

..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Valvular Insufficiency
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. H. Clark M. D.
3/27 1921 (Address) Moscow Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Moscow — DATE OF BURIAL: 3/28 1921

20. UNDERTAKER ..... ADDRESS .....

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33507
Registered No. 2

1. **PLACE OF DEATH**

Registration District No. 62
Primary Registration District No. 2142

County of Latah

City of Genesee (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED APR 6 1921 BUREAU OF STATISTICS

2. FULL NAME Ernest Leland Wahl

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	white	

6. DATE OF BIRTH: Mar (Month) 17 (Day) 1921 (Year)

7. AGE: ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many 2 hrs. or 30 min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Latah Co Idaho

10. NAME OF FATHER: Sherman L. Wahl

11. BIRTHPLACE OF FATHER (State or Country): California

12. MAIDEN NAME OF MOTHER: Mary C. McFarland

13. BIRTHPLACE OF MOTHER (State or Country): Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Sherman Wahl
(Address) Genesee Idaho

15. Filed 3-18- 1921 W. H. Eldredge Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mch (Month) 17 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mch 17- 1921, to Mch 17 1921, that I last saw h— alive on Mch 17 1921, and that death occurred on the date stated above, at 8 P M.

The CAUSE OF DEATH* was as follows:

Premature birth 7 mos.

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. H. Eldredge M. D.

3-17 1921 (Address) Genesee

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Genesee — DATE OF BURIAL: 3-18 1921

20. UNDERTAKER: F. E. Lambert — ADDRESS: Genesee Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Latah Registration District No. 2147
City of Deary Primary Registration District No. 67 St.)
File No. 33310
Registered No. 33

RECEIVED
APR 1921
BUREAU OF VITAL STATISTICS

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ray Dean Weber

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M.	W.	single

6. DATE OF BIRTH: Mar. 13 1921
(Month) (Day) (Year)

7. AGE: 0 Yrs. 0 Mos. 5 ds.
IF LESS than 1 day how many ____ hrs. or ____ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ida.

10. NAME OF FATHER: Charles Weber

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Elsie Comstock

13. BIRTHPLACE OF MOTHER (State or Country): Wis.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) D. C. Faust
(Address) Deary

15. Filed 3/18 1921 D. C. Faust
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar. 15 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from at birth 19__, to 19__, that I last saw h.. ..ive on Mar. 13 1921, and that death occurred on the date stated above, at 6:30 A.M.

The CAUSE OF DEATH* was as follows:
Unknown

(Duration) ____ Yrs. ____ mos. ____ ds.
Contributory (Secondary) Premature Birth

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) D. C. Faust M. D.
3/18 1921 (Address) Deary

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Elwood Cem.	3/19 1921

20. UNDERTAKER	ADDRESS
none	

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33511
Registered No.

Registration District No. 65
Primary Registration District No. 2145

1. PLACE OF DEATH
County of Latah
City of Princeton
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary A. Chapman
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word.): Widowed

6. DATE OF BIRTH: April (Month) 18 (Day) 1838 (Year)

7. AGE: 82 Yrs. 10 Mos. 16 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business or establishment in which employed (or employer): with Children

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Able J. Smith

11. BIRTHPLACE OF FATHER (State or Country): —do—

12. MAIDEN NAME OF MOTHER: Marquet Wheeler

13. BIRTHPLACE OF MOTHER (State or Country): Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) B F Thomas
(Address) Princeton

15. Filed 3/7 1921 D.J.M. Thompson Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 6 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....
and that death occurred on the date stated above, at 2 P.M.
The CAUSE OF DEATH* was as follows:

Natural Causes,
Paralysis (Duration) 6 Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Glen Rice Coroner M. D.
3/7 1921 (Address) Moscow

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Moscow
DATE OF BURIAL: 3/9 1921
20. UNDERTAKER: Glen Rice
ADDRESS: Moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33512

Registered No. 15

1. PLACE OF DEATH. RECEIVED Registration District No. 16

County of Lincoln APR 1 1921 Primary Registration District No. 1016

City of Shoshone BUREAU OF STA (No. Dills Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Edith Ethel Hubbard

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. April (Month) 21st (Day) 1898 (Year)

7. AGE: 22 Yrs. 10 Mos. 24 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: School Girl
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Elmore Co., Idaho.

10. NAME OF FATHER: Edward Hubbard

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Eva Harden.

13. BIRTHPLACE OF MOTHER (State or Country): Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Eva Hubbard
(Address) Shoshone, Idaho

15. Filed March 18 1921 J. L. Tillson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 15th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 10 1921, to March 15 1921, that I last saw h[illegible] alive on March 15 1921, and that death occured on the date stated above, at 4 P M.

The CAUSE OF DEATH* was as follows:
Acute intestinal obstruction

(Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary) Not Given

(Duration ..... yrs. ..... mos. ..... ds.

3/16 1921 (Signed) [signature] M. D.
(Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Glenns Ferry — DATE OF BURIAL 191

20. UNDERTAKER: O. J. Brennan — ADDRESS: Shoshone Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

EVANS - YORK CO., PTRS. & BDRS. 24853

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33513

Registered No. 35

1. PLACE OF DEATH. RECEIVED

County of Lincoln APR 1 1 13

City of Shoshone BUREAU OF STATISTICS (No. ..... St.)

Registration District No. 16

Primary Registration District No. 1016

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Henry Isbell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. 1834 ca[illegible] unknown as to month and day (Month) (Day) (Year)

7. AGE: 87 Yrs. 0 Mos. 0 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Painter
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: unknown

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: unknown

13. BIRTHPLACE OF MOTHER (State or Country): Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) C Hansen
(Address) Shoshone

15. Filed March 23 1914 J L Fuller Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 3 (Month) 13 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1914, to March 1914, that I last saw him alive on 3/20 1914, and that death occured on the date stated above, at 3 P M.

The CAUSE OF DEATH* was as follows:
Senility
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Not known
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) C H Dee M. D.
3/23 1914 (Address) Shoshone

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Shoshone — DATE OF BURIAL: 3-24-1914

20. UNDERTAKER: O J Brannan — ADDRESS: Shoshone

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOOKS. 24658

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. [illegible]
Primary Registration District No. 7-27-2-21

File No. 33514

Registered No. 4

1. PLACE OF DEATH

County of [redacted] Lewis

City of Winchester (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Infant Gibbons

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: March 8 1920 (Month) Feb. 27 (Day) 1921 (Year)

7. AGE: ..... Yrs. ..... Mos. 19 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Winchester Idaho

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Loretta Gibbons

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Harry Wright
(Address) Craigmont Ida.

15. Filed 3/29 1921 R E Bunch Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 27 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 27 1921 to Mar 27 1921 that I last saw her alive on Mar 27 1921 and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Whooping Cough

(Duration) ..... Yrs. ..... mos. 8 ds.

Contributory (Secondary) Weak Baby

(Duration) ..... yrs. ..... mos. 8 ds.

(Signed) [illegible] M. D.

1921 (Address) Winchester Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Town Cemetery	3/29 1921
20. UNDERTAKER	**ADDRESS**
T. O. Featherngill	Winchester Ida

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33515
Registered No. .....

1. PLACE OF DEATH.
County of Lewis
City of Kamiah
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 49
Primary Registration District No. 2425
(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Edith M Reed

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH.
June (Month) 23 (Day) 1880 (Year)

7. AGE
41 Yrs. 7 Mos. 16 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Wisconsin

10. NAME OF FATHER: Miller

11. BIRTHPLACE OF FATHER (State or Country): ?

12. MAIDEN NAME OF MOTHER: ?

13. BIRTHPLACE OF MOTHER (State or Country): ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Hiram J. Reed
(Address) Kamiah, Idaho

15.
Filed 2/10 19.. C. F. Johnson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Feb. (Month) 8 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191.., to ..... 191..., that I last saw h.. alive on Feb. 8 1921, and that death occured on the date stated above, at 3.40 P.M.

The CAUSE OF DEATH* was as follows:
Prolonged fast, self imposed

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) V. VanDuyn M.D.
19.. (Address) Kamiah Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: I.O.O.F. — DATE OF BURIAL: 2/10 1921

20. UNDERTAKER: C. F. Johnson — ADDRESS: Kamiah

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYMS - YORK CO., PTRS. & SONS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33516
Registered No. .....

1. PLACE OF DEATH.
County of Lewis
City of Kamiah
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 49
Primary Registration District No. 2424
(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Cyrus H Brown

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married
6. DATE OF BIRTH. (?) ..... (Month) ..... (Day) 1 (Year)
7. AGE: about 54 yrs ..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Farming
(b) General nature of industry, business, or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): Michigan
10. NAME OF FATHER: Marion S Brown
11. BIRTHPLACE OF FATHER (State or Country): New York
12. MAIDEN NAME OF MOTHER: Lavina Potter
13. BIRTHPLACE OF MOTHER (State or Country): Michigan
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Walter S. Brown
(Address) Kamiah
15. Filed 2/ 1921 C P Johnson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
2-5 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2-7 1921, to 2-8 1921, that I last saw h. alive on 2-7 1921, and that death occured on the date stated above, at 7 A. M.
The CAUSE OF DEATH* was as follows:

Alegia Pectoris

(Duration) ..... Yrs. ..... mos. 2 ds.
Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. 2 ds.
(Signed) E J Taylor M. D.
19.... (Address) Kamiah Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: I O O F Cemetery — DATE OF BURIAL: Feb 9 1921
20. UNDERTAKER: C P Johnson — ADDRESS: Kamiah

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & ROBS. 24853

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33517
Registered No. .....

1. PLACE OF DEATH.
County of Lewis
City of Kamiah
(No. ....., ... St.)
Registration District No. 49
Primary Registration District No. 2425

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Gilbert Herman Rosengrant

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Jan (Month) 9 (Day) 1921 (Year)

7. AGE ..... Yrs. 1 Mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Child
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) ~~Kan~~ Idaho

10. NAME OF FATHER Harold Page Rosengrants

11. BIRTHPLACE OF FATHER (State or Country) Colorado

12. MAIDEN NAME OF MOTHER Marie Florence Buson

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Harold Page Rosengrants
(Address) Asotin Wash

15.
Filed 2/24 1921
C E Johnson Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
February (Month) 23rd (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to Feb 23 - 1921, that I last saw him alive on Feb 23 - 1921, and that death occured on the date stated above, at 4 A.M.

The CAUSE OF DEATH* was as follows:
Lobar Pneumonia Jaun
.....(Duration) ..... Yrs. ..... mos. 4 ds.
Contributory (Secondary) .....
.....(Duration ..... yrs. ..... mos. ..... ds.

(Signed) C E Brazen M. D.
2/24 1921. (Address) Kamiah Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: I O O F Kamiah — DATE OF BURIAL: 2/24 1921

20. UNDERTAKER C E Johnson — ADDRESS Kamiah

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 49
Primary Registration District No. 2428
File No. 33518
Registered No. .....

1. PLACE OF DEATH.
County of Idaho
City of Kamiah
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William Crow

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH.
4 (Month) 6 (Day) 1835 (Year)

7. AGE
85 Yrs. 10 Mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Nova Scotia Canada

10. NAME OF FATHER: John Crow

11. BIRTHPLACE OF FATHER (State or Country): Nova Scotia Canada.

12. MAIDEN NAME OF MOTHER: Sarah Staples

13. BIRTHPLACE OF MOTHER (State or Country): Nova Scotia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant): Geo W Crow
(Address): Kamiah Idaho

15. Filed 2-17- 1921
Local Registrar: C J Johnson

SYMS - YORK CO., PTRS. & BORS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Feb. (Month) 17 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from January 10 1921, to Feb 16th 1921, that I last saw him alive on Feb. 16th 1921, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Influenza
.....
.....
(Duration) 3 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) C O Ryan M. D.
2/17 1921 (Address) Kamiah Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: .....
DATE OF BURIAL: .....191.....

20. UNDERTAKER: E J Johnson
ADDRESS: Kamiah Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 49

Primary Registration District No. 2418

File No. 33519

Registered No. .....

1. PLACE OF DEATH.

County of Lewis

City of Kamiah

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Martha A Sanderson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. Nov (Month) 19 (Day) 1845 (Year)

7. AGE: 75 Yrs. 3 Mos. 10 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer) Housekeeper

9. BIRTHPLACE (State or Country) Ontario Can

10. NAME OF FATHER John London

11. BIRTHPLACE OF FATHER (State or Country) Ontario Can

12. MAIDEN NAME OF MOTHER Do not know

13. BIRTHPLACE OF MOTHER (State or Country) unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W S Rankin

(Address) Kamiah Ida

15. Filed Feb 25 - 1921

Local Registrar E J Johnson

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 24 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 15th 1921, to Chance 1921, that I last saw h.. alive on Feb. 25 1921, and that death occured on the date stated above, at 2:30 P.M.

The CAUSE OF DEATH* was as follows:

Mitral Heart

.....(Duration) ..... Yrs. ..... mos. 2d ds.

Contributory (Secondary) Valvular Heart

.....(Duration ..... yrs. 6 mos. ..... ds.

(Signed) C E Bryan M. D.

2/26 1921 (Address) Kamiah, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Portland, Oregon

DATE OF BURIAL ..... 191.....

20. UNDERTAKER E J Johnson

ADDRESS Kamiah

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHRASE should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SVMS - YORK CO., PTRS. & SOLS. 24653

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33520
Registered No.

1. PLACE OF DEATH.
County of Lewis
City of Kamiah (No. , St.)
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

Registration District No. 90
Primary Registration District No.

2. FULL NAME Unnamed

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: July 14 1921 (Month) (Day) (Year)

7. AGE: — yrs. — mos. — ds.
IF LESS than 1 day how many ../..hrs. or ...../..mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: William Payne

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Elsie King

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): J. P. Daily
(Address): Orofino Ida

15. Filed 3/7 1921
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: July 15 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 14 1921, to July 15 1921, that I last saw h— alive on July 14 1921, and that death occurred on the date stated above, at 5:40 M.

The CAUSE OF DEATH* was as follows:

Premature
6 1/2 months
(Duration) — yrs. — mos. — ds.

Contributory (Secondary)
(Duration) — yrs. — mos. — ds.

(Signed) J. M. Daniel M. D.
7/15 1921 (Address) Orofino Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ...yrs...mos...days. In the State ...yrs...mos...days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Kamiah Ida
DATE OF BURIAL: July 16 1921

20. UNDERTAKER: None
ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33521

Registered No. 77

Registration District No. 16

Primary Registration District No. 1016

(No. .... St.)

1. PLACE OF DEATH.

County of Lincoln

City of Shoshone

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charles Wm Frey

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male W

4. COLOR OR RACE

5. SINGLE, ~~MARRIED, WIDOWED OR DIVORCED.~~ (Write the word.): Single

6. DATE OF BIRTH. April 30 1919 (Month) 22 months (Day) 1 (Year)

7. AGE: ..... Yrs. 2 2 Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Willis Frey

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Gladys Mary Franklin

13. BIRTHPLACE OF MOTHER (State or Country): .....

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Bill Frey

(Address) .....

15. Filed March 5 1921

J. L. Fuller
Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 3 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 20 1921, to March 3 1921, that I last saw h— alive on March 3 1921, and that death occurred on the date stated above, at 8 45 P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia

.....

.....

.....(Duration) 1 Yrs. ..... mos. ..... ds.

Contributory (Secondary) Do not know

.....(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. L. Fuller M. D.

3/4 1921 (Address) Shoshone

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Shoshone — DATE OF BURIAL: 3-5 1921

20. UNDERTAKER: O. F. Brennan — ADDRESS: Shoshone

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33522
Registered No. 17

RECEIVED
APR 27 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH. County of Madison City of Hibbard (No. St.) District No. 100 Primary Registration District No. 2178.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Dorothy Morris

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH. September (Month) 4 (Day) 1918 (Year)
7. AGE: 2 Yrs. 6 Mos. 17 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Hibbard - Idaho -
10. NAME OF FATHER: Henry Morris
11. BIRTHPLACE OF FATHER (State or Country): Monyon, Utah
12. MAIDEN NAME OF MOTHER: Lucy Cook
13. BIRTHPLACE OF MOTHER (State or Country): Hibbard Idaho.
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Henry Morris
(Address)
15. Filed 3/17 1921 G G Espe Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 16 (Day) 1921 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Feb. 23 1921, to Mch. 16 1921, that I last saw her alive on Mch 16 1921, and that death occured on the date stated above, at 7-a M.
The CAUSE OF DEATH* was as follows:
Broncho pneumonia
(Duration) Yrs. mos. 21 ds.
Contributory (Secondary)
(Duration yrs. mos. ds.
3/17 1921 (Signed) Louis L. Peck M. D.
(Address) Rupert Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rupert, Idaho. DATE OF BURIAL: 3-18 1921
20. UNDERTAKER: Jno. McRichards ADDRESS: Rupert, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BORS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33523

Registered No. [illegible]

RECEIVED
APR 27 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH.

Local Registration District No. .....

Primary Registration District No. .....

County of Madison

City of Rexburg (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Christina M. Walz

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH. December (Month) 20 (Day) 1845 (Year)

7. AGE: 75 Yrs. 2 Mos. 14 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: Johann Conrad Walz

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Annie M. P. Detgner

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Conrad Walz

(Address) .....

15. Filed 4/3 1921

G G Esper
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 4 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mch 3 1921, to March 4th 1921, that I last saw her alive on March 4 1921, and that death occured on the date stated above, at 5-15 P.M.

The CAUSE OF DEATH* was as follows:

Uraemia

(Duration) 2 Yrs. mos. 6 ds.

Contributory (Secondary) Senility

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Louis A. Fiehe M. D.

4/8 1921 (Address) Rexburg Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rexburg, Idaho. DATE OF BURIAL: 4-8 1921

20. UNDERTAKER: John M. Richards ADDRESS: Rexburg, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24654

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

RECEIVED
APR 7 1921
BUREAU OF VITAL STATISTICS

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No.
County of Madison Primary Registration District No.
City of Resburg (No. St.)
If death occurs away from usual residence, give facts called for under special information.

File No. 33524
Registered No. 19
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Emily Newby

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): widowed

6. DATE OF BIRTH: Feb (Month) 15 (Day) 1831 (Year)

7. AGE: 91 yrs. — mos. 21 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: Wm Augethorpe

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Mary Stara

13. BIRTHPLACE OF MOTHER (State or Country): England.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Ada Emily Newby
(Address) Resburg Ida

15. Filed 3/17 1921 G G Espe Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March (Month) 8 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 7 1921, to Mar 8 1921, that I last saw her alive on Mar 7 1921, and that death occurred on the date stated above, at 5 o'clock P. M.

The CAUSE OF DEATH* was as follows:
General debility

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G G Parkinson M. D.
19 (Address) Resburg Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL 191...

20. UNDERTAKER: John Phillips | ADDRESS: Resburg

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

RECEIVED APR 7 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 100
County of Madison Primary Registration District No. 2178
City of Rexburg (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

File No. 33525
Registered No. 21
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Zola Klinger

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	white	single (child)

6. DATE OF BIRTH: Feby (Month) 4 (Day) 1921 (Year)

7. AGE: ..... yrs. 1 mos. 5 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work: nil
(b) General nature of industry business, or dstablishment in which employed (or employer): nil

9. BIRTHPLACE (State or Country): Rexburg Idaho

10. NAME OF FATHER: Christopher C Klinger

11. BIRTHPLACE OF FATHER (State or Country): U.S.A.

12. MAIDEN NAME OF MOTHER: Mattie Gibson

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Jas. Gibson
(Address) Rexburg Ida

15. Filed 3/10 1921 Y E Espe Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March (Month) 9 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 8 1921, to March 8 1921
that I last saw her alive on March 8 1921
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Auto intoxication
(intestinal)

(Duration) ..... yrs. ..... mos. — ds.
Contributory (Secondary) Mal nutrition
(Duration) 2 yrs. 6 mos. 7 ds.

4/1 1921 (Signed) Lorin L Peel M. D.
(Address) Rexburg Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Rexburg Ida	Mar 10 1921

20. UNDERTAKER	ADDRESS
John Phillips	Rexburg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

RECEIVED
APR 7 1921
BUREAU OF VITAL STATISTICS

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 10
Primary Registration District No. 2178
File No. 33526
Registered No. 22

1. PLACE OF DEATH.
County of Madison
City of Redburg (No. St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Baby Norton

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): ~~Child~~

6. DATE OF BIRTH: Mar (Month) 17 (Day) 1921 (Year)

7. AGE: ..... yrs. ..... mos. ..... ds. 0
IF LESS than 1 day how many 8 hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Redburg Ida

10. NAME OF FATHER Robt R Norton

11. BIRTHPLACE OF FATHER (State or Country) Ill.

12. MAIDEN NAME OF MOTHER Hazel McCartney

13. BIRTHPLACE OF MOTHER (State or Country) Minn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Robert R Norton
(Address) .....

15. Filed 3/14 1921 E E Espe Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Mch (Month) 13 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mch 12 1921, to Mch 13 1921, that I last saw her alive on Mch 12 1921 and that death occurred on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:
Premature birth

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C.C. Martin M. D.
3-13 1921 (Address) Redburg Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL ..... 191...

20. UNDERTAKER Jno Phillips | ADDRESS Redburg Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
APR 7 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH. Registration District No. 10-
County of Madison Primary Registration District No. 2178
City of Archer (If outside limits, give township) St.)
File No. 33527
Registered No. 23

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Chester Burns Briggs

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Child

6. DATE OF BIRTH. Oct (Month) 19 (Day) 1923 (Year)

7. AGE: 9 Yrs. 4 Mos. 25 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: George Briggs

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Martha Briggs

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) George Briggs
(Address) Archer Ida.

15. Filed 3/18 1921 G Gillespie Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 16 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 9, 1921, to Mch 16 1921, that I last saw him alive on Mch 15 1921 and that death occured on the date stated above, at 3:35 A.M.

The CAUSE OF DEATH* was as follows:

Acute Parenchymatous Nephritis

(Duration) Yrs. mos. 21 ds.

Contributory (Secondary) Chronic Interstitial Nephritis

(Duration) yrs. mos. ds.

(Signed) A. V. Martin M. D.

3-16 1921 (Address) Rexburg, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Archer — DATE OF BURIAL: 3/18 1921

20. UNDERTAKER: W. A. Harris — ADDRESS: Rexburg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 24854

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

RECEIVED
APR 7 1921
BUREAU OF VITAL STATISTICS

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 102
Primary Registration District No. 2178
File No. 33528
Registered No. 24

1. PLACE OF DEATH.
County of Madison
City of Rexburg (St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Amelia Bitter

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	white	single

6. DATE OF BIRTH: November 18 1866
(Month) (Day) (Year)

7. AGE: 54 yrs. 3 mos. 29 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Traugott Bitter

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Wilamena R Aust

13. BIRTHPLACE OF MOTHER (State or Country): German

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Hyrum Ricks
(Address) Rexburg Ida

15. Filed 3/16 1921
G G Estes
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March 17 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 17 1921 to Mar 17 1921 that I last saw her alive on Mar 17 1921 and that death occurred on the date stated above, at 11 A. M.

The CAUSE OF DEATH* was as follows:
Chronic Nephritis

(Duration) yrs. mos. 1st ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) G T Parkinson M. D.
19 (Address) Rexburg Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Logan Utah
DATE OF BURIAL: 191

20. UNDERTAKER: Ford Phillips
ADDRESS: Rexburg Ida
Rexburg Furniture Co

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & SDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
APR 7 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH. Registration District No.....
County of Madison Primary Registration District No.....
City of Rexburg (or Village, or Township) St.)
If death occurs away from usual residence, give facts called for under special information.

File No. 33529
Registered No. 2nd

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Maggie Muir Eardley

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. February 12 (Month) (Day) 1883 (Year)

7. AGE: 38 Yrs. 1 Mos. 14 ds.
IF LESS than 1 day how many.....hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mendon, Utah

10. NAME OF FATHER: Walter Muir

11. BIRTHPLACE OF FATHER (State or Country): Scotland

12. MAIDEN NAME OF MOTHER: Margaret Bassett

13. BIRTHPLACE OF MOTHER (State or Country): Wales

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J Eardley
(Address) Rexburg, Idaho

15. Filed 3/24 1921
Local Registrar

SYMS - YORK CO., PTRS. & BOOKS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 26 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 13 1921, to March 24 1921, that I last saw her alive on March 24 1921, and that death occured on the date stated above, at 4. P. M.

The CAUSE OF DEATH* was as follows:
Diffuse Septic Peritonitis
(following ruptured appendix)
(Duration) Yrs. mos. 13 ds.
Contributory (Secondary) Lobar pneumonia
(Duration yrs. mos. 3 ds.

3/26 1921 (Signed) Lorin L. Rich M. D.
(Address) Rexburg Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Sugar City, Idaho — DATE OF BURIAL: 3-28 1921

20. UNDERTAKER: John M. Richards — ADDRESS: Rexburg, Ida

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33530
Registered No. 22

1. PLACE OF DEATH. Registration District No. 100
County of Madison Primary Registration District No. 2178.
City of Rexburg (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

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BUREAU OF VITAL STATISTICS

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Misawa Hanami

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: Jap.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): baby

6. DATE OF BIRTH. Feb. (Month) 1 (Day) 1921 (Year)

7. AGE ..... Yrs. 4 Mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: infant.
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Idaho.

10. NAME OF FATHER S. S. Hanami.

11. BIRTHPLACE OF FATHER (State or Country) Japan.

12. MAIDEN NAME OF MOTHER Wasa Sake

13. BIRTHPLACE OF MOTHER (State or Country) Japan.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Tamajiro Satow
(Address) Rexburg Ida.

15. Filed 4/14 1921 G. G. Espe Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24854

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March (Month) 13 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Pneumonia (Broncho)
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... Yrs. ..... mos. ..... ds.
(Signed) G. G. Espe M. D.
..... 19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rexburg — DATE OF BURIAL: 4/14 1921

20. UNDERTAKER: [illegible] — ADDRESS: Rexburg

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED APR 7 19

BUREAU OF STATISTICS

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33531

Registered No. 27

1. PLACE OF DEATH.

Registration District No. 100

Primary Registration District No. 2178

County of Madison

City of Rexburg (If not in incorporated limits, give township.) St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Christiane Pieper

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): widow

6. DATE OF BIRTH. November (Month) 4 (Day) 1845 (Year)

7. AGE: 75 Yrs. 4 Mos. 23 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Massenhausen, Germany

10. NAME OF FATHER: Henry Pieper

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Friedericke, Gerhard

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) H. C. Pieper

(Address) Rexburg

15. Filed 3/28 1921 G. G. Espe Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 29 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3-2- 1921, to 3-20 1921, that I last saw her alive on 3-20- 1921, and that death occured on the date stated above, at 5 a. M.

The CAUSE OF DEATH* was as follows:

Anasarca.

(Duration) Yrs. 6 mos. — ds.

Contributory (Secondary) Endocarditis

(Duration 3 yrs. — mos. — ds.

(Signed) Lorin L. Rich M. D.

3/28 1921 (Address) Rexburg Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rexburg, Idaho. DATE OF BURIAL: 3-29 1921

20. UNDERTAKER: John W. Richards ADDRESS: Rexburg Ida

Form V. S. No. 5 20M.1-16-12

RECEIVED APR 7 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33532

Registered No. 28

1. PLACE OF DEATH.

Registration District No.

Primary Registration District No.

County of Madison

City of Rexburg (If outside limits of city or village, write the word OUTSIDE and give name of township.) St. (No. 191 S. 3, St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Betsy Anderson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH: February 10 (Month) 1830 (Year)

7. AGE: 91 yrs. 1 mos. 17 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER: Lars Shenstraum

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Johanneh —

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Olof Anderson
(Address) Rexburg Ida

15. Filed 3/28 1921 G. G. Espy Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Mar 27 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 1st 1921, to March 27th 1921, that I last saw her alive on March 27 1921, and that death occurred on the date stated above, at 11:50 P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia.

(Duration) yrs. mos. 2 ds.

Contributory (Secondary) Senile exaustion

(Duration) 3 yrs. mos. ds.

(Signed) Lorin F. Rich M. D.

3/28 1921 (Address) Rexburg Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Rexburg City Cemetery — DATE OF BURIAL: 3/30 1921

UNDERTAKER: Rexburg FURNITURE CO. — ADDRESS: Rexburg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

RECEIVED
APR 7 1921
BUREAU OF VITAL STATISTICS

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
Registration District No. .....
County of Madison
Primary Registration District No. .....
File No. 33533
City of Rexburg (St.)
Registered No. 29
If death occurs away from usual residence, give facts called for under special information.
2. FULL NAME La Von Phillips Cook
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	white	Single

6. DATE OF BIRTH
Mar 22 1921
(Month) (Day) (Year)

7. AGE
— yrs. — mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Rexburg Idaho

10. NAME OF FATHER Chas R Cook

11. BIRTHPLACE OF FATHER (State or Country) Idaho

12. MAIDEN NAME OF MOTHER Hazel Phillips

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chas R Cook
(Address) Rexburg Ida

15.
Filed 3/23 1921 G V Espe
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Mar 22 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 22 1921, to Mar 22 1921, that I last saw living alive on Mar 22 1921, and that death occurred on the date stated above, at 11 P M.

The CAUSE OF DEATH* was as follows:

Premature birth

(Duration) ..... yrs. ..... mos. 2 hrs. ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G V Parkinson M. D.
19 ..... (Address) Rexburg Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Rexburg Cemetery	191

20. UNDERTAKER John Priday FURNITURE CO. REXBURG, IDAHO
ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

RECEIVED
APR 7 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Madison
City of Rexburg

Registration District No. 107
Primary Registration District No. 2078
(Name of St.)

File No. 33534
Registered No. 31

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Verla Phillips Cook

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Wife

6. DATE OF BIRTH March 27 1891
(Month) (Day) (Year)

7. AGE ____ yrs. ____ mos. 7 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ✓
(b) General nature of industry business, or dstablishment in which employed (or employer) ✓

9. BIRTHPLACE (State or Country) Rexburg Idaho

10. NAME OF FATHER Chas R Cook

11. BIRTHPLACE OF FATHER (State or Country) Idaho

12. MAIDEN NAME OF MOTHER Hazel Phillips

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chas R. Cook
(Address) Rexburg

15. Filed 3/30 1921 G G Eaton
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH March 28 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 22 1921, to Mar 28 1921, that I last saw her alive on Mar 27 1921, and that death occurred on the date stated above, at 4a M.

The CAUSE OF DEATH* was as follows:
Premature Birth

(Duration) ____ yrs. ____ mos. 7 ds.

Contributory (Secondary) ____

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) G G Parkinson M. D.
19 (Address) Rexburg Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs....mos....days. In the State....yrs....mos....days.

Where was disease contracted if not at place of death? ____

Former or usual residence ____

19. PLACE OF BURIAL OR REMOVAL: Rexburg City Cemetery — DATE OF BURIAL: Mar 30 1921

20. UNDERTAKER: John Phillips & Son — ADDRESS: Rexburg Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33535

Registered No. 32

RECEIVED
APR 7 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 100

Primary Registration District No. 2178

County of Madison

City of Rexburg (No.) St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Warren C. Jackson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): ~~Child~~ single

6. DATE OF BIRTH: February 25 1921 (Month) (Day) (Year)

7. AGE: ..... Yrs. 1 Mos. 6 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: ✓

(b) General nature of industry, business or establishment in which employed (or employer): ✓

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: George H Jackson

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Josephine Wemsley

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Geo H Jackson

(Address) .....

15. Filed 4/1 1921

G G Espe
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar 31 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 17 1921 to Mar 31 1921 that I last saw ~~him~~ alive on Mar 30 1921 and that death occurred on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

Pertussis

(Duration) ..... Yrs. ..... mos. 14 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Parley Nelson M. D.

4-1 1921 (Address) Rexburg

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Plano

DATE OF BURIAL: 4/2 1921

20. UNDERTAKER: John Phillips

ADDRESS: Rexburg

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33536
Registered No. 33

RECEIVED
APR 7 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No.
Primary Registration District No.
County of Madison
City of Rexburg (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Edwyn George Albert Green

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (~~Write the word.~~)

6. DATE OF BIRTH: July (Month) 5 (Day) 1913 (Year)

7. AGE: 7 Yrs. 9 Mos. — ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Driggs, Idaho

10. NAME OF FATHER George B Green

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Amelia Dalley

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Geo B Green
(Address) Driggs Ida

15. Filed 4/5 1921 G E Espe
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 5 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 3 1921, to April 5 1921 that I last saw h.im alive on April 4. 9:30 A.M. 1921 and that death occurred on the date stated above, at 12:10 P.M.

The CAUSE OF DEATH* was as follows:

General peritonitis,

(Duration) Yrs. mos. ds.

Contributory (Secondary) Ruptured appendix

(Duration) yrs. mos. ds.

(Signed) G E Espe M. D.

19 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Driggs Ida — DATE OF BURIAL 19

20. UNDERTAKER: John Phillips — ADDRESS Rexburg Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33537
Registered No. 11

1. PLACE OF DEATH

Registration District No. 19
Primary Registration District No. 2015
(No. ..... St.)

County of Minidoka.
City of Rupert.
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Edna Irene McElroy.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.):

6. DATE OF BIRTH: July (Month) 2nd (Day) 1920 (Year)

7. AGE: Yrs. 7 Mos. 23 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Minidoka Co. Idaho.

10. NAME OF FATHER: Joseph H. McElroy.

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Susan Miles

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Joseph H McElroy.
(Address) Rupert Idaho.

15. Filed Mar. 1921 E. O. Ehmore Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 23 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 22 1921 to Feb 23 1921 that I last saw h— alive on Feb 23 1921 and that death occurred on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... mos. ..... ds.

(Signed) ..... M. D.

2-25 1921 (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rupert Cemetery. DATE OF BURIAL: Feb. 24 1921

20. UNDERTAKER: Colvin Sellers ADDRESS: Rupert Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 19
Primary Registration District No. 2013
File No. 33538
Registered No. 12

1. PLACE OF DEATH
County of Minidoka
City of Rupert
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME David V. Moore

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word.): Single

6. DATE OF BIRTH: Sept (Month) 9 (Day) 1915 (Year)

7. AGE: 6 Yrs. 4 Mos. 27 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Roy Moore

11. BIRTHPLACE OF FATHER (State or Country): Nebraska

12. MAIDEN NAME OF MOTHER: Lucy Arendorf

13. BIRTHPLACE OF MOTHER (State or Country): Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Roy Moore
(Address) Rupert Idaho

15. Filed Mar 8 1921 E. O. Elmore, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 6 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 28 1920, to Feb. 6 1921, that I last saw h... alive on Feb 6 1921, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Acute Nephritis
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Scarlet Fever
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E. O. Elmore M. D.
2-6 1921 (Address) Rupert, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Ashton Idaho — DATE OF BURIAL: Feb 9 1921

20. UNDERTAKER: W. A. Goodman — ADDRESS: Rupert Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 19
Primary Registration District No. 2013
File No. 33539
Registered No. 13

1. PLACE OF DEATH
County of Minidoka
City of Rupert (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Joseph F Stewart
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Child (Write the word.)

6. DATE OF BIRTH: Aug (Month) 30 (Day) 1918 (Year)

7. AGE: 2 Yrs. 4 Mos. 18 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Nebraska

10. NAME OF FATHER William Stewart

11. BIRTHPLACE OF FATHER (State or Country) Indiana

12. MAIDEN NAME OF MOTHER Mary Nelson

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) William Stewart
(Address) Rupert Idaho

15. Filed Feb 8 1921 E. A. Elmore Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 17 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 16 1921, to Jan 17 1921, that I last saw h.. alive on Jan 16 1921, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Cardiac Failure.

..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Measles.
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E. F. Killen M. D.
19..... (Address) Rupert

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: L. D. S. Cemetery — DATE OF BURIAL: Jan 18 1920

20. UNDERTAKER: W. A. Goodman — ADDRESS: Rupert Idaho

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 19
Primary Registration District No. 2013
File No. 33540
Registered No. 14

1. PLACE OF DEATH
County of Minidoka
City of Rupert
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John T Wilkins

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH: April (Month) 3 (Day) 1849 (Year)

7. AGE: 72 Yrs. 10 Mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Georgia

10. NAME OF FATHER: Samuel Wilkins

11. BIRTHPLACE OF FATHER (State or Country): Georgia

12. MAIDEN NAME OF MOTHER: Dont Know

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. L. Wilkins
(Address) Rupert Idaho

15. Filed Mar. 6 1921
E. A. Elmore
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 8 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 1920 to Jan 1921 that I last saw h.im alive on Jan 3 1921 and that death occurred on the date stated above, at 2.30 P.M.

The CAUSE OF DEATH* was as follows:
Arteri Sclerosis
(Duration) About 4 Yrs. mos. ds.
Contributory (Secondary) Ch. Brights Disease
(Duration) About 2 yrs. mos. ds.
(Signed) Leland Frazier M. D.
19 (Address) Rupert Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Salt Lake City
DATE OF BURIAL 19

20. UNDERTAKER
ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 19

Primary Registration District No. 2013

(No. ....., ... St.)

Cannon

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33511

Registered No. 13

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Minidoka

City of Rupert

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Homer H Cannon

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. June (Month) 7 (Day) 1891 (Year)

7. AGE: 29 Yrs. 8 Mos. 13 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Farmer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Missouri

10. NAME OF FATHER John H Cannon

11. BIRTHPLACE OF FATHER (State or Country) Missouri

12. MAIDEN NAME OF MOTHER Malissa Hansen

13. BIRTHPLACE OF MOTHER (State or Country) Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Emmet W Cannon
(Address) Rupert Idaho

15. Filed Feb 28 1921 E H Ehrenz Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 20 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 11 1920, to Feb 20 1921, that I last saw him alive on Feb 18 1921, and that death occured on the date stated above, at 4 A. M.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis

.....(Duration) .....Yrs. .....mos. .....ds.

Contributory (Secondary) .....

.....(Duration .....yrs. .....mos. .....ds.

(Signed) E H Ehrenz M. D.

2-28-1921 (Address) Rupert Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: I O O F Cemetery — DATE OF BURIAL: Feb 22 1921

20. UNDERTAKER: W. A. Goodman — ADDRESS: Rupert

SYMS - YORK CO., PTRS. & SORS. 24658

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 19
Primary Registration District No. 2013
File No. 33544
Registered No. 18

1. PLACE OF DEATH
County of Minidoka
City of Rupert
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Norman C. Kidd
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Child

6. DATE OF BIRTH: Jan (Month) 2 (Day) 1921 (Year)

7. AGE: Yrs. 1 Mos. 9 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Norman Kidd

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Iva Newbolt

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John V Kidd
(Address) Rupert Idaho

15. Filed Mar. 3 1921 Ett Elmore, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 11 (Day) 19 21 (Year)

17. I ~~HEREBY~~ CERTIFY, That I attended deceased from Feb 11 19 21, to Feb 11 19 21
that I last saw h~~im~~ alive on Feb 11 19 21
and that death occurred on the date stated above, at 8 P. M.
The CAUSE OF DEATH* was as follows:
Pneumonia following Measles.

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... Yrs. ..... mos. ..... ds.
(Signed) [signature] M. D.
3-9 1921 (Address) Rupert Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rupert Cemetery
DATE OF BURIAL: Feb 12 1921

20. UNDERTAKER: W. J. Goodsmen
ADDRESS: Rupert

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33545
Registered No. 18

1. PLACE OF DEATH

RECEIVED APR - 4 1921 BUREAU OF VITAL STATISTICS

Registration District No. 92
Primary Registration District No. 2170
County of Nez Perce
City of Leland (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Leona Elizabeth Smith

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Infant (Write the word.)
6. DATE OF BIRTH: Feb. 9 1921 (Month) (Day) (Year)
7. AGE: Yrs. 1 Mos. 2 ds. IF LESS than 1 day how many ... hrs. or ... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)
9. BIRTHPLACE (State or Country): Leland Ida.
10. NAME OF FATHER: Harry Smith
11. BIRTHPLACE OF FATHER (State or Country): Canada
12. MAIDEN NAME OF MOTHER: Nida McCoy
13. BIRTHPLACE OF MOTHER (State or Country): Idaho.
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Harry Smith
(Address) Leland
15. Filed 3-12 1921 E. E. Watts Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar. (Month) 11 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 3 1921, to Mar 11 1921, that I last saw her alive on Mar. 11 1921, and that death occurred on the date stated above, at 1 P.M.
The CAUSE OF DEATH* was as follows:

Erysipelas

(Duration) ... Yrs. ... mos. 8 ds.

Contributory (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) J. W. Stoneburner M. D.
1921 (Address) Leland Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Cameron — DATE OF BURIAL: Mar. 12 1921

20. UNDERTAKER: Smith + son — ADDRESS: Leland Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 92

Primary Registration District No. 2170

File No. 39546

Registered No. 19

County of Nez Perce Co

City of Leland Ida (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
APR - 4 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME Edward Fleshmen.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Oct (Month) 19 (Day) 1863 (Year)

7. AGE: 57 Yrs. 5 Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ind

10. NAME OF FATHER: John Fleshman.

11. BIRTHPLACE OF FATHER (State or Country): Penn.

12. MAIDEN NAME OF MOTHER: Eliza Callison

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Julia F. Fleshmen.

(Address) .....

15. Filed 3-21 1921

E E Watts
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar. (Month) 19 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....

that I last saw him alive on Feb. 12 1921

and that death occurred on the date stated above, at 11 P. M.

The CAUSE OF DEATH* was as follows:

Paralyze

(Duration) 3 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. W. Stoneburner M. D.

1921 (Address) Leland Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Cameron — DATE OF BURIAL: Mar 21 1921

20. UNDERTAKER: Smith — ADDRESS: .....

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 33547
Registered No. 598

1. PLACE OF DEATH
County of Nez Perce
City of Lewiston
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Henry Harrison Williams

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: March (Month) 13 (Day) 1865 (Year)

7. AGE: 55 Yrs. 10 Mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Trucker
(b) General nature of industry, business or establishment in which employed (or employer): Camas Prairie Railroad

9. BIRTHPLACE (State or Country): Kentucky

10. NAME OF FATHER: H H Williams

11. BIRTHPLACE OF FATHER (State or Country): Kentucky

12. MAIDEN NAME OF MOTHER: Susan Ann Kaywood

13. BIRTHPLACE OF MOTHER (State or Country): Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs H H Williams
(Address) Clarkston, Wash.

15. Filed Mar 10 1921
Susan E. Burns
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 2 (Month) 3 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 18 1921, to Feb 3 1921, that I last saw h[illegible] alive on Feb 3 1921, and that death occurred on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:

Pulmonary Embolus.

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Broken Leg.

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Edgar L. White M. D.

19..... (Address) Lewiston Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death Lewiston Ida yrs. — mos. 16 days. In the State White Hospital yrs. — mos. 16 days
Where was disease contracted if not at place of death?
Former or usual residence Clarkston Wash

19. PLACE OF BURIAL OR REMOVAL: Yakima, Wash
DATE OF BURIAL: ..... 19.....

20. UNDERTAKER: H.R.Merchant
ADDRESS: Clarkston Wn.

FORM V. S. No. 5-A—25 M. 1-19.

White

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 33548
Registered No. 599

1. PLACE OF DEATH
County of Nez Perce
City of Lewiston
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Candler

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	white	single

6. DATE OF BIRTH: Feb (Month) 7 (Day) 21 (Year)

7. AGE: ..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or 10 min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: C. H. Candler

11. BIRTHPLACE OF FATHER (State or Country): N. Carolina

12. MAIDEN NAME OF MOTHER: Winifred Mudd

13. BIRTHPLACE OF MOTHER (State or Country): Wash.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. H. Candler
(Address) 1701 - 9 Street

15. Filed Mar 10 1921 Susan E. Bruce
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 5 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 5 1921, to Feb 8 1921
that I last saw h.er alive on Feb 5 1921,
and that death occurred on the date stated above, at 1 1-4 M.
The CAUSE OF DEATH* was as follows:
Monstrosity - (Hydrocephalus)

..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Edgar L. White M. D.
Feb 5 1921 (Address) Lewiston Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Lewiston Ida.	Mar 7 1921

20. UNDERTAKER: Bassar Undertaking Co ADDRESS: Lewiston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers,* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL *septicemia,*" "PUERPERAL *peritonitis,*" etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 33549
Registered No. 600

1. PLACE OF DEATH
County of Nez Perce
City of Lewiston
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Marie Lotz

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: (Write the word.) Married

6. DATE OF BIRTH: July 29th 1850 (Month) (Day) (Year)

7. AGE: 70 Yrs. 6 Mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER:

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) O. H. Ginsberg
(Address) Lewiston, Idaho

15. Filed Mar 10 1921
Susan E Bruce
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb 6th 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 1st 1921, to Feb. 6 1921, that I last saw her alive on Feb. 6 1921, and that death occurred on the date stated above, at 1 P. M.
The CAUSE OF DEATH* was as follows:
Lobar Pneumonia

..... (Duration) ..... Yrs. ..... mos. 6 ds.
Contributory (Secondary) Organic disease of heart
..... (Duration) many yrs. ..... mos. ..... ds.
(Signed) L. C. Cardin M. D.
2/7 1921 (Address) Lewiston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Culdesac Ida
DATE OF BURIAL: 2-8 1921
20. UNDERTAKER: Dessar Undertaking Co.
ADDRESS: Lewiston

Caraon

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 951
Primary Registration District No. 1009
File No. 33550
Registered No. 601

1. PLACE OF DEATH
County of Nez Perce
City of Lewiston Orchards (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Alvin T. Bowles
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: ~~(Write the word)~~ X

6. DATE OF BIRTH: July (Month) 4th (Day) 1911 (Year)

7. AGE: 9 Yrs. 7 Mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: S. C. Bowles

11. BIRTHPLACE OF FATHER (State or Country): Oregon

12. MAIDEN NAME OF MOTHER: Ida M. Stiles

13. BIRTHPLACE OF MOTHER (State or Country): Wash.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) S C Bowles
(Address) .....

15. Filed Mar 10 1921 Susan E. Bruce Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 6th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 5th 1921, to Feb 6 1921 that I last saw h.im alive on Feb 5th 1921 and that death occurred on the date stated above, at 7 A.M.
The CAUSE OF DEATH* was as follows:

Scarlet Fever
(Duration) ..... Yrs. ..... mos. 2 ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D. C. Carson M. D.
19..... (Address) Lewiston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Normal Hill Cemetery — DATE OF BURIAL 19.....

20. UNDERTAKER: Vassar Undertaking Co. — ADDRESS Lewiston Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
(No. ..... St.)

File No. 33551
Registered No. 682

1. PLACE OF DEATH
County of Nez Perce
City of Lewiston
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Martha Coburn

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.):

6. DATE OF BIRTH: Sept (Month) 24 (Day) 1840 (Year)

7. AGE: 86 Yrs. 4 Mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Del

10. NAME OF FATHER: John C Chauncey.

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ransom Coburn
(Address) City Lewiston

15. Filed Jan 10 1921 Ransom E Bruce Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Febr (Month) 7 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1919, to Jan 1921 that I last saw her alive on Edward Jenso 1921, and that death occurred on the date stated above, at 8 45 P.M.

The CAUSE OF DEATH* was as follows:
Arteriosclerosis
V-
1 (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Senile
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J C W Shaff M. D.
2-8 1921 (Address) Lewiston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston Ida — DATE OF BURIAL: 2/9 1921

20. UNDERTAKER: Bassar Undt Co. — ADDRESS: Lewiston Ida

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 33552
Registered No. 609

1. PLACE OF DEATH
County of Nezperce
City of Lewiston
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Hannah Robertson
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F	White	Widow

6. DATE OF BIRTH: Sept (Month) 17 (Day) 1838 (Year)

7. AGE: 83 Yrs. 4 Mos. 25 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home of
(b) General nature of industry, business or establishment in which employed (or employer): Tom Robertson

9. BIRTHPLACE (State or Country): Elmer — Canada.

10. NAME OF FATHER: — Ward

11. BIRTHPLACE OF FATHER (State or Country): — — —

12. MAIDEN NAME OF MOTHER: — — — —

13. BIRTHPLACE OF MOTHER (State or Country): — — — —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Tom Robertson
(Address) Nezperce Ida.

15. Filed Mar 10 1921 Susan E Bruce Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 12 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 31 1920 to Feb 12 1921 that I last saw her alive on Feb 12 1921 and that death occurred on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:
General Debility due to age and Confinement in bed following fracture of Left Shoulder
(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Edgar L White M. D.
2/13 1921 (Address) Lewiston Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death — yrs. 1 mos. 13 days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? Nezperce Ida.
Former or usual residence Nezperce Ida

19. PLACE OF BURIAL OR REMOVAL: Nezperce Ida — DATE OF BURIAL: Feb 15 1921

20. UNDERTAKER: H P Merchant — ADDRESS: Clarkston Wash.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Nez Perce — Registration District No. 96

City of Lewiston — Primary Registration District No. 1009

(No. ....., ... St.)

File No. 33553

Registered No. 604

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Jas B. Richardson

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. May (Month) 29 (Day) 1868 (Year)

7. AGE: 52 Yrs. 8 Mos. 14 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Mechanic
(b) General nature of industry, business, or establishment in which employed (or employer): (Railroad employee)

9. BIRTHPLACE (State or Country): Hartford Maine

10. NAME OF FATHER: Isaac Richardson

11. BIRTHPLACE OF FATHER (State or Country): Maine

12. MAIDEN NAME OF MOTHER: Susan Blackstone

13. BIRTHPLACE OF MOTHER (State or Country): Maine

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) O A Knutson Lewiston Idaho

15. Filed Mar 10 1921 — Susan E Bruce, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 13 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1 1920, to Feb 13 1921, that I last saw h.m. alive on Feb 13 1921, and that death occured on the date stated above, at 4:30 a. M.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) 3 or 4 Yrs. ..... mos. ..... ds.

Contributory (Secondary) Uremic Coma

(Duration ..... yrs. ..... mos. 1 ds.

(Signed) Paul S. Johnson M. D.

2/14 1921 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Lewiston Cemetery — DATE OF BURIAL: Feb 15 1921

20. UNDERTAKER: Sarsar — ADDRESS: Lewiston Ida

SYMS - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 33554
Registered No. 606

1. PLACE OF DEATH
County of Nez Perce
City of Lewiston
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Elvira Mitchell

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: April (May) (Month) 2 (Day) 1851 (Year)

7. AGE: 70 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mo.

10. NAME OF FATHER: Martin Rice

11. BIRTHPLACE OF FATHER (State or Country): Ky.

12. MAIDEN NAME OF MOTHER: — Lynch

13. BIRTHPLACE OF MOTHER (State or Country): Ky.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. H. Mitchell
(Address) Lewiston Idaho

15. Filed Mar 10 1921 Wm E Bruce
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 17 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Natural Causes
Found dead in Bed
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) W B Williamson Coroner M. D.
Feb 17 1921 (Address) Lewiston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston Ida. | DATE OF BURIAL ..... 19.....

20. UNDERTAKER: Lassar Und. Co. | ADDRESS: Lewiston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 33555
Registered No. .....

1. PLACE OF DEATH.
County of Nez Perce
City of Lewiston
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Martha Farthing

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. 2 (Month) 17 (Day) 1921 (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or 10 min.?

8. OCCUPATION ✓
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER W. B. Farthing

11. BIRTHPLACE OF FATHER (State or Country) N. C.

12. MAIDEN NAME OF MOTHER Martha L. Hale

13. BIRTHPLACE OF MOTHER (State or Country) Wash

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) W. B. Farthing
(Address) Clarkston Wn

15. Filed Mar 10 1921 Emma E. Bruce Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 2 (Month) 17 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2-17 1921 to 2-17 1921 that I last saw h[illegible] alive on 2-17 1921 and that death occured on the date stated above, at 2-[illegible] M.

The CAUSE OF DEATH* was as follows: Pneumonia Bron

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Lee M. D.
19..... (Address) Lewiston

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Clarkston Wn | DATE OF BURIAL 2-18 1921

20. UNDERTAKER H. R. Merchant | ADDRESS Clarkston

SYMS - YORK CO., PTRS. & BKBS. 24658

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
(No. ..... , ... St.)

File No. 33556
Registered No. 607

1. **PLACE OF DEATH**

County of Nez Perce
City of Lewiston

If death occurs away from usual residence, give facts called for under special information.

2. **FULL NAME** Gertrude Hicks.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. **SEX** Female

4. **COLOR OR RACE** White

5. **SINGLE, MARRIED, WIDOWED OR DIVORCED** Widow (Write the word.)

6. **DATE OF BIRTH** Oct 3 1856
(Month) (Day) (Year)

7. **AGE** 64 Yrs. 4 Mos. 22 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. **OCCUPATION**
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. **BIRTHPLACE** (State or Country) Norway.

10. **NAME OF FATHER** Hans Tetley.

11. **BIRTHPLACE OF FATHER** (State or Country) Norway.

12. **MAIDEN NAME OF MOTHER** Gertrude Tetley.

13. **BIRTHPLACE OF MOTHER** (State or Country) Norway

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**
(Informant) L. P. Smith
(Address) 137 Steel adt.

15. Filed Mar 10 1921 Simon E Bruce
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH** Feb 25 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 16 1921, to Feb 28th 1921, that I last saw h[er] alive on Feb 28th 1921, and that death occurred on the date stated above, at 3 20 M.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(Duration) ..... Yrs. ..... mos. — ds.

Contributory (Secondary) Pulmonary Tuberculosis

(Duration) + yrs. ..... mos. ..... ds.

(Signed) O. C. Carson M. D.

19 ..... (Address) Lewiston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. **PLACE OF BURIAL OR REMOVAL** Lewiston Idaho — **DATE OF BURIAL** 2/28/21

20. **UNDERTAKER** Bassar Undertaking — **ADDRESS** Sandpoint

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 33557
Registered No. 608

1. PLACE OF DEATH
County of Nezperce
City of Lewiston Ida
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Rudolph Holm
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH: ~~Still Born~~ Feb 26 1921
(Month) (Day) (Year)

7. AGE: ~~Still Born~~ Yrs. Mos. ds.
IF LESS than 1 day how many ..... hrs. or 12 min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Lewiston Ida.

10. NAME OF FATHER: N. J. Holm

11. BIRTHPLACE OF FATHER (State or Country): Minn.

12. MAIDEN NAME OF MOTHER: ~~Gudrid~~ Nelson

13. BIRTHPLACE OF MOTHER (State or Country): Norway Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Rev. N. J. Holm
(Address) Clarkston Wash.

15. Filed Mar 10 1921 Susan E Burns
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 26 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 26 1921 to Feb 26 1921 that I last saw him alive on Feb 26 1921, and that death occurred on the date stated above, at 3a M.

The CAUSE OF DEATH* was as follows:
Toxaemia from mother who had (albuminuria) nephritis of pregnancy.
(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Paul M. Johnson M. D.
2/26 1921 (Address) Clarkston Wash.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days
In the State ..... yrs. ..... mos. ..... days
Born at St Josephs Hospital, and lived at home
Where was disease contracted if not at place of death? .....
Former or usual residence Clarkston Wash

19. PLACE OF BURIAL OR REMOVAL: Clarkston Wash. DATE OF BURIAL: 2/26 1921

20. UNDERTAKER: A. P. Meacham ADDRESS: Clarkston Wash.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 33558
Registered No. 609

1. PLACE OF DEATH
County of Nez Perce
City of Lewiston
(No. Whites Hospital St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Elsie M. Smith

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Female	White	(Write the word) Married

6. DATE OF BIRTH: August 13 (Month) 1890 (Day) (Year)

7. AGE: 30 Yrs. 6 Mos. 15 ds.
IF LESS than 1 day how many..... hrs. or.....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wash

10. NAME OF FATHER: Thos Leffler

11. BIRTHPLACE OF FATHER (State or Country): Ill

12. MAIDEN NAME OF MOTHER: Arabella Ray

13. BIRTHPLACE OF MOTHER (State or Country): Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Gladys Leffler
(Address)

15. Filed Mar 10 1921 Susan E. Bruce
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 2 (Month) 28 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 18 1921, to Feb 28 1921, that I last saw h.e alive on Feb 28 1921, and that death occurred on the date stated above, at 12 30 A. M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast & Incurable Lung Pulmonary Embolus (immediate)
(Duration) 2 Yrs. mos. ds.

Contributory (Secondary) Same
(Duration) yrs. mos. ds.

(Signed) E. L. White M. D.
Feb 28 1921 (Address) Lewiston Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Kenmark Ida	Mar 1921
20. UNDERTAKER	ADDRESS
Vassar Und Co.	Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33559
Registered No. 8

1. PLACE OF DEATH
County of Oneida
City of Malad
If death occurs away from usual residence, give facts called for under special information.

RECEIVED APR 7 1921 BUREAU OF VITAL STATISTICS

Registration District No. 26
Primary Registration District No. 2069
No. 094
(St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Alice Ann Babbit

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (or Widowed)
6. DATE OF BIRTH: Sept. 5-70 (Month) (Day) 1863 (Year)
7. AGE: 37 Yrs. 5 Mos. 26 ds. IF LESS than 1 day how many ... hrs. or ... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Albion Idaho.
10. NAME OF FATHER: Nathanial Leavitt.
11. BIRTHPLACE OF FATHER (State or Country): Iowa.
12. MAIDEN NAME OF MOTHER: Minerva Ann Purson.
13. BIRTHPLACE OF MOTHER (State or Country): Willard Utah
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Thos Babbit
(Address) Malad Ida.
15. Filed April 4 1921 R M Mauer M.D. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 6 (Day) 1921 (Year)
17. I HEREBY CERTIFY, That I attended deceased from July 19, 1920 to Mar. 6, 1921 that I last saw h.er alive on Mar. 6, 1921 and that death occurred on the date stated above, at 2 9. M.
The CAUSE OF DEATH* was as follows:
Consumption
(Duration) about three Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) Geo. W. Wilson, D.C. M.D.
Mar. 7, 1921 (Address) Malad City, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Malad — DATE OF BURIAL: 3-7 1921
20. UNDERTAKER: W. S. Johnson — ADDRESS: Malad

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

Form V. S. No. 5 20M.1-16-12

RECEIVED
APR 7 1921
BUREAU OF STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 26

Primary Registration District No. 2069

File No. 33560

Registered No. 9

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Oneida

City of Malad (No. ....., St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Valley Peck.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Mar (Month) 2 (Day) 1921 (Year)

7. AGE: ..... yrs. ..... mos. 5 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) Child

9. BIRTHPLACE (State or Country) Malad Oneida Co.

10. NAME OF FATHER Ralph F Peck

11. BIRTHPLACE OF FATHER (State or Country) Malad,

12. MAIDEN NAME OF MOTHER Faye Thelma Rowe

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ralph F. Peck
(Address) .....

15. Filed April 4 1921 R. A. Milner M.D. Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 3 (Month) – 6 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 2 1921, to March 6 1921, that I last saw him alive on March 6 1921, and that death occurred on the date stated above, at 2.0 M.

The CAUSE OF DEATH* was as follows:
Non-Development.

(Duration) ..... yrs. ..... mos. 5 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Towns M. D.
19 ..... (Address) Malad Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Malad — DATE OF BURIAL: Mar. 7 1921

20. UNDERTAKER: Woodland Furniture Co. ADDRESS: Malad

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGINAL

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33561
Registered No. 10

RECEIVED
APR 2 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH.
County of Ouida
City of Malad (Village or Township) (St.)
Local (or Primary) Registration District No. 2069
Registration District No. 26
If death occurs away from usual residence, give facts called for under special information.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Alvin Wm Marston

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married
6. DATE OF BIRTH. Oct (Month) 27 (Day) 1920 (Year)
7. AGE: Yrs. 4 Mos. 27 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) Child
9. BIRTHPLACE (State or Country) Malad
10. NAME OF FATHER Alvin Marston
11. BIRTHPLACE OF FATHER (State or Country) Heber Idaho
12. MAIDEN NAME OF MOTHER Harriet Morgan
13. BIRTHPLACE OF MOTHER (State or Country) Vernal Utah
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) .....
(Address) Alvin D Marston
15.
Filed April 6 1921 R T Mauer M D Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
March (Month) 6 (Day) 1921 (Year)
17. I HEREBY CERTIFY, That I attended deceased from March 1 1921, to March 6 1921, that I last saw him alive on March 6 1921, and that death occured on the date stated above, at 3P. M.
The CAUSE OF DEATH* was as follows:
Bronchio-Pneumonia
(Duration) Yrs. mos. 6 ds.
Contributory (Secondary) Whooping cough
(Duration) yrs. mos. 20 ds.
(Signed) R T Mauer M. D.
Mch 6 1921 (Address) Box F Malad Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....daya In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Malad — DATE OF BURIAL: March 6 1921
20. UNDERTAKER: Woodland Furniture Co — ADDRESS: Malad

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

BYNS - YORK CO., PTRS. & ENGS. 24653

FORM V. S. No. 5-A—25 M. 1-19.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSES OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

RECEIVED
APR 6 1921
BUREAU OF VITAL STATISTICS

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. .....
Primary Registration District No. .....
File No. 33562
Registered No. .....

1. PLACE OF DEATH
County of Oyhee
City of Homedale (No. ....., St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Joe Yraola
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH: July (Month) 12 (Day) 1920 (Year)

7. AGE: Yrs. 7 Mos. 28 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At home
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: John Yraola

11. BIRTHPLACE OF FATHER (State or Country): Spain

12. MAIDEN NAME OF MOTHER: Mary Yrueta

13. BIRTHPLACE OF MOTHER (State or Country): Spain

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Juan Ezcurra
(Address) Boise Idaho

15. Filed Apr 1 1921 S. Hatfield Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 10 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 22 1921, to Mar 8 1921, that I last saw him alive on Mar 8 1921, and that death occurred on the date stated above, at 11-30 A.M.
The CAUSE OF DEATH* was as follows:
Pneumonia
(Duration) ..... Yrs. ..... mos. 14 ds.
Contributory (Secondary) Senticeus
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) C. F. Bruck M. D.
Mar 19 21 (Address) Wilder Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill — DATE OF BURIAL: 3-11 1921

20. UNDERTAKER: E. V. Peckham — ADDRESS: Caldwell

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED APR 8 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 5

County of Payette Primary Registration District No. 2009

City of New Plymouth (No. ....., ... St.)

File No. 33563

Registered No. 2

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Emelie Sathrop

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Divorced

6. DATE OF BIRTH. July (Month) 14 (Day) 1849 (Year)

7. AGE: 71 Yrs. 8 Mos. 12 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Wisconsin

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Nellie M. Perkins
(Address) 5228 S. L St. Tacoma Wash.

15. Filed Apr 7 1921 Wm J. Drysdale Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
March (Month) 27 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 16 1921, to March 27 1921, that I last saw her alive on March 21 1921, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

(Duration) many Yrs. ..... mos. ..... ds.

Contributory (Secondary) senility

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Wm J. Drysdale M. D.

4-4-1921 (Address) New Plymouth Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: New Plymouth Ida — DATE OF BURIAL: March 29 1921

20. UNDERTAKER: A. Meyer — ADDRESS: New Plymouth

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
APR - 4 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 4
Primary Registration District No. 1008
File No. 33565
Registered No. 8

County of Payette
City of Payette (Or Village, or Township) (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Bernice Addeline Chatfield

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Dec 23 1907 (Month) (Day) (Year)

7. AGE: 13 Yrs. 2 Mos. 22 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At School
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Ray Chatfield

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Rosa B Coats

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ray Chatfield
(Address) Payette Idaho

15. Filed Mar 19 1921 J C Woodward Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar (Month) 17 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 25 1921, to Mar 17 1921, that I last saw her alive on Mar 16 1921, and that death occurred on the date stated above, at 7 A.M.

The CAUSE OF DEATH* was as follows:

Lethargic Encephalitis

(Duration) ..... Yrs. ..... mos. 21 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J R Woodward M. D.

3/15 1921 (Address) Payette Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Payette Idaho — DATE OF BURIAL: March 19 1921

20. UNDERTAKER: Glenn C Landon — ADDRESS: Payette Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33566

Registered No. ____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

RECEIVED
APR 4 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 4

Primary Registration District No. 1008

County of Payette

City of Payette (No. ____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Delacena C Peterson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: May (Month) 14 (Day) 1863 (Year)

7. AGE: 57 Yrs. 10 Mos. 4 ds.

IF LESS than 1 day how many ____ hrs. or ____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer): ____

9. BIRTHPLACE (State or Country): Mo

10. NAME OF FATHER: L Crawford

11. BIRTHPLACE OF FATHER (State or Country): Mo

12. MAIDEN NAME OF MOTHER: Hannah Crawford

13. BIRTHPLACE OF MOTHER (State or Country): Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J C Peterson

(Address) Payette Idaho

15. Filed March 19 1921 J C Woodward Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 18 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 14 1921 to March 18 1921 that I last saw her alive on March 17 1921 and that death occurred on the date stated above, at 10 P M.

The CAUSE OF DEATH* was as follows:

Gastric Cancer

(Duration) ____ Yrs. ____ mos. ____ ds.

Contributory (Secondary) ____

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) J C Woodward M. D.

3/19/1921 (Address) Payette Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days

Where was disease contracted if not at place of death? ____

Former or usual residence ____

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Payette Idaho	March 19 21
20. UNDERTAKER	ADDRESS
Glenn E Landon	Payette Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33567

Registered No. 10

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

RECEIVED
APR - 4 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 4

Primary Registration District No. 1008

County of Latah

City of Troy-Mt (If outside limits, so state. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Rasmus Hanson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: July (Month) 30 (Day) 1847 (Year)

7. AGE: 73 Yrs. 8 Mos. — ds.

IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Denmark

10. NAME OF FATHER: Jorren Hanson

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: Not Known

13. BIRTHPLACE OF MOTHER (State or Country): Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) William Hanson
(Address) Council Ida

15. Filed Mar 31 1921 J.C. Woodward Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar (Month) 30 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 10 1921, to Mar 30 1921 that I last saw h— alive on Mar 29 1921, and that death occurred on the date stated above, at 11P M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Prostate

(Duration) 1 Yrs. 2 mos. 0 ds.

Contributory (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) William J Weeks M. D.

3/31 1921 (Address) Ontario Ore

*State the **Disease Causing Death**; or in deaths from **Violent Causes**, state (1) **Means of Injury**; and (2) whether **Accidental, Suicidal** or **Homicidal.**

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Council Ida — DATE OF BURIAL: Mar 31 1921

20. UNDERTAKER: J.V. Adair Cuprum Ida — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

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FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 4
Primary Registration District No. 1008
File No. 33568
Registered No. 5

1. PLACE OF DEATH
County of Bonneville
City of Payette
If death occurs away from usual residence, give facts called for under special information.
(No. ..... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Jasper W Toothaere

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Widowed

6. DATE OF BIRTH
Nov 28 1848
(Month) (Day) (Year)

7. AGE
72 Yrs. 2 Mos. 12 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Railroader
(b) General nature of industry, business or establishment in which employed (or employer) Lab. Farmer

9. BIRTHPLACE (State or Country) Vermont

10. NAME OF FATHER Isaac Toothaere

11. BIRTHPLACE OF FATHER (State or Country) Vermont

12. MAIDEN NAME OF MOTHER Mary Elliott

13. BIRTHPLACE OF MOTHER (State or Country) Vermont

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jay D. Keiser
(Address) Payette

15. Filed Feb. 11. 1921. J. C. Woodward
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Feb. 10 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 27 1920 to Feb 10 1921 19....., that I last saw h saw alive on Dec 6 1920 19....., and that death occurred on the date stated above, at 12:00 M.

The CAUSE OF DEATH* was as follows:
Chronic Diarrhoea

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. C. Woodward M. D.
2/11/1921 (Address) Payette Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Payette Ida	Feb 12 1921
20. UNDERTAKER	ADDRESS
D. Nidaw	Payette Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Payette

City of Payette

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 4

Primary Registration District No. 1008

(No. ....., ... St.)

File No. 33569

Registered No. 7

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary E Crewse

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: July (Month) 12. (Day) 1905 (Year)

7. AGE: 15 Yrs. 7 Mos. 5 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Student

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Kansas

10. NAME OF FATHER: John E Crewse

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Charlotte Pearson

13. BIRTHPLACE OF MOTHER (State or Country): Kansas.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John E Crewse

(Address) Payette Ida

15. Filed Feb 20 1921 J C Woodward Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 2 (Month) 19 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 18 1921, to Feb 19 1921, that I last saw her alive on Feb 19 1921, and that death occurred on the date stated above, at 7:30 P.M.

The CAUSE OF DEATH* was as follows:

Encephalotis and Meningitis

(Duration) ..... Yrs. ..... mos. 1 ds.

Contributory (Secondary): Measles

(Duration) ..... yrs. ..... mos. 5 ds.

(Signed) J. A. McDonald M. D.

2-20 1921 (Address) Payette Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Payette Ida — DATE OF BURIAL: Feb 21 1921

20. UNDERTAKER: J A Sudan Mgr — ADDRESS: Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33540

Registered No. 350

1. PLACE OF DEATH

County of Payette

City of Payette

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 4

Primary Registration District No. 1008

2. FULL NAME Mabel H Keeler

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: June (Month) 14 (Day) 892 (Year)

7. AGE: 28 Yrs. 8 Mos. 9 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Teacher
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kansas

10. NAME OF FATHER: L. E. Keeler

11. BIRTHPLACE OF FATHER (State or Country): Penn

12. MAIDEN NAME OF MOTHER: Ora Bosler

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) L. E. Keeler
(Address) Payette Ida

15. Filed Feb 24 1921. J C Woodward Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: February (Month) 23 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from October 1918, to February 1921, that I last saw her alive on February 15 1921, and that death occurred on the date stated above, at 7 A.M.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) About 3 years

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) O. H. Avery M. D.

2/24/1921 (Address) Payette, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Payette Ida — DATE OF BURIAL: Feb 25 1921

20. UNDERTAKER: F. N. Adair — ADDRESS: Payette Ida

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Payette
City of New Plymouth
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 5
Primary Registration District No. 2009
(No. ....., ... St.)

File No. 32571
Registered No. 1

2. FULL NAME Baby Hylton

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
F	W.	

6. DATE OF BIRTH
Dec (Month) 15 (Day) 1920 (Year)

7. AGE
..... yrs. 1 mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho -

10. NAME OF FATHER Geo B. Hylton

11. BIRTHPLACE OF FATHER (State or Country) Mo.

12. MAIDEN NAME OF MOTHER Nettie Burgin

13. BIRTHPLACE OF MOTHER (State or Country) Mo-

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Miss Elsa Boyd.
(Address) Payette Ida.

15.
Filed Jan 22 1921 Wm J. Drysdale Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Jan (Month) 20 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 18 1921, to Jan. 20 1921, that I last saw her alive on Jan. 20 1921, and that death occurred on the date stated above, at 11:30 A.M.

The CAUSE OF DEATH* was as follows:
Broncho-Pneumonia
..... (Duration) ..... yrs. ..... mos. 3 ds.
Contributory (Secondary) Whooping Cough
..... (Duration) — yrs. — mos. 21 ds.

(Signed) F. M. Drake. M. D.
19..... (Address) New Plymouth Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: New Plymouth Ida
DATE OF BURIAL: ..... 191...

20. UNDERTAKER
ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 25
Primary Registration District No. 2072
File No. 33572
Registered No. 1643

1. PLACE OF DEATH.

County of Power
City of American Falls (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information. Idaho

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Arthur Dee Decker

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. March 9 1918
(Month) (Day) (Year)

7. AGE: 2 Yrs. 11 Mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: "
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE
(State or Country) Onida Co, Idaho

10. NAME OF FATHER: Elmer E. Decker

11. BIRTHPLACE OF FATHER
(State or Country) Minn

12. MAIDEN NAME OF MOTHER: Miria Clark

13. BIRTHPLACE OF MOTHER
(State or Country) Cala

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Elmer E Decker
(Address) American Falls, Idaho

15. Filed 3/25 1921 R F York Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24858

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 15 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 8 1921, to July 15 1921, that I last saw him alive on July 15 1921 and that death occured on the date stated above, at 5:30 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) 0 Yrs. mos. 10 ds.

Contributory (Secondary) Empyema

(Duration ..... yrs. mos. 15 ds.

(Signed) C. F. Oelrich M. D.

7/16 1921 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: DATE OF BURIAL 7.16 1921

20. UNDERTAKER: Owl Davis ADDRESS American Falls Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33574

Registered No. 117

1. PLACE OF DEATH.

Registration District No. 25

Primary Registration District No. 207

County of Power

City of American Falls, Idaho (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME James J. Taylor.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write one word.): Single

6. DATE OF BIRTH.: May (Month) 22 (Day) 1865 (Year)

7. AGE: 55 Yrs. 9 Mos. 2 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country):

10. NAME OF FATHER: John H. Taylor

11. BIRTHPLACE OF FATHER (State or Country): Nev

12. MAIDEN NAME OF MOTHER: Catherin Thomas

13. BIRTHPLACE OF MOTHER (State or Country): Wales

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Constance Taylor.
(Address) 2414 A. Ave Ogden Utah

15. Filed 3/27 1921 R. E. Noth, Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 2 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jany 25 1921, to Mar 2 1921, that I last saw h alive on Mar 2 1921, and that death occured on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:
Lobar pneumonia

(Duration) ..... Yrs. ..... mos. 7 ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) C. F. Veith M. D.

3/27 1921 (Address) Amer. Falls Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Amer. Falls Idaho — DATE OF BURIAL: 3/3 1921

20. UNDERTAKER: C. W. Davis — ADDRESS: American Falls Idaho

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33576
Registered No. 9

1. PLACE OF DEATH.
Registration District No. 70
County of Shoshone
Primary Registration District No. 10 C
City of Mullan No. Wyoming Mult St.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED APR BUREAU OF VITAL STATISTICS

2. FULL NAME Joseph Langevin

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M.	white	widowed

6. DATE OF BIRTH.
(Month) (Day) 1 (Year)

7. AGE
78 Yrs. — Mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Day Laborer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE
(State or Country) Mass.

10. NAME OF FATHER Joe Langevin

11. BIRTHPLACE OF FATHER
(State or Country) Canada

12. MAIDEN NAME OF MOTHER not given

13. BIRTHPLACE OF MOTHER
(State or Country) not given

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Edward Langevin
(Address) Mullan Idaho

15. Filed Feb 7 1921 F. L. Jenney Local Registrar

SYMS - YORK CO., PTRS. & SDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 4 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from — 191— to 191—, that I last saw h— alive on Feb 4 1921, and that death occured on the date stated above, at 2 P. M.

The CAUSE OF DEATH was as follows: Fracture of Cervical Vertebrae 5, 6, 7 Severing of Cord

(Duration) Yrs. Instant ds.

Contributory (Secondary) None

(Duration) yrs. mos. ds.

(Signed) Fred Brownfield M. D.

2/3 1921 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence Mullan Idaho

19. PLACE OF BURIAL OR REMOVAL Wallace Ida — DATE OF BURIAL Feb 7th 1921

20. UNDERTAKER Harry Thompson — ADDRESS Wallace Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

RECEIVED APR 5 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33577
Registered No. 10

1. PLACE OF DEATH. Registration District No. 70
County of Shoshone Primary Registration District No. 1011
City of Wallace (No.) Providence Hospital St.
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William J. Ford

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M.	white	single

6. DATE OF BIRTH ..... 1 (Month) (Day) (Year)

7. AGE 59 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... miner
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Nova Scotia

10. NAME OF FATHER not given

11. BIRTHPLACE OF FATHER (State or Country) not given

12. MAIDEN NAME OF MOTHER not given

13. BIRTHPLACE OF MOTHER (State or Country) not given

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Tamarack Mine
(Address) Tamarack

15. Filed Feb 10 1921 F. L. Dunn Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Feby 10 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 15 1921 to Feby 10 1921, that I last saw h. alive on Feby 10 1921, and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows: Septicaemia

(Duration) ..... yrs. ..... mos. 7 ds.
Contributory (Secondary) Carbuncles of neck
(Duration) ..... yrs. ..... mos. ..... ds.

2/12 1921 (Signed) Wm Woodruff M. D.
(Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence Tamarack Mine

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Wallace Ida.	Feb 14 1921

20. UNDERTAKER	ADDRESS
Stacy Thompson	Wallace Ida

SYMS - YORK CO., PTRS. & BORS. 19760

Form V. S. No. 5 20M.1-16-12

RECEIVED APR 3 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33579

Registered No. 17

1. PLACE OF DEATH. Registration District No. 70

County of Shoshone Primary Registration District No. 1011

City of Burke (If not in incorporated territory, give name of locality, township, or precinct. Write Hercules Mine St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Frank Sickerman

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1 (Year)

7. AGE: 28 yrs. — mos. — ds.

IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work: miner
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Holland

10. NAME OF FATHER: not given

11. BIRTHPLACE OF FATHER (State or Country): not given

12. MAIDEN NAME OF MOTHER: not given

13. BIRTHPLACE OF MOTHER (State or Country): not given

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. E. Ward
(Address) Wallace Ida

15. Filed Feb 20 1921 F. L. Jensen Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb. (Month) 17 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191..., that I last saw him alive on ..... 191..., and that death occurred on the date stated above, at 7:30 A.M.

The CAUSE OF DEATH* was as follows:
Pneumonia Lobular
Edema of Lungs
Shock in Hercules Mine

(Duration) ..... yrs. one day ds.

Contributory (Secondary): None

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. E. Mowery Coroner

2/19 1921 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence: Burke Idaho

19. PLACE OF BURIAL OR REMOVAL: Wallace Ida — DATE OF BURIAL: Feb 20 1921

20. UNDERTAKER: Harry Thompson — ADDRESS: Wallace Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33580
Registered No. 6

1. PLACE OF DEATH
County of Shoshone
City of Wallace
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 10
Primary Registration District No. 10 11
(No. 121 River St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

RECEIVED APR 5 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME Stanley P. Fairweather

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): married
6. DATE OF BIRTH: Aug (Month) 7th (Day) 1860. (Year)
7. AGE: 60 Yrs. 6 Mos. 29 ds. IF LESS than 1 day how many .... hrs. or .... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: merchant
(b) General nature of industry, business, or establishment in which employed (or employer) ....
9. BIRTHPLACE (State or Country): Canada
10. NAME OF FATHER: Thos. Fairweather
11. BIRTHPLACE OF FATHER (State or Country): Canada
12. MAIDEN NAME OF MOTHER: Adelaide Bellagay
13. BIRTHPLACE OF MOTHER (State or Country): Canada
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs S Fairweather
(Address) Wallace Ida

Filed Mar 8 1921 F. L. Jennings Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 6 (Day) 1921 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Feb 28 1921 to Mar 6 1921 that I last saw him alive on March 6 1921 and that death occurred on the date stated above, at 11:45 A.M.

The CAUSE OF DEATH* was as follows:
Coronary Sclerosis (Angina Pectoris)
(Duration) .... Yrs. .... mos. .... ds.
Contributory (Secondary) Chronic Myocarditis
(Duration) about 2 Yrs. .... mos. .... ds.

(Signed) D. E. Mowry M. D.
3/7 1921 (Address) Wallace Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the ,State....yrs....mos....days
Where was disease contracted if not at place of death? ....
Former or usual residence ....

19. PLACE OF BURIAL OR REMOVAL: Wallace, Idaho — DATE OF BURIAL: Mch 8 1921
20. UNDERTAKER: Bruce G. Norstell — ADDRESS: Wallace

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-12 M. 6-15-17.

Dr Max J Smith. will call for

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33281
Registered No. 142

RECEIVED APR 5 1921 BUREAU OF VITAL STATISTICS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. If unknown, should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact language of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH
County of Shoshone
City of Wallace
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Terrence McGLaughlin

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

Registration District No. 70
Primary Registration District No. 1011
(No. 6, West Pearl St.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): married
6. DATE OF BIRTH: Aug. (Month) 27 (Day) 1858 (Year)
7. AGE: 62 Yrs. 6 Mos. 10 ds. IF LESS than 1 day how many .... hrs. or .....min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: miner
(b) General nature of industry, business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Vermont
10. NAME OF FATHER: John McGLaughlin
11. BIRTHPLACE OF FATHER (State or Country): Ireland
12. MAIDEN NAME OF MOTHER: Betty McGuire
13. BIRTHPLACE OF MOTHER (State or Country): Ireland
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Nelly D. Seeley
(Address): Wallace, Idaho

Filed Mar 12 1921 F. L. Jenny
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 9 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from November 1920 to Mch 9 1921 that I last saw h.im alive on Mch 9 1921 and that death occurred on the date stated above, at p. M.

The CAUSE OF DEATH* was as follows:

Uraemia

(Duration) Yrs. 2 wks mos. ds.

Contributory (Secondary) Chr Parenchymatous Nephritis

(Duration) 2 Yrs. mos. ds.

(Signed) Max J. Smith M. D.

3/14/21 19.... (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Wallace Idaho — DATE OF BURIAL: Mch 12 1921

20. UNDERTAKER: Bruce G. Worstell — ADDRESS: Wallace

Form V. S. No. 5 20M.1-16-12 RECEIVED APR 5 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 70
County of Shoshone Primary Registration District No. 1011
City of Mullan (No. ~~Hazelwood~~ St.),
If death occurs away from usual residence, give facts called for under special information.

File No. 33582
Registered No. 15
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lloyd Enfield

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M.	white	single

6. DATE OF BIRTH
X (Month) Nov (Day) ? (Year) 1914

7. AGE 6 yrs. 4 mos. 28 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... at home
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Washington

10. NAME OF FATHER George E. Enfield

11. BIRTHPLACE OF FATHER (State or Country) Washington

12. MAIDEN NAME OF MOTHER not known

13. BIRTHPLACE OF MOTHER (State or Country) " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H. F. Frazer
(Address) Mullan Idaho

15. Filed Mch 13 1921 F. L. Jeans Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Mar (Month) 10 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1920, to Mar 10 1921, that I last saw him alive on Mar. 10 1921, and that death occurred on the date stated above, at 6:30 P.M.

The CAUSE OF DEATH* was as follows:
Nephritis.

(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Mitral insufficiency.
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H W Ralfe M. D.
Mar. 12 1921 (Address) Mullan Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence... Near Mullan Idaho

19. PLACE OF BURIAL OR REMOVAL: Port Townsend | DATE OF BURIAL: Mar. 13 1921

20. UNDERTAKER Harry Thompson | ADDRESS Wallace Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-12 M. 6-15-17.

RECEIVED
APR 5 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33584
Registered No. 77

1. PLACE OF DEATH
County of Wallace, Registration District No. 70
City of Shsohone, Primary Registration District No. 104
If death occurs away from usual residence, give facts called for under special information. (No. Providence Hospital St.)
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William Chopeck

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single
6. DATE OF BIRTH. — — 1 (Month) (Day) (Year)
7. AGE: 48 Yrs. — Mos. — ds. IF LESS than 1 day how many .... hrs. or .....min.?'
8. OCCUPATION
(a) Trade, profession or particular kind of work: miner
(b) General nature of industry, business, or establishment in which employed (or employer)
9. BIRTHPLACE (State or Country): Rumania
10. NAME OF FATHER: not known
11. BIRTHPLACE OF FATHER (State or Country): " "
12. MAIDEN NAME OF MOTHER: " "
13. BIRTHPLACE OF MOTHER (State or Country): " "
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Providence Hospital
(Address) Wallace Ida
15. Filed Mch 24 1921 F. L. Zeuch Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar 20 1921 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from Mar 16 1921 to Mar 20 1921 that I last saw h~~im~~ alive on Mar 19 1921 and that death occurred on the date stated above, at 6 P.M.
The CAUSE OF DEATH* was as follows: Acute Lobar Pneumonia Right Lung & Pleurisy Lobar & Left Lower Lobar
(Duration) Yrs. mos. 8 ds.
Contributory (Secondary): Influenza
(Duration) Yrs. mos. ds.
(Signed) Des Mowary M.D.
3/21 1921 (Address) Wallace Ida.
*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Wallace Ida — DATE OF BURIAL: Mch 24 1921
20. UNDERTAKER: R. G. Worstell — ADDRESS: Wallace

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33585

Registered No. 16

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No. 70

Primary Registration District No. 10 11

County of Shoshone

City of Wallace

(No. Providence Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Couture

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1 (Year)

7. AGE: ..... yrs. ..... mos. 1/2 hr. ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: Arsene Couture

11. BIRTHPLACE OF FATHER (State or Country): Canada

12. MAIDEN NAME OF MOTHER: Leda Soucy.

13. BIRTHPLACE OF MOTHER (State or Country): Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Arsene Couture
(Address) Lane Idaho.

15. Filed Mar 28 1921 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Mar (Month) 26th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 20 1921, to Mar 26 1921, that I last saw h[illegible] alive on Mar 26 1921 and that death occurred on the date stated above, at [illegible] M.

The CAUSE OF DEATH* was as follows: Pneumonia Atelectasis

(Duration) ..... yrs. ..... mos. 20 days.

Contributory (Secondary) Bronchopneumonia Influenza

(Duration) ..... yrs. 7 mos. ..... ds.

(Signed) [illegible] M. D.

3/28 1921 (Address) Wallace

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence: none

19. PLACE OF BURIAL OR REMOVAL: Wallace Ida — DATE OF BURIAL: Mar 29 1921

20. UNDERTAKER: Harry Thompson — ADDRESS: Wallace Ida

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-12 M. 6-15-17.

RECEIVED
APR 5 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33586
Registered No. 77

1. PLACE OF DEATH
County of Shoshone
City of Wallace
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 76
Primary Registration District No. 1011
(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Elaine McDonald

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	white	Married

6. DATE OF BIRTH. April 6 1871
(Month) (Day) (Year)

7. AGE 50 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many .... hrs. or .....min.?'

8. OCCUPATION
(a) Trade, profession or particular kind of work Engineer
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE
(State or Country) Canada

10. NAME OF FATHER August McDonald

11. BIRTHPLACE OF FATHER
(State or Country) Canada

12. MAIDEN NAME OF MOTHER Elizbath Rayburn

13. BIRTHPLACE OF MOTHER
(State or Country) Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Mary McDonald
(Address) Wallace

Filed Mch 29 1921 F. L. Dent
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Mar 24 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 1918 ..... to Mar 26 1921
that I last saw him alive on Mar 23 1921
and that death occurred on the date stated above, at 7:15 P.M.

The CAUSE OF DEATH* was as follows:
Paresis Paralis
Paraplegia
(Duration) 3 Yrs. ..... mos. ..... ds.
Contributory (Secondary) Syphilis & Accident
(Duration) Years Yrs. ..... mos. ..... ds.
(Signed) ..... M. D.
3/26/1921 (Address) Wallace Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the ,State....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Greenmount	Mar 29. 1921

20. UNDERTAKER	ADDRESS
D. G. Hostetler by M.C.L.	

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

RECEIVED APR 5 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 70

County of Shoshone Registration District No. 1011

City of Wallace (No. Providence Hospital St.)

File No. 33587

Registered No. 38

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Howard Kaeble

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M.	white	single

6. DATE OF BIRTH ..... 1 (Month) (Day) (Year)

7. AGE 55 yrs. — mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... cook
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) not known

10. NAME OF FATHER " "

11. BIRTHPLACE OF FATHER (State or Country) " "

12. MAIDEN NAME OF MOTHER " "

13. BIRTHPLACE OF MOTHER (State or Country) " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) L. C. Kenrick
(Address) Mullan Ida

15. Filed Mch 31 1921 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Mar 24 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 26 21, to Mar 24 1921, that I last saw h. alive on Mar 24 1921, and that death occurred on the date stated above, at 8:00 P.M.

The CAUSE OF DEATH* was as follows: Ptomaine Poisoning

(Duration) yrs. mos. 2 ds.

Contributory (Secondary) Nil

(Duration) yrs. mos. ds.

(Signed) [signature] M. D.

3/31 1921 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence Mullan Idaho Shipped

19. PLACE OF BURIAL OR REMOVAL Pine City Minn | DATE OF BURIAL Apr 1st 1921

20. UNDERTAKER Harry Thompson | ADDRESS Wallace Ida

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-12 M. 6-15-17.

RECEIVED
APR 5 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33588
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Shoshone Registration District No. 20
City of Wallace Registration District No. 2011
If death occurs away from usual residence, give facts called for under special information.
(No. 9, Residence St., St.)
2. FULL NAME Jack West

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
6. DATE OF BIRTH. July 30th 1920 (Month) (Day) (Year)
7. AGE ... Yrs. 5 Mos. ... ds. IF LESS than 1 day how many .... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer)
9. BIRTHPLACE (State or Country): Wallace Idaho
10. NAME OF FATHER: T. E. West
11. BIRTHPLACE OF FATHER (State or Country): Kentucky
12. MAIDEN NAME OF MOTHER: M. J. Smallwood
13. BIRTHPLACE OF MOTHER (State or Country): Washington
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) T. E. West
(Address) Interstate Idaho
15. Filed Jan 20 1921 F. L. Jensen Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan 9 (Month) (Day) 21 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Dec 20 1920 to Jan 9 1921
that I last saw h... alive on Jan 9 1921
and that death occurred on the date stated above, at 2:00 P.M.
The CAUSE OF DEATH* was as follows:
Tubercular Meningitis
(Duration) Yrs. 2 mos. ds.
Contributory (Secondary)
(Duration) Yrs. mos. ds.
(Signed) Drs. Mowery & Wallace M. D.
1/9 1921 (Address) Wallace Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Wallace Ida — DATE OF BURIAL: Jany 20 1921
20. UNDERTAKER: E. G. Worstell — ADDRESS: Wallace

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED APR 5 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32589

Registered No. 27

1. PLACE OF DEATH.

Registration District No. 70

Primary Registration District No. 1011

County of Shoshone

City of Wallace

(No.) Providence Hospital (St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME James Rowan

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. (Month) (Day) 1 (Year)

7. AGE: 70 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: miner

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ireland

10. NAME OF FATHER: not given

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: not given

13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jas L Fitzgerald

(Address) Wallace Ida

15. Filed Jan 20 1921 T L Jenkins Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 14 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 10 1921, to Jan 14 1921, that I last saw him alive on Jan 14 1921, and that death occured on the date stated above, at 6 P M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) Yrs. mos. 7 ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed) Jno Hougen M. D.

Jan 14 1921 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence Mullan Idaho

19. PLACE OF BURIAL OR REMOVAL: Salem Mass. DATE OF BURIAL: Jan 20 1921

20. UNDERTAKER: Harry Thompson ADDRESS: Wallace Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

STATE YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33590
Registered No. 4

RECEIVED
APR 5 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Shoshone
City of Wallace,
If death occurs away from usual residence, give facts called for under special nformation.

Registration District No. 70
Primary Registration District No. 10 11
(No. Providence Hospital St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME (Isadore Jumer) Isadore Jumer

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
male	white	single

6. DATE OF BIRTH. Mar. 20 1874
(Month) (Day) (Year)

7. AGE 46 Yrs. 9 Mos. 19 ds.
IF LESS than 1 day how many .... hrs. or .....min.?'

8. OCCUPATION
(a) Trade, profession or particular kind of work Sugar maker
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Minn

10. NAME OF FATHER Jos Jumer

11. BIRTHPLACE OF FATHER
(State or Country) —

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER
(State or Country) —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Frank Jumer
(Address) Spokane Wash

15. Filed Jan 20 1921 F L Jumer
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan 19 191
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 11 1921 to Jan 18 1921
that I last saw him alive on Jan 18 1921
and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Tertiary Syphilis
(Duration) Yrs. mos. 4 ds.
Contributory (Secondary) Septicaemia
(Duration) Yrs. mos. 10 ds.

(Signed) D. Mowery M. D.
11/8 1921 (Address) Wallace Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Spokane, Washington.	Jan. 20. 1921

20. UNDERTAKER	ADDRESS
E. L. Mantell	Wallace, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 70

Primary Registration District No. 1011

BUREAU OF VITAL STATISTICS

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33591

Registered No. 6

1. PLACE OF DEATH.

County of Shoshone

City of Wallace (No.) Providence Hospital (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George Steelon

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M.	white	married

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE 55 Yrs. — Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... mining engineer

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) New York

10. NAME OF FATHER not given

11. BIRTHPLACE OF FATHER (State or Country) " "

12. MAIDEN NAME OF MOTHER "

13. BIRTHPLACE OF MOTHER (State or Country) " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George Steelon Jr.

(Address) Mullan Idaho

15. Filed Jan 22 1921 H. L. Jensen Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan. (Month) 19 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 10 1921, to Jan 19 1921, that I last saw him alive on Jan 19 1921, and that death occured on the date stated above, at 4:27 M.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis

(Duration) Yrs. 1½ mos. ..... ds.

Contributory (Secondary) Influenza

(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) Chas P. Moriarty M. D.

1/20 1970 (Address) Wallace Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence Mullan Idaho

19. PLACE OF BURIAL OR REMOVAL Mullan Ida — DATE OF BURIAL Jan 22 1921

20. UNDERTAKER Harry Thompson — ADDRESS Wallace Ida.

BYRNES - YORK CO., PTRS. & BDRS. 24658

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
APR 5 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH. Registration District No. 10

County of Shoshone Primary Registration District No. 10 C File No. 33592

City of Wallace (No.) Providence Hospital Registered No. 6

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Stankovich

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. (Month) (Day) 1 (Year)

7. AGE: 28 Yrs. — Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner & Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Austria

10. NAME OF FATHER: Martin Stankovich

11. BIRTHPLACE OF FATHER (State or Country): Austria

12. MAIDEN NAME OF MOTHER: Mary Stankovich

13. BIRTHPLACE OF MOTHER (State or Country): Austria

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mark Stankovich
(Address) Cherry Wash

15. Filed Jan 29 1921 F L Jenkins Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. (Month) 24 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 12 1921 to Jan 24 1921 that I last saw h[illegible] alive on Jan 24 1921 and that death occured on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows: Pneumonia [illegible]
Lobar of both lungs

(Duration) Yrs. mos. 4 ds.

Contributory (Secondary) Influenza

(Duration) yrs. mos. 15 ds.

1/2 1921 (Signed) Dr. Maxwell M. D.
(Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence Mullan Ida

19. PLACE OF BURIAL OR REMOVAL: Wallace Ida — DATE OF BURIAL: Jan 29 1921

20. UNDERTAKER: Harry Thompson — ADDRESS: Wallace Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRD - YORK CO., PTRS. & STRS. 24658

FORM V. S. No. 5-12 M. 6-15-17.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33593
Registered No. 7
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

RECEIVED
APR 25 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Shoshone
Registration District No. 10
Primary Registration District No. 10 11
City of Wallace (Sweets Hotel, Sixth Street St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Malcolm McKenzie

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married
6. DATE OF BIRTH. unknown (Month) 1 (Day) (Year)
7. AGE: Yrs. Mos. ds. IF LESS than 1 day how many .... hrs. or .....min.?'
8. OCCUPATION
(a) Trade, profession or particular kind of work: miner
(b) General nature of industry, business, or establishment in which employed (or employer)
9. BIRTHPLACE (State or Country): Unknown
10. NAME OF FATHER: Unknown
11. BIRTHPLACE OF FATHER (State or Country): Unknown
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (State or Country): Unknown
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) M. C. Lehner
(Address) Wallace Ida.
15. Filed 1/28/ 1921 F. L. Jennings Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 25 (Day) 1921 (Year)
17. I HEREBY CERTIFY, That I attended deceased from ..... 191.... to ..... 191...
that I last saw him alive on Jan 25 1921
and that death occurred on the date stated above, at 3.30 P.M.
The CAUSE OF DEATH* was as follows:
Carbolic acid poisoning
(Duration) .... Yrs. few hrs. mos. ds.
Contributory (Secondary)
(Duration) Yrs. mos. ds.
(Signed) Dr. Mowrey M. D.
1/28/ 1921 (Address) Wallace Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Butte, Mont. DATE OF BURIAL: Jan. 28th 1921
20. UNDERTAKER: Bruce G. Mostell ADDRESS: Wallace, Id

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 127
Primary Registration District No. 2400
File No. 1
Registered No. 32594

1. PLACE OF DEATH.
County of Shoshone
City of Cœur
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Richard Peter Mc Andrew

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH. August (Month) 17 (Day) 1843 (Year)

7. AGE: ....Yrs. 77 Mos. 7 ds. 8. IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Carman
(b) General nature of industry, business, or establishment in which employed (or employer)... In railway service

9. BIRTHPLACE (State or Country) Ireland

10. NAME OF FATHER Richard Mc Andrew.

11. BIRTHPLACE OF FATHER (State or Country) Ireland

12. MAIDEN NAME OF MOTHER Bridget Rowan

13. BIRTHPLACE OF MOTHER (State or Country) Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) George Francis Mc Andrew
(Address) Cœur d'Alene

15. Filed Mar 25 1921 C Bruce Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24858

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 25 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 14 1921, to March 24 1921, that I last saw him alive on March 24 1921, and that death occured on the date stated above, at 5-25 A M.

The CAUSE OF DEATH* was as follows:
Pneumonia

(Duration) Yrs. ..... mos. 13 ds.
Contributory (Secondary) Old Age
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) C Bruce M. D.
Mar 25 1921 (Address) Cœur d'Alene Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Spokane Wash — DATE OF BURIAL: March 26 1921

20. UNDERTAKER: Unknown — ADDRESS: Spokane, Wash

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Shoshone
City of Burke
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 127
Primary Registration District No. 2700
(No. Residence St.)

File No. 33595
Registered No. 5
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Bernard Richard Weber

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: ..... (Month) 1 (Day) ..... (Year)

7. AGE: ..... yrs. 9 mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Oklahoma

10. NAME OF FATHER: Philip Weber

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Ethel Starr

13. BIRTHPLACE OF MOTHER (State or Country): Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Philip Weber
(Address) Burke Ida

15. Filed March 19 21 A. J. Mowery Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March (Month) 6th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2/28/21 191 , to 3/6th 1921, that I last saw him alive on 3/5/21 191 , and that death occurred on the date stated above, at 7:30 A.M.

The CAUSE OF DEATH* was as follows:

Interstitial Meningitis

(Duration) ..... yrs. ..... mos. 10 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) James R Brown M. D.
3/6 1921 (Address) Wallace Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence Burke Ida

19. PLACE OF BURIAL OR REMOVAL: Wallace Ida — DATE OF BURIAL: Mar 7 1921

20. UNDERTAKER: Harry Thompson — ADDRESS: Wallace Ida

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Shoshone
City of Kellogg
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 12
Primary Registration District No. 2200
(No. Residence St.)

File No. 33596
Registered No. 4
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Andrew G. Flodstrom

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M.	white	married

6. DATE OF BIRTH
(Month) (Day) (Year)

7. AGE
62 yrs. mos. ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: miner
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER: John Johnson

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Christine Johnson

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Andrew Flodstrom
(Address) Kellogg Idaho.

15.
Filed Feb 23 1924 H. C. Mowry
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Feb 21 1924
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from — , 191 , to — 191 , that I last saw h. alive on 191 , and that death occurred on the date stated above, at 4 A. M.

The CAUSE OF DEATH* was as follows:
Acute Dilatation of Heart
Chronic Myocarditis
(Duration) yrs. mos. ds.
Contributory (Secondary) Angina Pectoris
(Duration) 2 H yrs. mos. ds.

(Signed) Dr. F. McDonald M. D.
2/24 1924 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence: Kellogg Idaho

19. PLACE OF BURIAL OR REMOVAL: Wallace Idaho | DATE OF BURIAL: Feb 25 1924

20. UNDERTAKER: Harry Thompson | ADDRESS: Wallace Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Shoshone
City of Mullan
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 122
Primary Registration District No. 2200
(No. Northern Pacific Ave. St.)

File No. 33597
Registered No. 3
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Henikman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	W	Single

6. DATE OF BIRTH
July (Month) 10 (Day) 1914 (Year)

7. AGE
6 yrs. 5 mos. 7 ds.
IF LESS than 1 day how many .....hrs. or .....mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... Student
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Wardner Ida.

10. NAME OF FATHER John Henikman

11. BIRTHPLACE OF FATHER (State or Country) Austria

12. MAIDEN NAME OF MOTHER Margret. Patricks

13. BIRTHPLACE OF MOTHER (State or Country) Austria -

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Dr. F. W. Rolf
(Address) Mullan Ida

15.
Filed 2/23 1921 H C Morris Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Feb (Month) 21 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 21 1921, to 40 min ~~1921~~, that I last saw h in alive on Feb 21 1921, and that death occurred on the date stated above, at 4:40 M.

The CAUSE OF DEATH* was as follows:
Had Coasting down hill
Sled by train. Fracture
B of Skull.
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory
(Secondary) Pneumonia
(Duration) ..... yrs. 40 mos. ..... ds.
(Signed) F W Rolf M. D.
2/24/1921 (Address) Mullan Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence Mullan Ida

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Mullan Ida	Feb 24 1921

20. UNDERTAKER	ADDRESS
Harry Thompson	Wallace Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Teton

City of Driggs (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
APR 11 1921
BUREAU OF VITAL STATISTICS

Registration District No. 77

Primary Registration District No. 2176

File No. 33604

Registered No. Eight

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Edward B. Seymour

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widowed (Write the word.)

6. DATE OF BIRTH: October 14, 1824 (Month) (Day) (Year)

7. AGE: 87 Yrs. 5 Mos. 6 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer): Farming

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER: Wright Seymour

11. BIRTHPLACE OF FATHER (State or Country): N.Y.

12. MAIDEN NAME OF MOTHER: Miss. Bishop

13. BIRTHPLACE OF MOTHER (State or Country): N.Y.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E A Seymour

(Address) .....

15. Filed Mar 24 Th 1921 Martha Marker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 20 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 16 1920, to March 20 1921 that I last saw h.e. alive on March 20 1921 and that death occurred on the date stated above, at 4Q, M.

The CAUSE OF DEATH* was as follows:

Enlargement of Prostate,

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas J Martin M. D.

3/21 1921 (Address) Driggs, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL ~~OR REMOVAL~~: Tetonia Idaho — DATE OF BURIAL: Mar 25 1921

20. UNDERTAKER: W.J.KING, — ADDRESS: Driggs Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

RECEIVED APR 11 1921 BUREAU OF VITAL STATISTICS

Registration District No. 77

Primary Registration District No. 2176

File No. 33605

Registered No. Denbo

County of Teton

City of Driggs (If outside limits, give township.) No. 5 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Samuel Leaves Sheets

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. ~~SINGLE, MARRIED, WIDOWED~~ OR DIVORCED (Write the word.)

6. DATE OF BIRTH: Jan (Month) 28 (Day) 1860 (Year)

7. AGE: 61 Yrs. 1 Mos. 13 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Salt Lake City, Ut.

10. NAME OF FATHER: Eliza F. Sheets

11. BIRTHPLACE OF FATHER (State or Country): Penn.

12. MAIDEN NAME OF MOTHER: Elizabeth Leaves

13. BIRTHPLACE OF MOTHER (State or Country): New York.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) M. L. Sheets
(Address) Victor Idaho.

15. Filed March 16 1921 Martha Marker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 13 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 15 1920 to May 13 1921 that I last saw h[illegible] alive on May 13 1921 and that death occurred on the date stated above, at 11th A.M.

The CAUSE OF DEATH* was as follows:
Chronic Nephritis (Bright's Disease)

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas J Master M. D.
March 1921 (Address) Driggs, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF ~~BURIAL, OR~~ REMOVAL: Salt Lake City, Utah. DATE OF BURIAL: Mar 18 1921

20. UNDERTAKER: [illegible] ADDRESS: Driggs Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
APR 11 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Teton — Registration District No. 77

City of Celta, Wyo. — Primary Registration District No. 2176.

(No. ..... St.)

File No. 33606

Registered No. Missing

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charles Forest Green

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH: March (Month) 23rd (Day) 1920 (Year)

7. AGE: 1 Yrs. Mos. 7 ds. — IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wyoming

10. NAME OF FATHER: Charles E Green

11. BIRTHPLACE OF FATHER (State or Country): Idaho.

12. MAIDEN NAME OF MOTHER: Hariett Stevens

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Rose Davidson
(Address) Letonia Idaho

15. Filed April 7th 1921 Martha Marker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 30th 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 26 1921, to March 30 1921, that I last saw him alive on March 30 1921, and that death occurred on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Duration) ..... Yrs. ..... mos. 4 ds.

Contributory (Secondary) None

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G. E. Carbaston M. D.

March 31 1921 (Address) Driggs Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Celta Wyo.	April 2 1920

20. UNDERTAKER: E. E. Merry — ADDRESS: Driggs Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

STEMS-YORK CO., PRINTERS & BINDERS, BOISE 51068

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Teton
City of Driggs
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 77
Primary Registration District No. 2176
(No. ....., ... St.)

File No. 33607
Registered No. Birth

2. FULL NAME Jeanette Griggs

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Jan (Month) 31 (Day) 1921 (Year)

7. AGE: Yrs. 1 Mos. 6 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Infant
(b) General nature of industry, business, or establishment in which employed (or employer)... Infant

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Robert E Griggs

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Estella Henrie

13. BIRTHPLACE OF MOTHER (State or Country) Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Robert E Griggs
(Address) Driggs Idaho

15. Filed Mar 8th 1921 (Martha Marks) Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 6 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 4 1921, to Mar 6 1921, that I last saw her alive on Mar 6 1921, and that death occured on the date stated above, at 11 A M.

The CAUSE OF DEATH* was as follows:
Broncho-Pneumonia

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration ..... Yrs. ..... mos. ..... ds.

(Signed) Chas J Mark M. D.
Mar 6 1921 (Address) Driggs Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Driggs Idaho — DATE OF BURIAL: Mar 8 1921

20. UNDERTAKER: W J King. — ADDRESS: Driggs, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STNRS. 24854

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 77

Primary Registration District No. 2176

(No. ....., ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33608

Registered No. Final

1. PLACE OF DEATH.

County of Teton

City of Driggs

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Chester D. Harris

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH. January 4th 1921 (Month) (Day) (Year)

7. AGE ....Yrs. 1 Mos. 19 ds. IF LESS than 1 day how many ....hrs. or ....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Infant

(b) General nature of industry, business, or establishment in which employed (or employer)..... Infant.

9. BIRTHPLACE (State or Country) Teton Driggs 2da

10. NAME OF FATHER William C. Harris

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Mary Dauphray

13. BIRTHPLACE OF MOTHER (State or Country) France

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) R. L. Knight

(Address) Driggs Ida

15.

Filed Mar 4th 1921 Martha Marker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. 24 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb-5- 1921, to Feb-24 1921, that I last saw him alive on Feb-18- 1921, and that death occured on the date stated above, at 2 A M.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

.....(Duration) ....Yrs. ....mos. 19 ds.

Contributory (Secondary)

.....(Duration ....yrs. ....mos. ....ds.

(Signed) H. K. Tilbertson M. D.

Feb-25 1921. (Address) Driggs Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Driggs Cemetery

DATE OF BURIAL 2-25 1921

20. UNDERTAKER W. Reiss

ADDRESS Driggs

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SVMB - YORK CO., PTRS. & BORS. 24654

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
APR 9 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 39
Primary Registration District No. 7087
File No. 33609
Registered No.

1. PLACE OF DEATH

County of Twin Falls
City of Buhl
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Emma Hershey Smith

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female

4. COLOR OR RACE White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED Widowed
(Write the word.)

6. DATE OF BIRTH March (Month) 2 (Day) 1856 (Year)

7. AGE 63 Yrs. 11 Mos. 24 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business or establishment in which employed (or employer) Retired

9. BIRTHPLACE (State or Country) Iowa

10. NAME OF FATHER Christian Hershey

11. BIRTHPLACE OF FATHER (State or Country) Penna

12. MAIDEN NAME OF MOTHER Dont Know

13. BIRTHPLACE OF MOTHER (State or Country) " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Chas D Snyder

(Address) Buhl Ida

15. Filed 2-26 1921 J. N. Murphy Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 26 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5-31 1921, to Feb. 26 1921, that I last saw h.r alive on Feb. 25 1921, and that death occurred on the date stated above, at 9 P M.

The CAUSE OF DEATH* was as follows:

Apoplexy.

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Senility

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. N. Murphy M. D.

2-27 1921 (Address) Buhl Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Buhl Ida — **DATE OF BURIAL** 2-27 1921

20. UNDERTAKER Homer B Evans — **ADDRESS** Buhl

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

Form V. S. No. 5 20M.1-16-12

RECEIVED
APR 9 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 34
Primary Registration District No. 2087
File No. 33610
Registered No.

1. PLACE OF DEATH.
County of Twin Falls
City of Buhl (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME ..... If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Feb. (Month) 28 (Day) 1921 (Year)

7. AGE: ..... yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Twin Falls Co. Ida.

10. NAME OF FATHER: J. W. Brewer.

11. BIRTHPLACE OF FATHER (State or Country): Ill

12. MAIDEN NAME OF MOTHER: Ethel Hawley.

13. BIRTHPLACE OF MOTHER (State or Country): Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): J. W. Brewer.
(Address): Buhl

15. Filed 3-1 1921 J. K. Murphy Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: ~~Feb.~~ Mar. 1 ~~28~~ (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 28 1921, to Feb. 28 1921, that I last saw h[er] alive on Feb. 28 1921, and that death occurred on the date stated above, at 1 a.m.

The CAUSE OF DEATH* was as follows:
Premature birth.
.....
.....
..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. K. Murphy M. D.
3-1 1921 (Address) Buhl

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Buhl — DATE OF BURIAL: 3-1 1921

20. UNDERTAKER: None — ADDRESS

GYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
APR 9 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 39
State Registration District No. 2087

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33612
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of Buhl
If death occurs away from usual residence, give facts called for under special information.

(No. ..... St.)

2. FULL NAME Baby Peck.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): ~~Single~~

6. DATE OF BIRTH: Feb (Month) 25 (Day) 1921 (Year)

7. AGE: — Yrs. — Mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Buhl

10. NAME OF FATHER: J F Peck.

11. BIRTHPLACE OF FATHER (State or Country): Penn

12. MAIDEN NAME OF MOTHER: Olga Boatman

13. BIRTHPLACE OF MOTHER (State or Country): Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J F Peck
(Address) Buhl Ida

15. Filed 3-8 1921 J. S. Murphy, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 7 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 25 1921, to March 7 1921, that I last saw him alive on March 6 1921, and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Icterus neonatorum

(Duration) — Yrs. — mos. 10 ds.

Contributory (Secondary) Asthenia, Inanition.

(Duration) — yrs. — mos. 10 ds.

(Signed) F. A. Ismen, M. D.

March 8 1921 (Address) Buhl Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Buhl Cemetery | DATE OF BURIAL: 3/8 1921

20. UNDERTAKER: Hamilton & Lipps | ADDRESS: Buhl Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51085

Form V. S. No. 5 20M.1-16-12

RECEIVED
APR 9 1921
BUREAU OF VITAL STATISTICS
STATE OF IDAHO

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33613

Registered No.

1. PLACE OF DEATH.
Registration District No. 39
County of Twin Falls. Registration District No. 208
City of Buhl (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Alice Weaver

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
F.	W.	Single

6. DATE OF BIRTH
Feb. (Month) 14 (Day) 1921 (Year)

7. AGE
..... yrs. ..... mos. 25 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... None
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE
(State or Country) Buhl Ida.

10. NAME OF FATHER D. C. Weaver Jr.

11. BIRTHPLACE OF FATHER
(State or Country) Neb.

12. MAIDEN NAME OF MOTHER Ida. Worley.

13. BIRTHPLACE OF MOTHER
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs D C Weaver
(Address) Buhl

15.
Filed 3-12 1921 J. H. Murphy
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Mar (Month) 11 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2-14-21 191..., to 3-11 1921, that I last saw her alive on 3-1 1921, and that death occurred on the date stated above, at 11 P. M.

The CAUSE OF DEATH* was as follows:
Inanition.

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. H. Murphy M. D.
19... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Buhl Ida.	3-12 1921

20. UNDERTAKER	ADDRESS
None	

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
APR 9 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 39
Primary Registration District No. 2087
File No. 33614
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of Castleford (No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jacob M. Cook

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widowed (Write the word.)

6. DATE OF BIRTH: March (Month) 15th (Day) 1921 (Year)

7. AGE: 74 Yrs. 11 Mos. 16 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER: Adam Henry Cook

11. BIRTHPLACE OF FATHER (State or Country): Dont know

12. MAIDEN NAME OF MOTHER: Dont know

13. BIRTHPLACE OF MOTHER (State or Country): Dont know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Julius Schake
(Address)

15. Filed Mar. 16 1921 J. H. Murphy Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 15 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar. 30 1920, to Mar. 15 1921, that I last saw h.im alive on Mar 15 1921, and that death occurred on the date stated above, at 7:30 A.M.
The CAUSE OF DEATH* was as follows:

Gastric Carcinoma

(Duration) 1 Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Geo. Fleming M. D.
3-18 1921 (Address) Burl. Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Parsons Kan	19
20. UNDERTAKER	ADDRESS
Romer B Evans	Burley Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED APR BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 39
Registration District No. 2087
File No. 33616
Registered No.

1. PLACE OF DEATH

County of Twin Falls
City of Burke (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Margaret Wacker

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female

4. COLOR OR RACE White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married (Write the word.)

6. DATE OF BIRTH January (Month) 30th (Day) 1839 (Year)

7. AGE 82 Yrs. 1 Mos. 25 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Brown Co. Indiana

10. NAME OF FATHER Thomas Waltman

11. BIRTHPLACE OF FATHER (State or Country) Penna.

12. MAIDEN NAME OF MOTHER Dont Know

13. BIRTHPLACE OF MOTHER (State or Country) Dont Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) T. D. Walker.

(Address) .....

15. Filed 3-26 1921 J. H. Murphy Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March (Month) 25 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar. 2 - 1921, to Mar. 25 1921 that I last saw h. alive on Mar 25 1921 and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo J Cummings M. D.

3-26 1921 (Address) Buhl Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Bloomington Neb. **DATE OF BURIAL** ..... 19.....

20. UNDERTAKER Homer B Evans **ADDRESS** Buhl Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED APR 9 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 39

Primary Registration District No. 2087

File No. 33617

Registered No. .....

County of Twin Falls.

City of Buhl Idaho (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Irene Marvilla Lowry.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Apr (Month) 15 (Day) 916 (Year)

7. AGE: 4 Yrs. 11 Mos. 17 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer) School Girl

9. BIRTHPLACE (State or Country) Does know Adopted

10. NAME OF FATHER Joe Gonsalie adopted by W. D. Lowry

11. BIRTHPLACE OF FATHER (State or Country) Does Know

12. MAIDEN NAME OF MOTHER " "

13. BIRTHPLACE OF MOTHER (State or Country) " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W. D. Lowry.

(Address) Buhl

15.

Filed Mar 28 1921

J. S. Merrifield Local Registrar

SYMS - YORK CO., PTRS. & STRS. 24853

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March (Month) 27 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 27 1921, to March 27 1921, that I last saw her alive on March 27 1921 and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Diphtheria.

(Diagnois not confirmed by culture).

(Duration) ..... Yrs. ..... mos. 4 ds.

Contributory (Secondary) Laryngeal obstruction Toxemia.

(Duration ..... yrs. ..... mos. 1 ds.

(Signed) F A Irmen. M. D.

Mch 28 1921 (Address) Buhl Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Buhl

DATE OF BURIAL: 3/30 1921

20. UNDERTAKER: Homer B Evans

ADDRESS: Buhl Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED
APR 7 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33618
Registered No. 3

1. PLACE OF DEATH
County of Twin Falls
City of Hansen
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Registration District No.
(No. Mountain St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mattie Jackson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Aug 28 1853 (Month) (Day) (Year)

7. AGE: 67 Yrs. 6 Mos. 13 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: maid
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: Joseph Burrows

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Morgred Ponsford

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Albert Bennett
(Address): Hansen

15. Filed Mar 15 1921 — J. M. Davis, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar 14 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 14 1921, to Mar 14 1921 that I last saw her alive on Mar 14 1921 and that death occurred on the date stated above, at 3:30 P.M.

The CAUSE OF DEATH* was as follows:
Chronic Valvular heart disease

(Duration) Many Yrs. — mos. ds.
Contributory (Secondary) —
(Duration) yrs. mos. ds.

(Signed) J. M. Davis M. D.
Mar 15 1921 (Address) Kimberly Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Idaho — DATE OF BURIAL: 3-17 1921

20. UNDERTAKER: L. E. Scott — ADDRESS: Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 39
Primary Registration District No. 2081
File No. 33619
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of Buhl
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Belle Cludas

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Widowed

6. DATE OF BIRTH: April (Month) 18 (Day) 1845 (Year)

7. AGE: 75 Yrs. 9 Mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: Mr Gateka

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Dont Know

13. BIRTHPLACE OF MOTHER (State or Country): Dont Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Frank Cludas
(Address)

15. Filed 2-8 1921 J. H. Murphy Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. 7th-1921 (Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9/7 19 20, to 2/7 19 21, that I last saw h.er alive on 2/7 19 21, and that death occurred on the date stated above, at 4P M.
The CAUSE OF DEATH* was as follows:

Pulmonary Oedema
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Chronic Interstitial Nephritis
(Duration) 2 Yrs at least Yrs. ..... mos. ..... ds.
(Signed) J. H. Murphy M. D.
2/7 19 21 (Address) Buhl Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Portland, Ore.	19
20. UNDERTAKER: Homer B. Evans	ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 39
Primary Registration District No. 7087
File No. 33620
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of Buhl
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William Benjamin Grather
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write word.): Single

6. DATE OF BIRTH: Feb. 4 1921
(Month) (Day) (Year)

7. AGE: — Yrs. — Mos. 18 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Buhl

10. NAME OF FATHER: W. H. Grather

11. BIRTHPLACE OF FATHER (State or Country): Ore.

12. MAIDEN NAME OF MOTHER: Gladys Brown

13. BIRTHPLACE OF MOTHER (State or Country): Colo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. W. H. Grather
(Address) Buhl

15. Filed 2-22 1921 J. F. Murphy Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 2-22 21
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2-4-1921, to 2-22-1921, that I last saw h[illegible] alive on 2-22-1921, and that death occurred on the date stated above, at 8 A. M.
The CAUSE OF DEATH* was as follows:

Erysipelas

(Duration) Yrs. mos. 3 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Geo. Jennings M. D.
2-22 1921 (Address) Buhl, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Buhl Cemetery	2-22 1921
20. UNDERTAKER	ADDRESS
Melville & Pugsley	Buhl Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Twin Falls
City of Buhl.
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2087
Primary Registration District No. 39
(No. ....., ... St.)

File No. 33621
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Jay Rouse

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M.	W.	Single

6. DATE OF BIRTH: Feb. (Month) 24 (Day) 1921 (Year)

7. AGE: 0 yrs. 4 mos. 20 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Cal.

10. NAME OF FATHER: A. L. Rouse

11. BIRTHPLACE OF FATHER (State or Country): Mo

12. MAIDEN NAME OF MOTHER: Hattie Howard.

13. BIRTHPLACE OF MOTHER (State or Country): Ark.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A. L. Rouse
(Address) .....

15. Filed Feb 24 1921 J. H. Murdock Reg
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 2 (Month) 24 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2-23- 1921, to 2-24- 1921, that I last saw him alive on 2-24- 1921, and that death occurred on the date stated above, at 3:30 P.M.

The CAUSE OF DEATH* was as follows:

Epilepsy

(Duration) ..... yrs. ..... mos. 1 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo. Jennings M. D.
2-24 1921 (Address) Buhl, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Buhl Cemetary — DATE OF BURIAL: Feb. 25 1921

20. UNDERTAKER: W. Ferrill & Son — ADDRESS: Buhl Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Pete Mc

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Twin Falls
City of " "
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 37
Primary Registration District No. 1 0 6 5
(No. ..... St.)

File No. 33622
Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME W. H. Scott

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH
July (Month) 7 (Day) 1859 (Year)

7. AGE
61 Yrs. 7 Mos. 17 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Laborer,
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Ohio

10. NAME OF FATHER Wm Scott.

11. BIRTHPLACE OF FATHER (State or Country) Ken.

12. MAIDEN NAME OF MOTHER Sarah Walker

13. BIRTHPLACE OF MOTHER (State or Country) Mary.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) D. A. McMillen
(Address) Twin Falls

15.
Filed March 4 1921
J. F. Coughlin
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
February (Month) 24 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 29, 1920, to Feb 24 1921, that I last saw ~~him~~ alive on Feb. 24, 1921, and that death occurred on the date stated above, at 8:30 P. M.

The CAUSE OF DEATH* was as follows:
Myocardial degeneration

(Duration) 4 or 5 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. W. Pike M. D.
2/26 1921 (Address) Twin Falls Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Twin Falls	2/27 1921
20. UNDERTAKER	ADDRESS
J. J. Isaacson	Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1085
File No. 33623
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of 11 1 4 (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William O Harstad
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Sept. (Month) 25 (Day) 1920 (Year)

7. AGE: Yrs. 4 Mos. 22 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) Dentist

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Olver Harstad

11. BIRTHPLACE OF FATHER (State or Country) Norway.

12. MAIDEN NAME OF MOTHER Amy Rauty.

13. BIRTHPLACE OF MOTHER (State or Country) Ohio.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Dr. Olver Harstad
(Address) Twin Falls

15. Filed March 4 1921 J. F. Coughlin Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: February (Month) 16 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 14 1921, to Feb. 16 1921 that I last saw him alive on Feb 15 1921, and that death occurred on the date stated above, at 8a. M.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease
Congenital
(Duration) Yrs. 4 mos. 22 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas. R. Scott M. D.
2-17 1921 (Address) Twin Falls Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls
DATE OF BURIAL: 2/19 1921

20. UNDERTAKER: J. B. Lawrence
ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Twin Falls
City of [illegible]
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 37
Primary Registration District No. 1085
(No. at Home St.)

File No. 33624
Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Margarett B. Rice

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6. DATE OF BIRTH: Nov. (Month) [illegible] (Day) 1858 (Year)

7. AGE: 62 Yrs. 3 Mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Home Wife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: John Hamlin

11. BIRTHPLACE OF FATHER (State or Country): Canada

12. MAIDEN NAME OF MOTHER: Hulda Eastman

13. BIRTHPLACE OF MOTHER (State or Country): New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) T. T. Varney
(Address) Twin Falls

15. Filed Feb 17 1921
J. F. Coughlin
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 1/26 (Month) 16 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2/9 1921, to 2/15 1921
that I last saw her alive on 2/15 1921
and that death occurred on the date stated above, at 4 P.M.
The CAUSE OF DEATH* was as follows:
Cancer of Uterus

(Duration) 1 Yrs. 6 mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) C. D. Weaver M. D.
2/16 1921 (Address) Twin Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls
DATE OF BURIAL: 2/17 1921
20. UNDERTAKER: [illegible]
ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1085
File No. 33625
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of
(No. St. Marys Hospital St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Marshall Bassel
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH
(Month) (Day) 1 (Year)

7. AGE: 72 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Nat Kansas

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C H Berry
(Address) Twin Falls

15. Filed March 4 1921 J. F. Coughlin Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
2 (Month) 25 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2.10 1921, to 2-25 1921 that I last saw h... alive on 2.24 1921 and that death occurred on the date stated above, at 5- P.M.

The CAUSE OF DEATH* was as follows:
Cardiac Carcinoma
(Duration) Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) T S Mason M. D.
2/26 1921 (Address) Twin Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Ida — DATE OF BURIAL: 2-26 1921

20. UNDERTAKER: E E Brott — ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 34

Primary Registration District No. 1085

File No. 33626

Registered No.

1. PLACE OF DEATH

County of Twin Falls

City of

(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Eula Leigh Sweet

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write one word.)

6. DATE OF BIRTH: Feb 3 (Month) (Day) 1 (Year)

7. AGE: 18 Yrs. Mos. 21 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: School Girl

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): MO

10. NAME OF FATHER: Hugh R Sweet

11. BIRTHPLACE OF FATHER (State or Country): MO

12. MAIDEN NAME OF MOTHER: Ida Saunders

13. BIRTHPLACE OF MOTHER (State or Country): MO

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant): C E Sweet

(Address):

15. Filed Feb 24 1921

J H Coughlin
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb 24 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 18 19..., to Feb 24 1921, that I last saw her alive on Feb 24 19..., and that death occurred on the date stated above, at 4:30 P.M.

The CAUSE OF DEATH* was as follows:

Obstruction of bowels

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) H W Clendenin M. D.

19... (Address) Twin Falls, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Ida — DATE OF BURIAL: 2-25-1921

20. UNDERTAKER: L E Reeds — ADDRESS: Twin Falls

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 37 Shoshone

Primary Registration District No. 2085

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33627

Registered No. .....

1. PLACE OF DEATH.

County of Twin Falls

City of Curry

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Shadrach Bonwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.) widowed

6. DATE OF BIRTH. Oct (Month) 19 (Day) 1825 (Year)

7. AGE 95 Yrs. 5 Mos. 5 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Farmer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Hiland Co. Ohio

10. NAME OF FATHER Nathaniel Bonwell

11. BIRTHPLACE OF FATHER (State or Country) Ohio

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) A N Bonwell
(Address) Filer Ida.

15. Filed March 8 1921 J. F. Coughlin Local Registrar

SYMS - YORK CO., PTRS. & STNRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 27 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw him alive on ..... 191...,
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.
(Duration) ..... Yrs. ..... mos. 10 ds.
Contributory (Secondary) Arteria-sclerosis
(Duration 10 yrs. — mos. — ds.
(Signed) F. A. Dwight M. D.
Mch 2 1921 (Address) Twin Falls Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Twin Falls cemetery — DATE OF BURIAL Mch 1 1921

20. UNDERTAKER F. E. Ewell — ADDRESS Twin Falls

Dr Price.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 2685
File No. 33628
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of Hansen
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Howard Miller
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Aug 29 (Month) (Day) 1916 (Year)

7. AGE: 4 Yrs. 5 Mos. 16 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Ark.

10. NAME OF FATHER: Elmer Miller

11. BIRTHPLACE OF FATHER (State or Country): Ark

12. MAIDEN NAME OF MOTHER: Mattie Calico

13. BIRTHPLACE OF MOTHER (State or Country): Ark.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): R. C. Calico
(Address): Hansen Ida.

15. Filed Feb. 17 1921 J. F. Coughlin Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb 15 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2/9 1921, to 2/15 1921 that I last saw him alive on 2/13/ 1921, and that death occurred on the date stated above, at M.
The CAUSE OF DEATH* was as follows:
Pneumonia

(Duration) Yrs. mos. 7 ds.
Contributory (Secondary) Contusion
(Duration) yrs. mos. 21 ds.
(Signed) W. F. Price, M. D.
2/16/1921 (Address) Twin Falls, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls | DATE OF BURIAL: 2/17 1921
20. UNDERTAKER: J. F. Sorensen | ADDRESS: Twin Falls

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1085
File No. 33629
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of (No. St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Kenneth Williams.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Mar 11 (Month) (Day) 1920 (Year)

7. AGE: Yrs. 11 Mos. 12 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Chas L Williams

11. BIRTHPLACE OF FATHER (State or Country): Minn

12. MAIDEN NAME OF MOTHER: Maud Stevens

13. BIRTHPLACE OF MOTHER (State or Country): Minn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chas L Williams
(Address) 257 Jerome

15. Filed March 4 1921
J. F. Coughlin
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 2 — 23 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2-23 1921, to 2-23 1921
that I last saw h... alive on 2-23 1921,
and that death occurred on the date stated above, at 2 P.M.
The CAUSE OF DEATH* was as follows:
Broncho pneumonia

(Duration) Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) T O Mason M. D.
2-24 1921 (Address) Twin Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Ida
DATE OF BURIAL: 2 25 1921

20. UNDERTAKER: F E Wood
ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1085.
File No. 33630
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of
(No. Terrace & Field St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William T. McKinney
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	White	Married

6. DATE OF BIRTH: July (Month) 26 (Day) 1883 (Year)

7. AGE: 38 Yrs. 7 Mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Realestate Salesman
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa.

10. NAME OF FATHER: Finn McKinney

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. E. Wescott
(Address)

15. Filed March 2. 1921 J. F. Coughlin Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: February (Month) 28 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....
and that death occurred on the date stated above, at 2:30 A.M.
The CAUSE OF DEATH* was as follows:
Acute dilatation of heart from valvular heart disease, determined at necropsy
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) John H Coughlin M. D.
3-2 1921 (Address) Twin Falls Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence Oakland Calif

19. PLACE OF BURIAL OR REMOVAL: Knobnoster Iowa
DATE OF BURIAL ..... 19.....

20. UNDERTAKER: J E Wescott
ADDRESS: Twin Falls

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

Murphy.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 2085
File No. 33631
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of " "
(No. County Hospital, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary N Ray.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (write the word.)

6. DATE OF BIRTH: July 23 1870 (Month) (Day) (Year)

7. AGE: 50 Yrs. 6 Mos. 19 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Wm Butler

11. BIRTHPLACE OF FATHER (State or Country): Tenn

12. MAIDEN NAME OF MOTHER: Sarah Doak

13. BIRTHPLACE OF MOTHER (State or Country): Penn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W.B. Ray
(Address) Buhl, Ida.

15. Filed Feb 23 1921 John F Coughlin
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb 22 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 15 1921 to Feb 22 1921 that I last saw her alive on Feb 21 1921 and that death occurred on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:
Sepsis from abdominal abscess—appendix?

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) 2 yrs. ..... mos. ..... ds.

(Signed) John Murphy M. D.
19 (Address) Buhl Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Buhl Ida
DATE OF BURIAL ..... 19 .....

20. UNDERTAKER: P J Corcoran
ADDRESS Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1085
File No. 33632
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of Hansen
(No. County Hospital St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Hattie Gager

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: married (Write the word.)

6. DATE OF BIRTH: Oct 25 (Month) (Day) 1896 (Year)

7. AGE: 24 Yrs. 3 Mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wyo

10. NAME OF FATHER: Henry Wirth

11. BIRTHPLACE OF FATHER (State or Country): Ill

12. MAIDEN NAME OF MOTHER: Liddie Strang

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H. E. Wirth
(Address) Hansen

15. Filed Feb. 17 1921 J. F. Loughlin Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb 15 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 14th 1921, to Feb 15th 1921 that I last saw her alive on Feb 15th 1921, and that death occurred on the date stated above, at 8:25 P.M.
The CAUSE OF DEATH* was as follows:

Peritonitis General -

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Ruptured appendix

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D. Merrill Brandt M. D.
2/17 1921 (Address) Twin Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Ida — DATE OF BURIAL: Feb 17 1921

20. UNDERTAKER: H. E. Wirth — ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1085
File No. 33633
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of
(No. County Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME St John Skinner

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Nov 17 (Month) (Day) 1857 (Year)

7. AGE: 69 Yrs. 2 Mos. 27 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ore

10. NAME OF FATHER: Eugene Kenna

11. BIRTHPLACE OF FATHER (State or Country): Ill

12. MAIDEN NAME OF MOTHER: Mary Cook

13. BIRTHPLACE OF MOTHER (State or Country): Ill

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Eugene F. Skinner
(Address)

15. Filed Feb. 16 1921 — J. F. Loughlin, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb 14 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 4 1921, to Feby 14 1921, that I last saw h[illegible] alive on Feb 14 1921, and that death occurred on the date stated above, at 8:30 P.M.
The CAUSE OF DEATH* was as follows:

Acute Dilation Heart

(Duration) Yrs. mos. 4 ds.
Contributory (Secondary) Appendicitis Chr. Suppuration
arteriosclerosis
(Duration) yrs. mos. ds.
(Signed) Simeon L Alexander M. D.
2/15 1921 (Address) Twin Falls Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Owyhee Ore — DATE OF BURIAL ..... 19.....

20. UNDERTAKER: J E Wyatt — ADDRESS Twin Falls Idaho

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 87
Primary Registration District No. 1085
File No. 33634
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Marcia Jennison
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Jan 1 1913 (Month) (Day) (Year)

7. AGE: 8 Yrs. 2 Mos. 7 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: School Girl
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: M E Jennison

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Allie Sheldon

13. BIRTHPLACE OF MOTHER (State or Country): Ill

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) M E Jennison
(Address)

15. Filed March 8. 1921 J. D. Coughlin Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar 7 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 18 1921, to March 7 1921, that I last saw h-- alive on March 6 1921, and that death occurred on the date stated above, at 6:45 M.

The CAUSE OF DEATH* was as follows:
Acute Nephritis & Pyelitis.

(Duration) Yrs. 2 mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) H W Wilson M. D.
March 8 1921 (Address) Twin Falls Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Ida. DATE OF BURIAL: 3-9 1921

20. UNDERTAKER: J E Elwell ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1085
(No. La Mercy Hospital St.)

File No. 33635
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Catharine McCarthy
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widow

6. DATE OF BIRTH: June 11 (Month) (Day) 1867 (Year)

7. AGE: 53 Yrs. 7 Mos. 27 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work:
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: John Kelly

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Mat Knowles

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): C M Kelly
(Address): 736 Fair E

15. Filed Feb 11 1921 J. F. Coughlin Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb 8 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 7 1921, to Feb 8" 1921
that I last saw her alive on Feb 8" 1921
and that death occurred on the date stated above, at 9 A.M.
The CAUSE OF DEATH* was as follows:
Meningitis.
complicating a Mastoiditis
(Duration) Yrs. mos. 15 ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) J. H. Bryan M. D.
2/10 1921 (Address) Twin Falls, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Ida | DATE OF BURIAL: Feb 11 1921

20. UNDERTAKER: J. E. Wood | ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

FORM V. S. No. 6-25 M. 1-19.

RECEIVED
APR 26 1921
BUREAU OF VITAL STATISTICS

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APR 14 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33636
Registered No. 2

Registration District No. 12
Primary Registration District No.

1. PLACE OF DEATH
County Boise
City of Garden Valley (No. Ward, St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Amelia Gardner
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widowed

6. DATE OF BIRTH: May 18 (Month) (Day) 1865 (Year)

7. AGE: 55 Yrs. 8 Mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farm House Wife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Placerville Idaho

10. NAME OF FATHER: John Sittig

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Johanna Foy

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Herman Sittig
(Address) Garden Valley Ida

15.
Filed ..... 19.....
Mrs E L Robison
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 29 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 27 1921 to Jan 29 1921 that I last saw her alive on Jan 28 1921 and that death occurred on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:
Pneumonia
Lobar.

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E. G. Fritz M. D.
Feb. 1921 (Address) Emmett Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? at place of death
Former or usual residence Fifty Nine Boise Co. Ida

19. PLACE OF BURIAL OR REMOVAL: Garden Valley Ida
DATE OF BURIAL: Feb 1 1921

20. UNDERTAKER: none
ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Twin Falls

City of .....

(No. ....., ... St.)

Registration District No. 37

Primary Registration District No. 1085

File No. 33638

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Arabelle Shotwell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
female	white	Married

6. DATE OF BIRTH: June 4 (Month) (Day) 1840 (Year)

7. AGE: 80 Yrs. 8 Mos. 22 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) New York

10. NAME OF FATHER Joseph Cox

11. BIRTHPLACE OF FATHER (State or Country) Not Known

12. MAIDEN NAME OF MOTHER Hannah Cox

13. BIRTHPLACE OF MOTHER (State or Country) Not Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W M Shotwell

(Address) Twin Falls

15. Filed March 4. 1921 J. F. Engheim Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb 26 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 15th 1921, to Feb 26 1921, that I last saw her alive on Feb 19 1921, and that death occurred on the date stated above, at 7:30 P.M.

The CAUSE OF DEATH* was as follows:

Acute dilation of Heart

..... (Duration) ..... Yrs. ..... mos. 20 ds.

Contributory (Secondary) Senility

..... (Duration) ..... yrs. 12 mos. ..... ds.

(Signed) S. A. Alexander M. D.

2/28 1921 (Address) Twin Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Twin Falls Ida	Feb 27 1921
20. UNDERTAKER L. S. Stewart	ADDRESS Twin Falls

In plain terms, so that it may be properly classified. Exact statement of OCCUPA

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33639
Registered No. 11

1. PLACE OF DEATH. Registration District No. 57
County of Blaine Primary Registration District No. 2057
City of Hailey (No. , St.)
If death occurs away from usual residence, give facts called for under special information.

RECEIVED APR 11 1921 BUREAU OF VITAL STATISTICS

2. FULL NAME William Walker.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.
4. COLOR OR RACE: White.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married.
6. DATE OF BIRTH: Nov. 5 1860 (Month) (Day) (Year)
7. AGE: 60 yrs. 4 mos. 18 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner.
(b) General nature of industry business, or dstablishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Wisconsin.
10. NAME OF FATHER: Thos. Walker.
11. BIRTHPLACE OF FATHER (State or Country): —
12. MAIDEN NAME OF MOTHER: —
13. BIRTHPLACE OF MOTHER (State or Country): —
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Geo P Walker
(Address) Hailey, Ida.
15. Filed Apr- 1 1921 R. H. Wright Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Wright
Mar. 23 1921.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov-21 1920 to Mar-22 1921; that I last saw him alive on Mar-22 1921 and that death occurred on the date stated above, at 7:30 P.M.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis
(Duration) 2 yrs. mos. ds.
Contributory
(Secondary)
(Duration) yrs. mos. ds.

(Signed) Robert H. Wright M. D.
3-24 1921 (Address) Hailey, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Hailey, Ida — DATE OF BURIAL: 3-25 1921
20. UNDERTAKER: R. D. Harris — ADDRESS: Hailey

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19780

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 25 — 3364
Primary Registration District No. 2072
File No. 6
Registered No. 115

1. PLACE OF DEATH.
County of Power
City of Am Falls
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John B. Cardell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married
6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)
7. AGE: 54 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work... Field man for
(b) General nature of industry, business, or establishment in which employed (or employer)..... Creamery.
9. BIRTHPLACE (State or Country) England.
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (State or Country)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (State or Country)
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) N. R. Ricks
(Address) 359 Eccles Ave.
15. Filed Mch 1 19[illegible] R F Nothmo
Local Registrar
By C C

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Feby 28 (Month) (Day) 191[illegible] (Year)
17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occured on the date stated above, at 7.30 A. M.
The CAUSE OF DEATH* was as follows:
Sun time after death. Think
it was
Cerebral hemorrhage
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration ..... yrs. ..... mos. ..... ds.
3/2 19[illegible] (Signed) C. F. Schultz M. D.
(Address) Amer. Falls Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Provo Utah — DATE OF BURIAL: ..... 191...
20. UNDERTAKER: Am Dan — ADDRESS: Am Falls Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

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FORM V. S. No. 5-25 M, 1-19.

Back.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33642

Registered No. 112

RECEIVED
MAY 7 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 2

County of Ada

Primary Registration District No.

City of Boise (No. 811 Eastman St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Samuel E. Johnson.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
M.	White.	Married (Write the word.)

6. DATE OF BIRTH: Jan (Month) 1 (Day) 1849 (Year)

7. AGE: 72 Yrs. 3 Mos. 22 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Mining Engineer.

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New Jersey.

10. NAME OF FATHER: Samuel Johnson.

11. BIRTHPLACE OF FATHER (State or Country): Penn.

12. MAIDEN NAME OF MOTHER: Wilhelmina Kennedy

13. BIRTHPLACE OF MOTHER (State or Country): Penn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Norma Johnson

(Address)

15. Filed Apr 25 1921 — R. H. Pratt, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April 22 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 22nd 1921 to April 22nd 1921 that I last saw him alive on April 22nd 1921 and that death occurred on the date stated above, at 10 A M.

The CAUSE OF DEATH* was as follows:

Dilatation of Heart

(Duration) X Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Wm Beck M. D.

4-24 1921 (Address) Boise Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Morris Hill Cemetery	Apr 26 1921
20. UNDERTAKER	**ADDRESS**
Summers & Kirk	Boise Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33643

Registered No. 99

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Ada

City of Boise (No.) St. Lukes Hospital St.)

Registration District No. 2

Primary Registration District No. 1004

If death occurs away from usual residence, give facts called for under special information.

RECEIVED MAY 7 1921 BUREAU OF VITAL STATISTICS

2. FULL NAME Fred Diaz

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: (Month) (Day) 1898. (Year)

7. AGE: 23 Yrs. — Mos. — ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Cook

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Spain

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Clyde E. Summers

(Address) Boise Idaho

15. Filed April 1 1921 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 29 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I ~~attended~~ saw deceased from March 29 1921, to 19, that I last saw h alive on 19, and that death occurred on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:

Gun shot Wound
Murder

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Clyde E Summers Coroner M. D.

3/31/1921 (Address) Boise Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: St Johns Cemetery | DATE OF BURIAL: Apr 1 1921

20. UNDERTAKER: Summers & Kirtos | ADDRESS: Boise Idg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FO[illegible]V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33644
Registered No. 164

RECEIVED
MAY 7 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
Registration District No. 1
Primary Registration District No. 1004
County of Ada
City of Boise (No. St. Lukes Hos. St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME M. C. Mc Fadden
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widower (Write the word.)

6. DATE OF BIRTH: (Month) (Day) 1850 (Year)

7. AGE: 70 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Wood Business
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ind

10. NAME OF FATHER: Mr. Mc Fadden

11. BIRTHPLACE OF FATHER (State or Country): U. S. A

12. MAIDEN NAME OF MOTHER: Not obtainable

13. BIRTHPLACE OF MOTHER (State or Country): U. S. A.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs C E Marion
(Address) Boise

15. Filed April 2 1921 P. H. Prato Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 12 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 26 1921 to April 12 1921
that I last saw h[illegible] alive on March 31 1921
and that death occurred on the date stated above, at 2:30 A.M.
The CAUSE OF DEATH* was as follows:
Carcinoma of Stomach
(Duration) Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) John Boeck M. D.
4-4 1921 (Address) Boise Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 4/3 1921

20. UNDERTAKER: Schreiber & Siddenfaden — ADDRESS: Boise

Book

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

Forney.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2

Primary Registration District No. 1004

File No. 33645

Registered No. 101

1. PLACE OF DEATH

County of Ada

City of Boise. (If outside limits, give township.) No. St Lukes Hospital. St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary A. Wooden.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Aug 9. (Month) (Day) 1906. (Year)

7. AGE: 14 Yrs. 7 Mos. 29 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: William Wooden.

11. BIRTHPLACE OF FATHER (State or Country): Missouri.

12. MAIDEN NAME OF MOTHER: Mary Peebles.

13. BIRTHPLACE OF MOTHER (State or Country): Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mary Wooden
(Address)

15. Filed Apr 2 1921. [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr 1 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 27 1921, to Apr 1 1921, that I last saw her alive on Apr 1 1921, and that death occurred on the date stated above, at 11:20 P M.

The CAUSE OF DEATH* was as follows:
Generale Peritonitis

(Duration) Yrs. 1/2 mos. ds.
Contributory (Secondary) Ruptured Appendix
(Duration) yrs. mos. 7 ds.

(Signed) Gratomey M. D.
4-2 1921 (Address) Boise Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Council Idaho. DATE OF BURIAL: Apr 4 1921

20. UNDERTAKER: Summers & Webb ADDRESS: Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

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MAY 7 19
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 1004
File No. 33646
Registered No. 102

1. PLACE OF DEATH
County of Ada
City of Boise (No. 1490 State St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Alice G. Hull
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Sept. 11 1891 (Month) (Day) (Year)

7. AGE: 29 Yrs. 6 Mos. 23 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: G. W. Frey

11. BIRTHPLACE OF FATHER (State or Country): Not

12. MAIDEN NAME OF MOTHER: Ellie Holland

13. BIRTHPLACE OF MOTHER (State or Country): Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Alice Hull
(Address) Barber Idaho

15. Filed 4/6/21 19.....
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 4 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 31 1921, to April 4 1921, that I last saw h[illegible] alive on 4—4 1921, and that death occurred on the date stated above, at 6 P M.

The CAUSE OF DEATH* was as follows:
Streptococcic Peritonitis.

..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Pyosalpynx
..... (Duration) ..... yrs. 6 mos. — ds.

(Signed) W. L. Frazier M. D.
4/4 1921 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: April 6 1921
20. UNDERTAKER: Summers & Kirk — ADDRESS: Boise Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33647

Registered No. 103

1. PLACE OF DEATH

County of Ada

City of Boise (No. 1210 State St. St.)

Registration District No. V

Primary Registration District No. 1004

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BUREAU OF VITAL STATISTICS

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William Elias Sutton

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widower (Write the word.)

6. DATE OF BIRTH: July 9 1848
(Month) (Day) (Year)

7. AGE: 72 Yrs. 8 Mos. 25 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ky.

10. NAME OF FATHER: Thomas Sutton

11. BIRTHPLACE OF FATHER (State or Country): Ky

12. MAIDEN NAME OF MOTHER: Fitzhugh

13. BIRTHPLACE OF MOTHER (State or Country): Ky.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wm McPratney
(Address) Boise, Idaho

15. Filed April 5 1921 R H Pratt
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr. 4, 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar. 20. 1921, to April 4th 1921, that I last saw him alive on 4/4 — 1921, and that death occurred on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

Pulmonary Abscess
following Spanish
influenza

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Spanish influenza

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. L. Sutton M. D.

4/5 1921 (Address) Boise, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Parma Idaho — DATE OF BURIAL: 4/6/21

20. UNDERTAKER: W M McPratney — ADDRESS: Boise Idaho

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33648
Registered No. 104

RECEIVED
MAY 7 19
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Ada Registration District No. 7
City of Boise (No.) 1302 Grove St.) Primary Registration District No. 1004
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Antonia Milinkovich
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Nov 25th 1919 (Month) (Day) (Year)

7. AGE: 1 Yrs. 4 Mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Boise Idaho

10. NAME OF FATHER: Mike Milinkovich

11. BIRTHPLACE OF FATHER (State or Country): Austria

12. MAIDEN NAME OF MOTHER: Ika Stilnovich

13. BIRTHPLACE OF MOTHER (State or Country): Austria

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) M. Milinkovich
(Address) Boise, Idaho

15. Filed April 6 1921 R H Pratt Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April 5th 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ~~March 30~~ 1921, to April 5 1921, that I last saw h..... alive on ..... 19....., and that death occurred on the date stated above, at 11 A.M.
The CAUSE OF DEATH* was as follows:
Pneumonia
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Oedema of lungs
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) I V N Stevenson M. D.
4/5/1921 (Address) 517 Empire B.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: St Johns Cem — DATE OF BURIAL: 4/6 1921

20. UNDERTAKER: Schreiber & Sidenfaden — ADDRESS: Boise

Dr. Stevenson

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33649
Registered No. 108

1. PLACE OF DEATH

County of Ada
City of Boise
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 7
Primary Registration District No. 1007
(No.) 710 E. Bannock St.)

RECEIVED
MAY 7 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME John D. Bloomfield

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: July (Month) 1 (Day) 1870 (Year)

7. AGE: 50 Yrs. 9 Mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Accountant
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ill.

10. NAME OF FATHER: T. S. Bloomfield

11. BIRTHPLACE OF FATHER (State or Country): Ill.

12. MAIDEN NAME OF MOTHER: Helgah Gounter

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Alice M. Bloomfield
(Address) 411-10th Nampa

15. Filed April 7 1921
R. H. Pratt
Local Registrar
Idaho

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr. (Month) 5 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 27 1920 19..., to Apr. 5 1921, that I last saw him alive on Apr. 4 1921, and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:
Cancer of Rectum

(Duration) ... Yrs. 6 mos. ... ds.

Contributory (Secondary) .....
(Duration) ... yrs. ... mos. ... ds.

(Signed) James L. Stewart M. D.
4/7 1921 (Address) Boise Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Nampa, Idaho. DATE OF BURIAL: Apr. 8 1921

20. UNDERTAKER: Timmons & Trebs ADDRESS: Boise Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

Springer

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33650

Registered No. 186

1. PLACE OF DEATH

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
MAY 7 1921
BUREAU OF VITAL STATISTICS

Registration District No. 2

Primary Registration District No. 1004

(No. 1221 St. Lukes Hospital St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Edna C. Dems

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Mar (Widowed)

6. DATE OF BIRTH: May 17 (Month) (Day) 79 (Year)

7. AGE: 41 Yrs. 10 Mos. 20 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Wisconsin

10. NAME OF FATHER: Ole Iverson

11. BIRTHPLACE OF FATHER (State or Country): Norway.

12. MAIDEN NAME OF MOTHER: Unknown.

13. BIRTHPLACE OF MOTHER (State or Country): Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) S. B. Luckey

(Address) Notus Ida.

15. Filed April 7 1921 — R. H. Mann, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April 7 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 28 1921, to April 7 1921, that I last saw h.. alive on April 7 1921 and that death occurred on the date stated above, at 9 A M.

The CAUSE OF DEATH* was as follows:

Dilation of stomach following operation

(Duration) ..... Yrs. ..... mos. 10 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. B. Springer M. D.

4/7 1921 (Address) Boise

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Parma Idaho — DATE OF BURIAL: Apr. 10 1921

20. UNDERTAKER: Summers & Krebs. — ADDRESS: Boise Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

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FORM V. S. No. 5-25 M. 1-19.

RECEIVED MAY 7 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 7

Primary Registration District No. 1004

File No. 33651

Registered No. 787

County of Ada

City of Boise (If outside limits, give township) St. Grove

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Maudel Cornelio

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Oct (Month) 9th (Day) 1918 (Year)

7. AGE: 2 Yrs. 5 Mos. 29 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Boise Ida

10. NAME OF FATHER: Alfred J. Cornelio

11. BIRTHPLACE OF FATHER (State or Country): Minn.

12. MAIDEN NAME OF MOTHER: Maud Maudel

13. BIRTHPLACE OF MOTHER (State or Country): Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Alfred Cornelio

(Address) R.R. F. Eagle #1

15. Filed April 8 1921 P. H. Pratt Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 8th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 6th 1921, to Apr 8th 1921, that I last saw him alive on April 8th 1921, and that death occurred on the date stated above, at 2.30 A.M.

The CAUSE OF DEATH* was as follows:

Acute inflation of throat and Larynx

(Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Taylor M. D.

Apr 8 1921 (Address) Boise, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence Ada Co. Idaho

19. PLACE OF BURIAL OR REMOVAL: St Johns Cemetery — DATE OF BURIAL ..... 19.....

20. UNDERTAKER: Schreiber & Sidenfaden — ADDRESS Boise

Taylor

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33652
Registered No. 107

RECEIVED
MAY 7 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
Registration District No. 7
Primary Registration District No. 1004
County of Ada
City of Boise (If outside limits, give township) No. 1111 Alphonsus St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ruth Riggs
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: June (Month) 10th (Day) 1898 (Year)

7. AGE: 22 Yrs. 9 Mos. 29 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: housekeeper
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Oregon

10. NAME OF FATHER: Joe George

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Mary Cooley

13. BIRTHPLACE OF MOTHER (State or Country): Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Mary George
(Address) Bowmont Idaho

15. Filed April 8 1921 P. H. Peate Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 7 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4/3 1921, to 4/7 1921
that I last saw her alive on 4/7 1921,
and that death occurred on the date stated above, at 10:30 P.M.
The CAUSE OF DEATH* was as follows:
Shock following
Caesarian Section
(Duration) ..... Yrs. ..... mos. 4 ds.
Contributory (Secondary) Marginal placenta
Acute hemorrhage
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Ray Folk M. D.
4/8 1921 (Address) Boise

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence Bowmont Idaho

19. PLACE OF BURIAL OR REMOVAL: St Johns Cemetery — DATE OF BURIAL: 4/9 1921

20. UNDERTAKER: Schreiber & Sidenfaden — ADDRESS

Dr. Folk.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33653
Registered No. 116

1. PLACE OF DEATH

Registration District No. V
Primary Registration District No. 1004
County of Ada
City of Boise (Bureau No. 1203, Euclid St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

FULL NAME Frances Tyler

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: June (Month) 6th (Day) 1918 (Year)

7. AGE: 2 Yrs. 10 Mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Boise, Idaho

10. NAME OF FATHER: C. C. Tyler

11. BIRTHPLACE OF FATHER (State or Country): Neb

12. MAIDEN NAME OF MOTHER: Cylethia Beckman

13. BIRTHPLACE OF MOTHER (State or Country): Minn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. H. Tyler
(Address) Boise

15. Filed April 7 1921 — R. H. Pratt, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 8th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4/6 1921, to 4/8 1921, that I last saw h.er alive on 4/8 1921, and that death occurred on the date stated above, at 7 A.M.

The CAUSE OF DEATH* was as follows:
Measles and teething was only ill 2 days no Physicians in attendance
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chester C Tyler M.D.
19..... (Address) Father

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence So Boise

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cem — DATE OF BURIAL: 4/11 1921

20. UNDERTAKER: Schreiber & Gideon — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33654

Registered No. 111

RECEIVED
MAY 7 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Ada — Registration District No. 7

City of Boise (No. 422 So 11th St.) — Primary Registration District No. 1004

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James Howard Ivers

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Dec (Month) 3 (Day) 1919 (Year)

7. AGE: 1 Yrs. 4 Mos. 6 ds. — IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Boise Idaho

10. NAME OF FATHER: Bert Ivers

11. BIRTHPLACE OF FATHER (State or Country): Kans

12. MAIDEN NAME OF MOTHER: Eva Lewis

13. BIRTHPLACE OF MOTHER (State or Country): Minn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. Ivers.
(Address)

15. Filed April 9 1921 — R. H. Pratt — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 9th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 9 1921 to April 9th 1921, that I last saw him alive on April 9th 1921, and that death occurred on the date stated above, at 4 A M.

The CAUSE OF DEATH* was as follows:
was known to me, at Lewis ran twins before - but presume it was due to Convulsions

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Lew Beck M. D.

4-9 1921 (Address) Boise Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Boise — DATE OF BURIAL: April 19 21

20. UNDERTAKER: Schreiber & Bidenfadin — ADDRESS: Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33655
Registered No. 112

1. PLACE OF DEATH

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

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MAY 7
BUREAU OF STATISTICS

Registration District No. 2
Primary Registration District No. 1004
(No. 712, State St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Hailey.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: American

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widower

6. DATE OF BIRTH: August (Month) 29th (Day) 1835 (Year)

7. AGE: 85 Yrs. 7 Mos. 12 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: State Historian
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Tennessee.

10. NAME OF FATHER: John Hailey.

11. BIRTHPLACE OF FATHER (State or Country): Virginia

12. MAIDEN NAME OF MOTHER: Nancy Baird

13. BIRTHPLACE OF MOTHER (State or Country): Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Geo. C. Hailey
(Address) 712 State St Boise Ida

15. Filed April 12 1921 — R. H. Coats, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 10 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4-7 1921, to 4-9 1921, that I last saw him alive on 4-9 1921, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Senility

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary): Prostatitis

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [signature] M. D.

4-11-1921 (Address) Boise Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Masonic Cemetery — DATE OF BURIAL: 4/12 1921

20. UNDERTAKER: Schreiber & Sidenfaden — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

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MAY 7 19[illegible]
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33656

Registered No. 113

1. PLACE OF DEATH

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2

Primary Registration District No. 1004

No. St. Alphonsus Hospital

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Gladys Audrey Dimock

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: June - 2 - 1907
(Month) (Day) (Year)

7. AGE: 13 Yrs. 10 Mos. 10 ds.

IF LESS than 1 day how many ____ hrs. or ____ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: In School
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wis.

10. NAME OF FATHER: A. L. Dimock

11. BIRTHPLACE OF FATHER (State or Country): Nova Scotia.

12. MAIDEN NAME OF MOTHER: Alma Johnson

13. BIRTHPLACE OF MOTHER (State or Country): Wis.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wm. McCloskey
(Address) Boise, Idaho.

15. Filed April 13 1921 R. H. Coate
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr. 12 - 1921
(Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4/12 1921, to 4/12 1921, that I last saw h[illegible] alive on 4/12/21 19[illegible], and that death occurred on the date stated above, at 8:30 M.

The CAUSE OF DEATH* was as follows:

Diabetic coma.

(Duration) Yrs. mos. 2 ds.

Contributory (Secondary) Diabetes mellitus

(Duration) About 2 yrs. mos. ds.

(Signed) [signature] M. D.

4/13/21 (Address) Boise, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 4/15 1921

20. UNDERTAKER: W. McCloskey — ADDRESS: Boise Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33657

Registered No. 114

RECEIVED
MAY 7 1921
BUREAU OF VITAL STATISTICS

Registration District No. 8

Primary Registration District No. [illegible]

1. PLACE OF DEATH

County of Ada

City of Boise (If outside limits of city or village, write the name of township.) 1010 E. Jamison (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Gladys Fay Compton

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Sept 25 1907 (Month) (Day) (Year)

7. AGE: 13 Yrs. 6 Mos. 19 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Student

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ida

10. NAME OF FATHER: Kenneth Compton

11. BIRTHPLACE OF FATHER (State or Country): Virginia

12. MAIDEN NAME OF MOTHER: Ida Fern Corder

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Kenneth Compton

(Address) Boise Idaho

15. Filed April 15 1921 R. H. Pratt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr 15 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 13 1921, to Apr 14 1921, that I last saw h[illegible] alive on Apr 13 1921, and that death occurred on the date stated above, at 1 P. M.

The CAUSE OF DEATH* was as follows:

Cerebral Septicaemia

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary): Abscess of face

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) James L Clawson M. D.

19 ..... (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Apr 15 1921

20. UNDERTAKER: Summers & Trebo — ADDRESS: Boise Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

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FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

RECEIVED
MAY 7 1921
BUREAU OF VITAL STATISTICS

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33658
Registered No. 1115

1. PLACE OF DEATH
County of Ada — Registration District No. 3
City of Boise — Primary Registration District No. 1007
(No. 1812 No. 10 St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Naomi C. Wells

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: ~~Single~~ Widow (Write this word.)

6. DATE OF BIRTH: Dec 3 1 (Month) (Day) (Year)

7. AGE: 9 Yrs. 4 Mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: Wm W. Wells.

11. BIRTHPLACE OF FATHER (State or Country): Illinois

12. MAIDEN NAME OF MOTHER: Naomi C. Carter.

13. BIRTHPLACE OF MOTHER (State or Country): Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W W Wells
(Address) 1812 N. 10 St Boise Ida

15. Filed April 18 1921 — R. H. Cook — Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr 16 19 21 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 15 1921, to April 16 1921, that I last saw h[illegible] alive on April 16 1921 and that death occurred on the date stated above, at 6 A M.
The CAUSE OF DEATH* was as follows:
Endocarditis,

(Duration) 3 Yrs. mos. ds.
Contributory (Secondary) Articular Rheumatism
(Duration) yrs. 1 mos. 7 ds.

(Signed) C D Anderson M. D.
Apr 18 1921 (Address) 319 Idaho Bldg Boise

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Apr 19 1921

20. UNDERTAKER: Summers & Cobb — ADDRESS: Boise Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33659

Registered No. 116

1. PLACE OF DEATH

County of Ada

City of Boise (No. 410, State St.)

If death occurs away from usual residence, give facts called for under special information.

REC'D MAY BUREAU STATE

Registration District No. 7

Primary Registration District No. 1004

2. FULL NAME M. E. Duncan Jr. 2.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: April 18 (Month) (Day) 1921 (Year)

7. AGE: — Yrs. — Mos. — ds.

IF LESS than 1 day how many 2 hrs. or — min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Boise, Idaho

10. NAME OF FATHER: M. E. Duncan Jr.

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Grace V. McInnis

13. BIRTHPLACE OF MOTHER (State or Country): California

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mattie E. Duncan

(Address) Boise

15. Filed April 9 1921 — P. H. Cradle, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April 18 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 18 1921, to Apr 18 1921, that I last saw h[illegible] alive on Apr 18 1921, and that death occurred on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:

Premature birth at 5 months

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) M. H. Tallman M. D.

7/19 1921 (Address) Boise, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 4/19 1921

20. UNDERTAKER: Schreiber & Siddenfaden — ADDRESS: Boise, Ida.

Tallman

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 3660

Registered No. 117

1. PLACE OF DEATH

County of Ada

Registration District No. 7

Primary Registration District No. 704

City of Boise. (If not in incorporated limits, give township.) No. 1508 No 15 St.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED MAY 7 1921 BUREAU OF VITAL STATISTICS

2. FULL NAME Elisada R. Cole.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widow (write the word.)

6. DATE OF BIRTH: Nov 9 (Month) (Day) 1831 (Year)

7. AGE: 89 Yrs. 5 Mos. 14 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Carpenter.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mass.

10. NAME OF FATHER: Sedgwick W. Cole.

11. BIRTHPLACE OF FATHER (State or Country): Mass.

12. MAIDEN NAME OF MOTHER: Lorinda Brown.

13. BIRTHPLACE OF MOTHER (State or Country): Mass.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J B Cole
(Address)

15. Filed Apr 25 1921 — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr. 23 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 20 1921, to Apr. 23 1921, that I last saw h.m. alive on Apr. 23 1921, and that death occurred on the date stated above, at 6:45 P.M.

The CAUSE OF DEATH* was as follows:

Senile Gangrene. Lungs

(Duration) Yrs. mos. 3 ds.

Contributory (Secondary): Old age.. Embolism

(Duration) yrs. mos. ds.

(Signed) O H Parker M. D.

19 (Address) Boise, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Morris Hill Cem.	Apr 25 1921
20. UNDERTAKER	ADDRESS
Summers & Webb.	Boise Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED MAY 7 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 1004
File No. 33661
Registered No. 121

1. PLACE OF DEATH
County of Ada
City of Boise
(No. 410 State St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Elizabeth Ward
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: March 5 1855 (Month) (Day) (Year)

7. AGE: 66 Yrs. ... Mos. ... ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Pa

10. NAME OF FATHER: Mr Sloan

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Not obtainable

13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs E Vincent
(Address)

15. Filed April 28 1921 — D P Hughes, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 27 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4-26 1921, to 4-27 1921, that I last saw her alive on 4-27 1921, and that death occurred on the date stated above, at 9:30 P.M.

The CAUSE OF DEATH* was as follows:
Operation for Pain stones + Adhesions of bowels

(Duration) ... Yrs. ... mos. 2 ds.
Contributory (Secondary) Pain stones
(Duration) 2 yrs. ... mos. ... ds.

(Signed) D P Hughes M. D.
4-27-1921 (Address) 1677 Warm St

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
St Johns Cemetery	4/28 1921
20. UNDERTAKER: Schreiber & Siebenfaden	ADDRESS: Boise

Weeks

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

Springer

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33662
Registered No. 122

1. PLACE OF DEATH

Registration District No. 2
Primary Registration District No. 1004

County of Ada RECEIVED
City of Boise MAY 7 1921 No. St. Lukes Hospital (St.)

If death occurs away from usual residence, give facts called for under special information.

BUREAU OF VITAL STATISTICS

2. FULL NAME Mariella Danskin.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Apr 27 (Month) (Day) 1893 (Year)

7. AGE: — Yrs. — Mos. 1 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: John M. Danskin.

11. BIRTHPLACE OF FATHER (State or Country): Idaho.

12. MAIDEN NAME OF MOTHER: Edna Millard

13. BIRTHPLACE OF MOTHER (State or Country): Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John M. Danskin
(Address) 506 Washington

15. Filed April 29 1921 C. H. Isaac Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr. (Month) 28 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 27 1921, to April 28 1921, that I last saw h.. alive on Apr 28 1921, and that death occurred on the date stated above, at 11 P M.

The CAUSE OF DEATH* was as follows:
Cerebral injury due to Forceps delivery.

(Duration) ..... Yrs. ..... mos. 1 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. O. Springer M. D.
4-29 1921 (Address) Boise - Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Masonic Cemetery — DATE OF BURIAL: Apr 29 1921

20. UNDERTAKER: Summers & Kerb. — ADDRESS: Boise Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33663

Registered No. 1-3

1. PLACE OF DEATH

County of Ada

City of Boise (No. 112 E. Bannock St.)

Registration District No. 7

Primary Registration District No. 1001

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mr. Oscar Ruhl

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Feb (Month) 2nd (Day) 1864 (Year)

7. AGE: 57 Yrs. 2 Mos. 27 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Hotel Clerk Capitol
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kansas

10. NAME OF FATHER: John Ruhl

11. BIRTHPLACE OF FATHER (State or Country): Penn

12. MAIDEN NAME OF MOTHER: Anna Ruhl.

13. BIRTHPLACE OF MOTHER (State or Country): Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Lillian Standish
(Address) Boise Idaho

15.
Filed Apr 30 1921 I. T. Pratt
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April 29th (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 28 1921, to Apr 29 1921, that I last saw him alive on Apr 29 1921, and that death occurred on the date stated above, at 12:40 PM.

The CAUSE OF DEATH* was as follows:

Pneumonia.

(Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary) Toxaemia

(Duration) ..... yrs. ..... mos. 2 ds.

(Signed) F. N. Brayton M. D.

Apr 29 1921 (Address) Boise, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the St. Lukes Hospital State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence Boise Idaho.

19. PLACE OF BURIAL OR REMOVAL: Highland. Kas — DATE OF BURIAL: 4/30 1921

20. UNDERTAKER: Schreiber & Siedenfaden — ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33664

Registered No. 32

Registration District No. 8

Primary Registration District No. 27

1. PLACE OF DEATH

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

(No. 1 mile North Cole School St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Marjorie Ruth Bowman

RECEIVED MAY BUREAU STA

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Mch. 28 — 1908
(Month) (Day) (Year)

7. AGE: 13 Yrs. — 6 Mos. ds.

IF LESS than 1 day how ~~many~~ hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: In Schools.

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Earl Wayland Bowman

11. BIRTHPLACE OF FATHER (State or Country): Mo

12. MAIDEN NAME OF MOTHER: Elva Moss.

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. M. Britney

(Address) Boise Idaho

15. Filed April 5 1921 R. H. Pratt Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr. 4 — 1921
(Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 14 1921, to Apr 4 1921, that I last saw her alive on Apr 4 1921, and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows: Typhoid Fever

(Duration) Yrs. mos. 21 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) A. E. Lind Chiropractor M. D.

4/5/21 (Address) Boise Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 4/6/21

20. UNDERTAKER: W. M. Britney — ADDRESS: Boise Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33665

Registered No. 33

RECEIVED
MAY 7
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No.

Primary Registration District No.

County of Ada

City of Boise (No. Soldiers Home St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Finnegan

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widower

6. DATE OF BIRTH: (Month) (Day) 1848 (Year)

7. AGE: 73 Yrs. 8 Mos. 0 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Veteran Civil War.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Unknown

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Clyde E. Summers
(Address) Boise Idaho

15. Filed April 18 1921 R. H. Coats Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 15 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4/1 1921, to 4/15 1921
that I last saw him alive on 4/15 1921
and that death occurred on the date stated above, at 7 P M.
The CAUSE OF DEATH* was as follows:

Uremia

(Duration) Yrs. mos. ds.
Contributory (Secondary) Hyp. for Prostatic Hypertrophy
(Duration) 1 yrs. mos. ds.

(Signed) H. Pettengill M. D.
4/18 1921 (Address) Boise Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Apr. 17 1921

20. UNDERTAKER: Summers & Kreta — ADDRESS: Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33666

Registered No. 34

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

1. PLACE OF DEATH. Registration District No. 8

County of Ada Primary Registration District No. 2004

City of Boise (No. 40 Boise St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Marie Johnson

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Apr 4 1917 (Month) (Day) (Year)

7. AGE: 4 yrs. — mos. 17 ds. IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: James M. Johnson

11. BIRTHPLACE OF FATHER (State or Country): Penna.

12. MAIDEN NAME OF MOTHER: Anna Marie.

13. BIRTHPLACE OF MOTHER (State or Country): Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Anna M. Johnson
(Address) .....

15. Filed April 2 1921 D. H. Pratt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr 20 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 20 191 , at 11 P.M. to 191
that I last saw her alive on Apr 20 191 ,
and that death occurred on the date stated above, at 11.30 P. M.

The CAUSE OF DEATH* was as follows:
Rachitis from birth
(Duration) yrs. mos. ds.
Contributory (Secondary) Eclampsia, infantile
(Duration) yrs. mos. 1 ds.

(Signed) H. M. Halverson M. D.
Apr 21 1921 (Address) Boise Idaho

State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cem. DATE OF BURIAL: Apr 23 1921

20. UNDERTAKER: Summers & Kebs. ADDRESS: Boise Idaho

SYMS-YORK CO. PRINTERS & BINDERS, BOISE 16672

FORM V. S. No. 5-25 M. 1-19.

RECEIVED MAY 7 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33667

Registered No. 30

1. PLACE OF DEATH

County of Ada — Registration District No. 8

City of Boise — Primary Registration District No. 2007

(If outside limits, give township.) — (No. Barber St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Rosa Palmatier

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Feb (Month) 21st (Day) 1902 (Year)

7. AGE: 19 Yrs. 2 Mos. 1 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Oklahoma

10. NAME OF FATHER: Curt Smiley

11. BIRTHPLACE OF FATHER (State or Country): Ky

12. MAIDEN NAME OF MOTHER: Daisy Bridges

13. BIRTHPLACE OF MOTHER (State or Country): Okla

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Edmund E. Palmatier

(Address) Barber Idaho.

15. Filed April 25 1921 — O. H. Parker, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 23 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 11 1921, to April 22 1921, that I last saw h.. alive on April 21 1921, and that death occurred on the date stated above, at 11.. M.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(Duration) ..... Yrs. ..... mos. 11 ds.

Contributory (Secondary) Pneumonia, Chill Bath

(Duration) ..... yrs. ..... mos. 11 ds.

(Signed) O. H. Parker M. D.

4/23 1921 (Address) Boise, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Riverdale, Cal. — DATE OF BURIAL: 4/25 1921

20. UNDERTAKER: Schreiber & Siedenfaden — ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED MAY 7 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33668
Registered No. 36

1. PLACE OF DEATH
County of Ada — Registration District No. 8
City of — Registration District No. 2.007
(If outside limits of city or village, give township) 3 miles North of Boise (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Issac C. Pinegar

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	White	Widower

6. DATE OF BIRTH: Feb (Month) 21 (Day) 1865 (Year)

7. AGE: 56 Yrs. 2 Mos. 6 ds. — IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Montana

10. NAME OF FATHER: William Pinegar

11. BIRTHPLACE OF FATHER (State or Country): Penn

12. MAIDEN NAME OF MOTHER: Sarah Wade

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Alice Beaumont
(Address) 207 Myrtle St. Boise Idaho,

15. Filed April 29 1921 — [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 27 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I saw deceased ~~attended~~ ~~from~~ April 28 1921, to ..... 19....., that I last saw him alive on and April 28 1921, and that death occurred on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:
Valvular heart disease

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Clyde E. Summers Coroner M. D.
4/29 1921 (Address) Boise, Idaho Ada County

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Morris Hill Cemetery	May 1 1921
20. UNDERTAKER	**ADDRESS**
Summers & Trebe	Boise Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33670
Registered No.

RECEIVED
APR 16 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 9

County of Ada

Primary Registration District No.

City of Boise (No. ward, etc.) Idaho (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Albert Edward Gould.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married. (Write the word.)

6. DATE OF BIRTH: July 16 1879 (Month) (Day) (Year)

7. AGE: 41 Yrs. 7 Mos. 18 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: Francis Marion Gould

11. BIRTHPLACE OF FATHER (State or Country): Indiana.

12. MAIDEN NAME OF MOTHER: Mary Frances Closson

13. BIRTHPLACE OF MOTHER (State or Country): Wis.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wm McC Bratney
(Address) Boise Idaho.

15. Filed Mch 15 1921 Frederic L Lewis Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mch 14, 1921 (Month) (Day) (Year)
Jan

17. I HEREBY CERTIFY, That I attended deceased from Jan 29 1921, to Mar 13 1921 that I last saw h[illegible] alive on Jan 29 1921, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Pulmonary T.B.

(Duration) Two Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H W Mahoney M. D.

19 ..... (Address) 517 Empire B. Boise

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 3/16 1921

20. UNDERTAKER: Wm McC Bratney — ADDRESS: Boise Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33671

Registered No.

1. PLACE OF DEATH

County of Bannock

City of Chesterfield (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

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BUREAU OF VITAL STATISTICS

Registration District No. 84

Primary Registration District No. 2161

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Baby Perkins

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: single (Write the word.)

6. DATE OF BIRTH: April 21 (Month) (Day) 1921 (Year)

7. AGE: ...Yrs. ...Mos. 2 ds.

IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Chesterfield, Idaho

10. NAME OF FATHER: J.W. Perkins

11. BIRTHPLACE OF FATHER (State or Country): Logan, Utah

12. MAIDEN NAME OF MOTHER: Ray Still

13. BIRTHPLACE OF MOTHER (State or Country): Chesterfield

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Father

(Address)

15. Filed 5-1-21 19...

Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April 23 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ...19..., to ...19..., that I last saw her alive on 4-21-21 19..., and that death occurred on the date stated above, at ...M.

The CAUSE OF DEATH* was as follows:

congenital adelectasis

...(Duration) ...Yrs. ...mos. ...ds.

Contributory (Secondary) premature birth

...(Duration) ...yrs. ...mos. ...ds.

(Signed) ... M. D.

4-23 1921 (Address) Bancroft

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ...yrs. ...mos. ...days. In the State ...yrs. ...mos. ...days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL ...19...

20. UNDERTAKER | ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
MAY 10 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 84

County of Bannock

Primary Registration District No. 2161

File No. 33672

City of Hatch (St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Baby Chritiensen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: single (Write the word.)

6. DATE OF BIRTH: April 21 (Month) (Day) 1921 (Year)

7. AGE: ....Yrs. ....Mos. 1 ds.

IF LESS than 1 day how many....hrs. or....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work....

(b) General nature of industry, business or establishment in which employed (or employer)....

9. BIRTHPLACE (State or Country): Hatch Idaho

10. NAME OF FATHER: Alex McGee Christirnsen

11. BIRTHPLACE OF FATHER (State or Country): Thatcher, Idaho

12. MAIDEN NAME OF MOTHER: Diana Hogan

13. BIRTHPLACE OF MOTHER (State or Country): Hatch, Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Father

(Address)....

15. Filed 4-31 19 21

Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April 21 (Month) 1921 (Day) 19 W (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 21 19 21 to ....19....

that I last saw h.er alive on April 21 19 21,

and that death occurred on the date stated above, at 8 P M.

The CAUSE OF DEATH* was as follows:

Failure of clsure of the foramen ovalae

....(Duration) ....Yrs. ....mos. ....ds.

Contributory (Secondary) premature birth

....(Duration) ....yrs. ....mos. ....ds.

(Signed) [signature] M. D.

4-21 19 21 (Address) Bancroft

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death....yrs....mos....days. In the State....yrs....mos....days

Where was disease contracted if not at place of death?....

Former or usual residence....

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL ....19....

20. UNDERTAKER | ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 28
Primary Registration District No. 24
File No. 33673
Registered No. 3547

1. PLACE OF DEATH
County of Bannock
City of POCATELLO. IDAHO
If death occurs away from usual residence, give facts called for under special information.

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BUREAU OF VITAL STATISTICS

Bannock Hotel (St.)
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Frederick R Reed

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	white	Married

6. DATE OF BIRTH: Aug. 6 1858 (Month) (Day) (Year)

7. AGE: 62 Yrs. 7 Mos. 17 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Secretary Idaho
(b) General nature of industry, business or establishment in which employed (or employer): Reclamation association

9. BIRTHPLACE (State or Country): New Jersey

10. NAME OF FATHER: Reed

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Mary Remington

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ethelyn Glasser
(Address) 836 E. Center st.

15. Filed May 24 1921 J. M. Young Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 22 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows: PM Finding
Fatty degeneration & infiltration of heart. Chr. nephritis

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. C. Dunn M. D.
3/23 1924 (Address) Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 3 yrs. ..... mos. ..... days. In the State 40 yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence Boise Idaho

19. PLACE OF BURIAL OR REMOVAL: Boise, Idaho
DATE OF BURIAL: May 24 1921

20. UNDERTAKER: H. L. McHAN
ADDRESS: POCATELLO, IDAHO

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-12 M. 6-15-17.

RECEIVED
MAY 5 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33674
Registered No. 353

1. PLACE OF DEATH
County of Bannock Registration District No. 28
City of Pocatello Registration District No. 71.61
If death occurs away from usual residence, give facts called for under special information. (Ward) 525 So 9th ave St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ralph W Ellis

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	white	Single

6. DATE OF BIRTH. February 15 1921
(Month) (Day) (Year)

7. AGE
— Yrs. 1 Mos. 14 ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Pocatello Idaho

10. NAME OF FATHER Joseph C. Ellis

11. BIRTHPLACE OF FATHER (State or Country) Virginia

12. MAIDEN NAME OF MOTHER Elsie Riddle

13. BIRTHPLACE OF MOTHER (State or Country) Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Joseph C. Ellis
(Address) 525 So 9th ave

15.
Filed Apr 22 1921 J. H. Young Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 2 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 7th 1921 to Apr 2nd 1921
that I last saw him alive on Apr 2nd 1921
and that death occurred on the date stated above, at 3 a. M.

The CAUSE OF DEATH* was as follows:
mucous colitis
(Duration) Yrs. mos. 6 ds.
Contributory (Secondary) convulsions 24 hours
(Duration) Yrs. mos. ds.
(Signed) Arthur M. D.
Apr 2nd 1921 (Address) Pocatello Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ...yrs. ...mos. ...days, In the State ...yrs. ...mos. ...days
at Lyric Room. Hosp. 1 day.
Where was disease contracted if not at place of death? Here
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Roberts Idaho — DATE OF BURIAL Apr 4 1921

20. UNDERTAKER MC How Undertaking — ADDRESS Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 393675
Registered No. 3554

1. PLACE OF DEATH
County of Bannock
City of Pocatello
If death occurs away from usual residence, give facts called for under special information.

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BUREAU OF VITAL STATISTICS

Registration District No. 28
Primary Registration District No. 1161
(No. 721 So. 4th ave St.)

2. FULL NAME Mary Elizabeth Starr

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow
6. DATE OF BIRTH. April (Month) 27. (Day) 1850 (Year)
7. AGE: 70 Yrs. 11 Mos. 6 ds. IF LESS than 1 day how many .... hrs. or .....min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: House keeper
(b) General nature of industry, business, or establishment in which employed (or employer) .....
9. BIRTHPLACE (State or Country): Indeanna
10. NAME OF FATHER: Jacob Hopkins
11. BIRTHPLACE OF FATHER (State or Country): Kentucky
12. MAIDEN NAME OF MOTHER: Elizabeth Scott
13. BIRTHPLACE OF MOTHER (State or Country): Kentucky
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Maudy Dayton
(Address) 721 So. 4th ave Poca.
15. Filed April 4 1921 J. H. Young Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 3 (Day) 1921 (Year)
17. I HEREBY CERTIFY, That I attended deceased from March 2 1921 to April 3 1921
that I last saw h er alive on April 1 1921
and that death occurred on the date stated above, at 7.45 A. M.
The CAUSE OF DEATH* was as follows:
Decompensation of heart
.....
.....
(Duration) ..... Yrs. 1 mos. 2 ds.
Contributory (Secondary) Hypertensional tension
(Duration) 3 Yrs. ..... mos. ..... ds.
(Signed) A. M. Newton M. D.
April 1924 (Address) Pocatello, Ida.
*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 15 yrs. 6 mos. .... days. In the State .... yrs. .... mos. .... days
Where was disease contracted if not at place of death? .....
Former or usual residence Indeanna

19. PLACE OF BURIAL OR REMOVAL: Mt View Pocatello — DATE OF BURIAL: Apr 6. 1921
20. UNDERTAKER: McFaw undertaking Co — ADDRESS: Pocatello.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-12 M. 6-15-17.

RECEIVED
MAY 9 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 28

Registrar's Sub-District No. 21-61

(No. [illegible] National Ave. St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5606
Registered No. 3556

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Bannock
City of Pocatello
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Allie Sherwood

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Married

6. DATE OF BIRTH: July (Month) 30 (Day) 1888 (Year)

7. AGE: 32 Yrs. 8 Mos. 4 ds.
IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) House Keeper

9. BIRTHPLACE
(State or Country) Colorado

10. NAME OF FATHER Addison Sherwood

11. BIRTHPLACE OF FATHER
(State or Country) Iowa

12. MAIDEN NAME OF MOTHER Elizabeth Chambers

13. BIRTHPLACE OF MOTHER
(State or Country) Nebraska

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Roe Spencer Perkins
(Address) Fort Hall Idaho

15. Filed 4/4 1921

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 3, (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 3rd 1921 to Apr. 3rd 1921 that I last saw her alive on Apr 3rd 1921 and that death occurred on the date stated above, at 7.30 P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia & Stomach

(Duration) .... Yrs. .... mos. .... ds.

Contributory (Secondary) .....

(Duration) .... Yrs. .... mos. .... ds.

(Signed) W. Guy Bowen M. D.

Apr. 4 1921 (Address) Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs....mos....days. In the State....yrs....mos....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mt View Cemetery — DATE OF BURIAL: Apr. 8 1921

20. UNDERTAKER: J. McTavish Und. Co. — ADDRESS: Pocatello

FORM V. S. No. 5-12 M. 6-15-17.

RECEIVED
MAY 5 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 38677
Registered No. 3550

1. PLACE OF DEATH
County of Bannock
City of Pocatello
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 28
Primary Registration District No. 2141
(No. 525 So. 5th ave. St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Isaac Wood Nomey

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. Sept. (Month) 11th (Day) 1850 (Year)

7. AGE: 70 Yrs. 7 Mos. 3 ds.
If LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer and Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Missouria

10. NAME OF FATHER: James Nomey.

11. BIRTHPLACE OF FATHER (State or Country): Indiana

12. MAIDEN NAME OF MOTHER: Ellen Hayden

13. BIRTHPLACE OF MOTHER (State or Country): Ind.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Nancy Anne Nomey
(Address) 525 So. 5th ave.

15. Filed 4/5 1921 — J. H. Young, Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 3 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mch 30 1921 to April 3 1921
that I last saw him alive on April 3 1921
and that death occurred on the date stated above, at 4:30 P. M.

The CAUSE OF DEATH* was as follows:
Acute Uremia
of Chronic Interstitial Nephritis
(Duration) — Yrs. — mos. 4 ds.

Contributory (Secondary): Mitral Insufficiency
(Duration) Several Yrs. — mos. — ds.

(Signed) W. F. Howard M. D.
4/4 1921 (Address) Pocatello, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs. 1 mos. ....days, In the State....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence: Buhl Idaho.

19. PLACE OF BURIAL OR REMOVAL: Mt View Cem — DATE OF BURIAL: Apr 5 1921

20. UNDERTAKER: H. L. McClain — ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-12 M. 6-15-17.

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MAY [illegible] 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 99678
Registered No. 3559
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Bannock Registration District No. 28
City of Pocatello Primary Registration District No. 7161
If death occurs away from usual residence, give facts called for under special information.
(No. 448 E. Hayden St.)

2. FULL NAME Mersede Morales

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: Mexican
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. February 20 1921
(Month) (Day) (Year)

7. AGE: Yrs. 1 Mos. 17 ds.
IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Pocatello Ida.

10. NAME OF FATHER: Mersed Morales

11. BIRTHPLACE OF FATHER (State or Country): Mexico

12. MAIDEN NAME OF MOTHER: Juana Herrera

13. BIRTHPLACE OF MOTHER (State or Country): Mexico

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Mersed Morales
(Address) 448 E. Hayden

15. Filed Apr 7, 1921 [illegible] Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April 6 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191.... to ..... 191...
that I last saw h.....alive on ..... 191....
and that death occurred on the date stated above, at .....M.

The CAUSE OF DEATH* was as follows:

Acute Pneumonia

.....(Duration) ..... Yrs..... mos. ..... ds.

Contributory (Secondary)

.....(Duration) ..... Yrs..... mos. ..... ds.

(Signed) L. B. Ferguson M. D.
4-7-1921 (Address) Pratt Blk

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mt View Cem. | DATE OF BURIAL: Apr 7 1921

20. UNDERTAKER: H. L. McHan | ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
MAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-12 M. 6-15-17.

RECEIVED
MAY 9 - 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 39079
Registered No. 3558

Registration District No. 28
Primary Registration District No. 2141

1. PLACE OF DEATH
County of Bannock
City of POCATELLO. IDAHO.
If death occurs away from usual residence, give facts called for under special information.
(No. 318 So. 2nd Ave. St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Laura Smith

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): Widow
6. DATE OF BIRTH. January 2 1843 (Month) (Day) (Year)
7. AGE: 78 Yrs. 3 Mos. 8 ds. IF LESS than 1 day how many .... hrs. or .... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: House Keeper
(b) General nature of industry, business, or establishment in which employed (or employer) ....
9. BIRTHPLACE (State or Country): Canada
10. NAME OF FATHER: Ralph Ford
11. BIRTHPLACE OF FATHER (State or Country): Scotland
12. MAIDEN NAME OF MOTHER: Lucy Baldwin
13. BIRTHPLACE OF MOTHER (State or Country): Scotland
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Lena Hicks
(Address) POCATELLO. IDAHO
15. Filed April 11 1921. J. H. Young Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
POCATELLO. IDAHO April 11 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 2 1921 to April 9 1921
that I last saw h[illegible] alive on April 9 1921.
and that death occurred on the date stated above, at 5:45 P. M.

The CAUSE OF DEATH* was as follows:
Pneumonia, Flu
and Stricken
(Duration) .... Yrs. .... mos. .... ds.
Contributory (Secondary) ....
(Duration) .... Yrs. .... mos. .... ds.
(Signed) [illegible] M. D.
April 11 1921. (Address) POCATELLO. IDAHO

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 10 yrs. .... mos. .... days. In the State. 10 yrs. .... mos. .... days
Where was disease contracted if not at place of death? ....
Former or usual residence Pleasanton Kansas

19. PLACE OF BURIAL OR REMOVAL: Pleasanton, Kansas — DATE OF BURIAL: Apr 15 1921
20. UNDERTAKER: H. L. McHan — ADDRESS: POCATELLO. IDAHO

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
MAY 5 - 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 28
Primary Registration District No. 2141
(No. St Anthonys Hospl)

File No. 35680
Registered No. 3559

1. PLACE OF DEATH

County of Bannock
City of Pocatello

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Masuko Ando.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	Japanese	Single

6. DATE OF BIRTH: Dec (Month) 25 (Day) 1915 (Year)

7. AGE: 5 Yrs. 2 Mos. 19 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Helper Utah

10. NAME OF FATHER: J. K. Ando.

11. BIRTHPLACE OF FATHER (State or Country): Japan

12. MAIDEN NAME OF MOTHER: Not Known

13. BIRTHPLACE OF MOTHER (State or Country): Japan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Masa Ando.
(Address) 132 So. 1st ave. Pocatello

15.
Filed Apr 14 1921
E. [illegible]
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 13 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 12 1921, to April 13 1921, that I last saw h.er alive on April 13 1921, and that death occurred on the date stated above, at 5-15 a. M.

The CAUSE OF DEATH* was as follows:
Bronchial Pneumonia Bacillus Botulinus

(Duration) ..... Yrs. ..... mos. 3 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A. M. Newton M. D.
Apr 14 1921 (Address) Pocatello Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 5 yrs. ..... mos. ..... days. In the State 5 yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence Helper Utah

19. PLACE OF BURIAL OR REMOVAL: Mt View Cem Pocatello | DATE OF BURIAL: Apr 16 1921

20. UNDERTAKER: H. L. McHan | ADDRESS: Pocatello Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
MAY 6 1921
BUREAU OF STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 28

Idaho Registration District No. 2141

File No. 33681

County of Bannock

City of Pocatello (No.) 1st Ave. N Bros Hosp

Registered No. 3560

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME J. K. Ando.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Male	Japanese	Married

6. DATE OF BIRTH

Not Known
(Month) (Day) (Year)

7. AGE

41 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Proprietor Pool

(b) General nature of industry, business or establishment in which employed (or employer) Pocatello Hall, So 1st Ave Pda

9. BIRTHPLACE (State or Country) Japan

10. NAME OF FATHER K. Ando

11. BIRTHPLACE OF FATHER (State or Country) Japan

12. MAIDEN NAME OF MOTHER Not Known

13. BIRTHPLACE OF MOTHER (State or Country) Japan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Masea Ando.

(Address) 122 So. 1st Ave. Pocatello, Ida

15. Filed April 16 1921 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 12 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 10 1921, to April 12 1921, that I last saw h[illegible] alive on April 12 1921, and that death occurred on the date stated above, at 4.30 P. M.

The CAUSE OF DEATH* was as follows:

Lung Pneumonia

(Duration) Yrs. mos. 6 ds.

Contributory (Secondary) None

(Duration) yrs. mos. ds.

(Signed) J. W. Lyons M. D.

April 16 1921 (Address) Pocatello Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 5 yrs. mos. days. In the State 5 yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence Helper Utah

19. PLACE OF BURIAL OR REMOVAL: Mt View Cem. Pocatello | DATE OF BURIAL: Apr 16 1921

20. UNDERTAKER: H. L. McClaran. | ADDRESS: Pocatello Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

RECEIVED
MAY 5 - 1921
BUREAU OF VITAL STATISTICS

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 28
Primary Registration District No. 2161
File No. 393682
Registered No. 351

1. PLACE OF DEATH
County of Bannock
City of Pocatello (No. if in a city) 406 West Carson St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Laura Hackworth
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): married

6. DATE OF BIRTH: Dec 22 1874 (Month) (Day) (Year)

7. AGE: 46 Yrs. 3 Mos. 18 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: Wm. Wilson

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Street

13. BIRTHPLACE OF MOTHER (State or Country): Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) George Hackworth
(Address) 406 West Carson St

15. Filed April 16 1921 [signature] Deputy Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April 15 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 17 - 1919, to April 15 1921, that I last saw her alive on April 13 1921, and that death occurred on the date stated above, at 2 10 P. M.
The CAUSE OF DEATH* was as follows:
Tuberculosis of Lungs
(Duration) 4 Yrs. — mos. — ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) [signature] M. D.
April 16 1921 (Address) Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 9 yrs. ..... mos. ..... days. In the State 9 yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence: Missouri

19. PLACE OF BURIAL OR REMOVAL: Mt View Cem. DATE OF BURIAL: Apr 17 1921

20. UNDERTAKER: H. L. McHan ADDRESS: Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
Item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH thus, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33683

Registered No. 3562

1. PLACE OF DEATH

County of Lemhi — Registration District No. 28

City of Salmon — Primary Registration District No. [illegible] (St.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED MAY [illegible] BUREAU OF VITAL STATISTICS

2. FULL NAME Thomas [illegible] Dillard

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: American

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: July 15 (Month) (Day) 1856 (Year)

7. AGE: 64 Yrs. 9 Mos. 7 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Stock-Live Stock
(b) General nature of industry, business or establishment in which employed (or employer): Government Employ.

9. BIRTHPLACE (State or Country): Placerville Ida.

10. NAME OF FATHER: Godfrey LeDieu D.

11. BIRTHPLACE OF FATHER (State or Country): New Madrid Mo

12. MAIDEN NAME OF MOTHER: Elizabeth Marshall

13. BIRTHPLACE OF MOTHER (State or Country): Middleville Tenn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. H. Elmer.
(Address) Fort Hall

15. Filed 4/20 1921 — J. P. Young, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 19 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 3 1921 to April 19 1921
that I last saw h[illegible] alive on April 19th 1921
and that death occurred on the date stated above, at 12 M.
The CAUSE OF DEATH* was as follows:
Cancer Stomach

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Intestinal obstruction
(Duration) — yrs. — mos. 2 ds.

(Signed) Hamner C Davis M. D.
4/4 1921 (Address) Pocatello Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. 3 days. In the State 24 yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? Like
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Fort Hall	4/21 1921
20. UNDERTAKER	ADDRESS
[illegible] Tucker	Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 38684
Registered No. 3563

RECEIVED
MAY 5 1921
BUREAU OF VITAL STATISTICS

Registration District No. 28
Primary Registration District No. 7161

1. PLACE OF DEATH
County of Bannock
City of Pocatello (No. McCammon Ida St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Joseph A Green.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male X
4. COLOR OR RACE: White X
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single X (Write the word.)

6. DATE OF BIRTH: December 17th 1919 (Month) (Day) (Year)

7. AGE: 1 Yrs. 4 Mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: X None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): X Idaho

10. NAME OF FATHER: Joseph A. Green

11. BIRTHPLACE OF FATHER (State or Country): Woodruff, Ida,

12. MAIDEN NAME OF MOTHER: Edna Evans

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Joseph A Green
(Address) McCammon Ida.

15. Filed April 22 1921 J P Young Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April 20 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 13 1921 to April 20 1921 that I last saw h[illegible] alive on April 20 1921, and that death occurred on the date stated above, at 4 P. M.
The CAUSE OF DEATH* was as follows:
Broncho-Pneumonia

(Duration) ..... Yrs. ..... mos. 7 ds.
Contributory (Secondary) Measles and Whooping Cough
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J Nelson Jones M. D.
4/21 1921 (Address) McCammon Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: McCammon Ida. DATE OF BURIAL: April 22 1921

20. UNDERTAKER: McHan Undertaking ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
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FORM V. S. No. 5-A--25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 28

County of Bannock

Registration District No. 2161

File No. 42685

City of Pocatello (Or Precinct Magdalena South of Calif.)

Registered No. 3564

If death occurs away from usual residence, give facts called for under special information.

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MAY 4 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME Infant (Drington)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Infant (Write the word.)

6. DATE OF BIRTH: April (Month) 18 (Day) 1921 (Year)

7. AGE: — Yrs. — Mos. 5 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Pocatello Ida

10. NAME OF FATHER: J. M. Drington

11. BIRTHPLACE OF FATHER (State or Country): Tennessee

12. MAIDEN NAME OF MOTHER: Helen Bradford

13. BIRTHPLACE OF MOTHER (State or Country): La Angela Colo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. M. Drington

(Address) Pocatello

15. Filed 4/25 1921

Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 23 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 18 1921, to Apr 23 1921, that I last saw him alive on Apr 23 1921, and that death occurred on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Icterus gravis neonatorum

(Duration) ..... Yrs. ..... mos. 5 ds.

Contributory (Secondary) prematurity

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J M Kay M. D.

4/25/21 19..... (Address) Pocatello, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain View Com — DATE OF BURIAL: Apr 26 1921

20. UNDERTAKER: Schumacher & Hall — ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33686
Registered No. 3565

Registration District No. 28
Primary Registration District No. 7161

RECEIVED
MAY 18 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Bannock
City of Pocatello (If outside limits, give township) St. 1st East Bannock
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ford Augusta

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Mexican
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: July (Month) 13 (Day) 1920 (Year)

7. AGE: Yrs. 0 Mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Elias Augustra

11. BIRTHPLACE OF FATHER (State or Country): Mexico

12. MAIDEN NAME OF MOTHER: Semona Lobbae

13. BIRTHPLACE OF MOTHER (State or Country): Mexico

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ed Bronelenz
(Address) Idaho

15. Filed 4/25 1921
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April 24 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 19 1921 to April 22 1921 that I last saw h. mi alive on April 22 1921 and that death occurred on the date stated above, at 2:10 A.M.

The CAUSE OF DEATH* was as follows:
Bronchio-pneumonia

(Duration) ..... Yrs. ..... mos. 4 ds.

Contributory (Secondary) None

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Dr Lynn M. D.
April 24th 1921 (Address) Pocatello Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Ft Hall Indian cemetery — DATE OF BURIAL: April 25 1921

20. UNDERTAKER: W. M. Walker — ADDRESS: Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32687

Registered No. 3566

PLACE OF DEATH

Registration District No. 28

Primary Registration District No. 2161

County of Bannock

City of Pocatello (No. 152 General Hosp. St.)

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MAY [illegible] 1921
BUREAU OF VITAL STATISTICS

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Joe Burkett.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: March (Month) 30 (Day) 1881 (Year)

7. AGE: 41 Yrs. — Mos. 26 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Civil Engineer.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Salt Lake City.

10. NAME OF FATHER: Joseph Miller Burkett.

11. BIRTHPLACE OF FATHER (State or Country): Waldeboro Maine

12. MAIDEN NAME OF MOTHER: Ida Pinney.

13. BIRTHPLACE OF MOTHER (State or Country): Ohio.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mr Starr
(Address) Pocatello

15. Filed 4/24 1921 — J. W. Young, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 27th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 20, 1921, to Apr 24 1921, that I last saw him alive on April 24 1921, and that death occurred on the date stated above, at 1.26 P.M.

The CAUSE OF DEATH* was as follows:

Acute Appendicitis

(Duration) ..... Yrs. ..... mos. 4 ds.

Contributory (Secondary) Intestinal Obstruction

(Duration) ..... yrs. ..... mos. 3 ds.

(Signed) Thos. F. Mueen M. D.

4/25 1921 (Address) Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Boise Ida — DATE OF BURIAL ..... 19.....

20. UNDERTAKER: H. E. McNary — ADDRESS Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY; PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

33687

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No.

Local Registrar's No. 2566

Registration District No. 28

Primary Registration District No. 461

(No. [illegible])

(If death occurred in a hospital or institution, give its name instead of street and number.)

PLACE OF DEATH

County of Bannock

City of Pocatello

2. **FULL NAME** [illegible]

(a) Residence. No. [illegible] St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov 30 - 1880

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
41		26	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Civil Engineer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Utah

PARENTS

10. NAME OF FATHER Joseph Miller Tanner

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Maine

12. MAIDEN NAME OF MOTHER Ida Gurney

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ohio

14. Informant Mrs Tanner

(Address) Pocatello

15. Filed 4-26-1921 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 4 - 25 - 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 20, 1921, to Apr 24, 1921, that I last saw him alive on 4-24, 1921 and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Uremia Appendicitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Intestinal Obstruction

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Geo F Miller, M. D.

4-26, 1921 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Rose Hill	4-28 1921

20. Undertaker	Address
H. A. McNaa	Pocatello

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 23688
Registered No. 3567

1. PLACE OF DEATH

County of Bannock. Registration District No. 28

City of Pocatello (If not in incorporated limits, give township.) Registration District No. 2161

(No. Emergency Hosp. St.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED MAY 5 1921 BUREAU OF VITAL STATISTICS

2. FULL NAME Florentino Zuniga.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
male	mexican	single (Write the word.)

6. DATE OF BIRTH: Oct. (Month) 16 (Day) 1902 (Year)

7. AGE: 18 Yrs. 6 Mos. 8 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Railroad shops.
(b) General nature of industry, business or establishment in which employed (or employer): Machine Dept.

9. BIRTHPLACE (State or Country): Mexico

10. NAME OF FATHER: Faelipe Zuniga.

11. BIRTHPLACE OF FATHER (State or Country): Mexico

12. MAIDEN NAME OF MOTHER: Luisa Rodrges.

13. BIRTHPLACE OF MOTHER (State or Country): Mexico

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) M. L. Aguilera
(Address) Pocatello

15. Filed 4/27 1921 J. R. Young. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 26 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4-26 1921 to 4-26 1921 that I last saw h[illegible] alive on 4-26 1921 and that death occurred on the date stated above, at 10.30 A.M.

The CAUSE OF DEATH* was as follows:

Shock.

(Duration) ..... Yrs. ..... mos. ½ hrs.

Contributory (Secondary) [illegible] (Duration) ..... yrs. ..... mos. ½ hrs.

(Signed) [illegible] M. D.

4/27 1921 (Address) Pocatello.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Mt View	4/27 1921
20. UNDERTAKER	**ADDRESS**
H. S. McHam	Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4033690
Registered No. 3569

Registration District No. 28
Primary Registration District No. 2141

1. PLACE OF DEATH
County of Bannock
City of Pocatello (If outside limits, give township) St. Anthonys Hosp (No. St.)
If death occurs away from usual residence, give facts called for under special information.

RECEIVED
MAY 3 - 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME Susie L. Monson
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	white	Married

6. DATE OF BIRTH: Sept 1st. (Month) (Day) 1867 ~~1921~~ (Year)

7. AGE: 54 Yrs. 7 Mos. 25 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: George Spuck

11. BIRTHPLACE OF FATHER (State or Country): Penn.

12. MAIDEN NAME OF MOTHER: Amond Samsell

13. BIRTHPLACE OF MOTHER (State or Country): Maryland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. C. Monson
(Address) 545 So. Arthur Pocatello Ida.

15. Filed Apr 28 1921 J. H. Young. Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April 25 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 1st. 1920, to April 25th 1921 that I last saw her alive on April 25th 1921 and that death occurred on the date stated above, at 8:50 P. M.

The CAUSE OF DEATH* was as follows:

Syncope : Myocarditis

(Duration) ..... Yrs. ..... mos. 1 ds.
Contributory (Secondary) Mitral Regurg. Arterio-sclerosis
(Duration) 3 yrs. — mos. — ds.

(Signed) W. A. Wright M. D.
4/28 1921 (Address) Pocatello, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 33 yrs. ..... mos. ..... days. In the State 33 yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence Pocatello Idaho

19. PLACE OF BURIAL OR REMOVAL: Mt View Cem. Pocatello — DATE OF BURIAL: Apr. 28 1921

20. UNDERTAKER: H. L. McHan — ADDRESS: Pocatello Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 40 33691
Registered No. 3570

1. PLACE OF DEATH

County of Bannock — Registration District No. 28

City Pocatello (If outside limits of city or village, give township) — Primary Registration District No. 7161 — (Ward) — (St.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
MAY 1 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME Luck R. Bill

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Chinaman

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): married

6. DATE OF BIRTH: Exact date unknown 1856
(Month) (Day) (Year)

7. AGE: 65 Yrs. Mos. ds. — Near as known — IF LESS than 1 day old, ... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business or establishment in which employed (or employer): Restaurant man

9. BIRTHPLACE (State or Country): China

10. NAME OF FATHER: — Bill

11. BIRTHPLACE OF FATHER (State or Country): China

12. MAIDEN NAME OF MOTHER: unknown

13. BIRTHPLACE OF MOTHER (State or Country): unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Frank Louie
(Address) 156 S. 1st ave

15. Filed 4/29 1921 — J. H. Young, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April 26th 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Accidental Drowning

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) S. S. Ferguson Coroner M. D.
4-28-1921 (Address) Pocatello Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mountain View — DATE OF BURIAL: April 29 1921

20. UNDERTAKER: Chamberlain Bros — ADDRESS: City

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 28
Primary Registration District No. 2161
File No. 33692
Registered No. 3571

1. PLACE OF DEATH
County of Bannock
City of Pocatello (No. 355 N. 15th Ave St.)
If death occurs away from usual residence, give facts called for under special information.

RECEIVED
MAY 3 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME Frances Alice Davis
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Sept (Month) 6. (Day) 1844 (Year)

7. AGE: 57 Yrs. 7 Mos. 12 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: house wife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ontario Canada

10. NAME OF FATHER: John Petit

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Sarah Monday

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mester Henry Davis
(Address) 355 N. 15th Ave

15.
Filed April 19 1921
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 18 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 7 1920 to Apr 18 1921, that I last saw h[illegible] alive on Apr 18 1921, and that death occurred on the date stated above, at 11 a. M.
The ~~CAUSE~~ CAUSE OF DEATH* was as follows: Carcinoma of breast,

(Duration) ..... Yrs. 6 mos. ..... ds.
Contributory (Secondary) Age —
(Duration) ~~obst~~ yrs. ~~0~~ mos. ~~ds.~~

(Signed) W M Day M. D.
4/19 1921 (Address) Pocatello, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 2 yrs. ..... mos. ..... days. In the State 2 yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence Wyoming

19. PLACE OF BURIAL OR REMOVAL: Mt View Cem. Pocatello — DATE OF BURIAL: Apr 19 1921

20. UNDERTAKER: H. L. McClain — ADDRESS: Pocatello Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35693
Registered No. 3527

RECEIVED
MAY 5 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
Registration District No. 28
County of Bannock
Primary Registration District No. 216
City of Pocatello (or Robin) Idaho (St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Dudley P. Armstrong
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	White	Married

6. DATE OF BIRTH
Dec. 1 1
(Month) (Day) (Year)

7. AGE
51 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) West Virginia

10. NAME OF FATHER D. P. Armstrong

11. BIRTHPLACE OF FATHER (State or Country) Va.

12. MAIDEN NAME OF MOTHER Williame Amos

13. BIRTHPLACE OF MOTHER (State or Country) Va.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) David Armstrong
(Address) Robin Idaho

15.
Filed Mar 21 1921
H Young
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
May 20 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 8 1921, to Mar 20 1921, that I last saw him alive on Mar 20 1921, and that death occurred on the date stated above, at 1245 A. M.
The CAUSE OF DEATH* was as follows:
Apoplexy
(Duration) Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) Wm E McDill M. D.
Mar 21 1921 (Address) Mc Cammon Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Robin Idaho	May 22 1921
20. UNDERTAKER	ADDRESS
H. L. McClanahan	Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED
MAY 5 - 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 28
Primary Registration District No. 2141.
File No. 33694
Registered No. 3528

1. PLACE OF DEATH
County of Bannock
City of Pocatello
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Dewey Joseph Barnard

If death occurred in a hospital, institution or camp, give its NAME instead of street and number. St. Joseph's Hospital

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: January (Month) 9 (Day) 1920 (Year)

7. AGE: 1 Yrs. 1 Mos. 19 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Salt Lake City Utah

10. NAME OF FATHER: Dewey Walter Barnard

11. BIRTHPLACE OF FATHER (State or Country): Nampa Ida

12. MAIDEN NAME OF MOTHER: Elizabeth Croston

13. BIRTHPLACE OF MOTHER (State or Country): Salt Lake City Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Dewey Walter Barnard
(Address) 540 No 12th Ave Pocatello

15. Filed 3/1 1921
J. P. Young
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 1 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 26 1921, to March 1 1921
that I last saw him alive on March 1st 1921,
and that death occurred on the date stated above, at 10-20 P.M.
The CAUSE OF DEATH* was as follows:
Broncho pneumonia

(Duration) — Yrs. — mos. 3 ds.
Contributory (Secondary) measles
(Duration) — yrs. — mos. 7 ds.

(Signed) J. V. Tyson M. D.
Mar 1 1921 (Address) Pocatello Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. 3 days. In the State 1 yrs. 1 mos. 19 days
Where was disease contracted if not at place of death 540 No 12 Pocatello Ida
Former or usual residence Pocatello Ida.

19. PLACE OF BURIAL OR REMOVAL: Mt View Cemetery — DATE OF BURIAL: 3/2 1921
20. UNDERTAKER: H. D. Tracker — ADDRESS: Pocatello Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33695

Registered No. 5529

RECEIVED
MAY 9 - 1921
BUREAU OF VITAL STATISTICS

Registration District No. 28

Primary Registration District No. 2141

1. PLACE OF DEATH

County of Bannock

City of Pocatello,

If death occurs away from usual residence, give facts called for under special information.

(Street) N. E. of Inkom

Buckskin Valley

2. FULL NAME Minnie Caroline Miller

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widow

6. DATE OF BIRTH: May 27 (Month) (Day) 1867 (Year)

7. AGE: 53 Yrs. 9 Mos. 5 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: House Keeper

(b) General nature of industry, business or establishment in which employed (or employer): for 2 sons

9. BIRTHPLACE (State or Country): N. Carolina

10. NAME OF FATHER: Fogan Young

11. BIRTHPLACE OF FATHER (State or Country): N. Carolina

12. MAIDEN NAME OF MOTHER: Minnie Carter

13. BIRTHPLACE OF MOTHER (State or Country): N. Carolina

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Charles Miller

(Address) Inkom Idaho

15. Filed Mar 4 1921

J. H. Young
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 1st (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....

that I last saw h..... alive on ..... 19.....,

and that death occurred on the date stated above, at 6.0 P. M.

The CAUSE OF DEATH* was as follows:

Suicide by gun shot wound in head

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) S. B. Sorgnan M. D.

3-3-1921 (Address) Pocatello Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 7 yrs. ..... mos. ..... days. In the State 7 yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence North Carolina,

19. PLACE OF BURIAL OR REMOVAL: Mt View Cemetery — DATE OF BURIAL: Mar 4 1921

20. UNDERTAKER: M C Haw Undertaking — ADDRESS: Pocatello Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35696
Registered No. 3530

1. PLACE OF DEATH
County of Bannock
City of Pocatello (If outside limits, give township)
(No. 416 Wooley Apts St.)
If death occurs away from usual residence, give facts called for under special information.

RECEIVED
MAY 9 1921
BUREAU OF STATISTICS

Registration District No. 28
Primary Registration District No. 2141

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Robert Wendell Hammer

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.): Single
6. DATE OF BIRTH: Feb (Month) 12 (Day) 1921 (Year)
7. AGE: ___ Yrs. 1 Mos. 19 ds. IF LESS than 1 day how many ___ hrs. or ___ min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Pocatello Idaho
10. NAME OF FATHER: Thomas T Hammer
11. BIRTHPLACE OF FATHER (State or Country): Texas
12. MAIDEN NAME OF MOTHER: Idetta Lurine Cooper
13. BIRTHPLACE OF MOTHER (State or Country): Rexburg Idaho
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Thomas T Hammer
(Address) Pocatello Idaho
15. Filed 5/4 1921
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 3 (Day) 1921 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Feb 12, 1921 to March 3 1921
that I last saw him alive on Mar 3 1921
and that death occurred on the date stated above, at 5. P. M.
The CAUSE OF DEATH* was as follows:

Premature Birth

(Duration) ___ Yrs. ___ mos. ___ ds.
Contributory (Secondary)
(Duration) ___ yrs. ___ mos. ___ ds.

(Signed) J. H. Lamm M. D.
May 1921 (Address) Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ___ yrs. ___ mos. ___ days. In the State ___ yrs. ___ mos. ___ days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Burley Idaho — DATE OF BURIAL: 3/6 1921
20. UNDERTAKER: H. D. Naeve — ADDRESS: Pocatello

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33697
Registered No. 35-31

1. PLACE OF DEATH
County of Bannock
City of Pocatello (If outside limits, give township) Registration District No. 28
Primary Registration District No. 2161
No. 410 Wesley Ave (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Cleota Delilah Cooper

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

RECEIVED MAR 10 1921 BUREAU OF STATISTICS STATE

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single
6. DATE OF BIRTH: Sept 25 1908 (Month) (Day) (Year)
7. AGE: 12 Yrs. 5 Mos. 13 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: School Girl
(b) General nature of industry, business or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Burley Ida
10. NAME OF FATHER: Wm Logan Cooper
11. BIRTHPLACE OF FATHER (State or Country): Missouri
12. MAIDEN NAME OF MOTHER: Catherine Bennett
13. BIRTHPLACE OF MOTHER (State or Country): Fillmore Utah
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Catherine Cooper
(Address) Pocatello
15. Filed 3/9 1921 J. H. Lyons Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 8 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feby 28 1921, to March 8 1921, that I last saw her alive on March 8 1921, and that death occurred on the date stated above, at 4-20 P. M.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia
Contributory to measles

(Duration) ..... Yrs. ..... mos. 10 ds.

Contributory (Secondary) Measles

(Duration) ..... yrs. ..... mos. 12 ds.

(Signed) J. H. Lyons M. D.
3-9 1921 (Address) Pocatello Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Burley Ida — DATE OF BURIAL: 3/10 1921
20. UNDERTAKER: J. M. Tracker — ADDRESS: Pocatello Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bannock Registration District No. 28

BUREAU OF VITAL STATISTICS Primary Registration District No. 2161 File No. 33698

City of Pocatello State of Idaho Lyons Rest Hospital St. Registered No. 3532

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Robert J. Morgan

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH Feb (Month) 15 (Day) 1887 (Year)

7. AGE 34 Yrs. 1 Mos. 23 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Baker maker
(b) General nature of industry, business or establishment in which employed (or employer) U.S. L.R.B. Shops

9. BIRTHPLACE (State or Country) Colorado.

10. NAME OF FATHER Robert J. Morgan

11. BIRTHPLACE OF FATHER (State or Country) New York

12. MAIDEN NAME OF MOTHER Alice Miller

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Richard W. Reppen
(Address) 820 Capital Ave Pocatello Idaho

15. Filed 3/10 19 21 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March (Month) 8 (Day) 19 21 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Gunshot wound
.....
.....
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) B B Jorgenson Coroner M. D.
3-10 19 21 (Address) Pocatello Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Ogden Utah	Mar 12 19 21
20. UNDERTAKER	ADDRESS
Schumacher Bros	City

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33899
Registered No. 5533

1. PLACE OF DEATH

Registration District No. 28

Primary Registration District No. 2161

County of Bannock

City of Pocatello No. 650 N. Arthur St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William H. Blakely

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

RECEIVED
MAY 5 1921
BUREAU OF VITAL STATISTICS
STATE OF IDAHO

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Dec 28 (Month) 1916 (Day) (Year)

7. AGE: 4 Yrs. 2 Mos. 10 ds.

IF LESS than 1 day how many..... hrs. or.....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work \

(b) General nature of industry, business or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Utah

10. NAME OF FATHER William A. Blakely

11. BIRTHPLACE OF FATHER (State or Country) Mass—

12. MAIDEN NAME OF MOTHER Anna M. Elliott

13. BIRTHPLACE OF MOTHER (State or Country) Wyo—

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) William A Blakely

(Address) 650 N. Arthur

15. Filed 5/10 1921 J. R. Young Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 8 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 28 1921, to Mord 8 1921 that I last saw h-im alive on Mar. 8 1921, and that death occurred on the date stated above, at 9 p. M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ... Yrs. ... mos. 10 ds.

Contributory (Secondary) Mening. tuberculosis.

(Duration) ... yrs. ... mos. 4 ds.

(Signed) J. R. Spargue M. D.

3-9 1921 (Address) Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Dull Lake Utah — DATE OF BURIAL: Mar 11 1921

20. UNDERTAKER: Schumacher Hall — ADDRESS: Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 28
Primary Registration District No. 7141
File No. 383700
Registered No. 3534

1. PLACE OF DEATH
County of Bannock
City of Pocatello (No. Ward) 605 N. Garfield St.)
If death occurs away from usual residence, give facts called for under special information.

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MAY 9 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME Celia Bassett Graham
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6. DATE OF BIRTH: Nov 5 (Month) (Day) 1864 (Year)

7. AGE: 55 Yrs. 4 Mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa.

10. NAME OF FATHER: John Bassett

11. BIRTHPLACE OF FATHER (State or Country): Wales

12. MAIDEN NAME OF MOTHER: Mary Jones

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Robert C. Graham
(Address) 605 N. Garfield

15. Filed Mar 10 1921 J. M. Young Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 9 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 12 1920 to March 9 1921 that I last saw h[illegible] alive on March 9 1921 and that death occurred on the date stated above, at 6 15 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia
Broncho (Lobar)
(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [signature] M. D.
March 9 1921 (Address) Pocatello Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 17 yrs. ..... mos. ..... days. In the State 17 yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence Wyoming

19. PLACE OF BURIAL OR REMOVAL: Mt View Cem — DATE OF BURIAL: Mar 11 1921

20. UNDERTAKER: McHan Undertaking — ADDRESS: Pocatello Ida

FORM V. S. No. 5-25 M. 1-19.

RECEIVED MAY 5 1921 BUREAU OF STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33701
Registered No. 5535

1. PLACE OF DEATH
County of Bannock
City of Pocatello (If outside limits, give township.) 709 N. 13th St. (If in hospital or institution, give its NAME instead of street and number.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 28
Primary Registration District No. 2161

2. FULL NAME Jesus M. Chacon

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Mexican
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single
6. DATE OF BIRTH: May 24 1908 (Month) (Day) (Year)
7. AGE: 12 Yrs. 9 Mos. 16 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Utah
10. NAME OF FATHER: Manis Chacon
11. BIRTHPLACE OF FATHER (State or Country): New Mexico
12. MAIDEN NAME OF MOTHER: Pabuita Martinez
13. BIRTHPLACE OF MOTHER (State or Country): Colorado
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Manis Chacon
(Address) 709 N. 13th Pocatello Idaho
15. Filed 5/10 1921 J. P. Gunning Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb 9 1921 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from Dec. 10 1920 to Feb 9 1921
that I last saw h.... alive on Feb. 6 1921
and that death occurred on the date stated above, at 9 A M.
The CAUSE OF DEATH* was as follows:
Myocarditis.
(Duration) 0 Yrs. 4 mos. ds.
Contributory (Secondary) Rheumatism
(Duration) 0 yrs. mos. ds.
(Signed) J. P. Gunning M. D.
5/6 1921 (Address) Pocatello

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain View — DATE OF BURIAL: 5/11 1921
20. UNDERTAKER: Schumacher Bros — ADDRESS: City

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
MAY 9 - 19
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH — Registration District No. 28
County of Bannock — Primary Registration District No. 2161
City of Pocatello (No. 1028 E. Harrison St.) — File No. 33809
Registered No. 3586

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Peter Theodore Wrensted

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: March 28 1863 (Month) (Day) (Year)

7. AGE: 58 Yrs. 11 Mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired rancher
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Denmark

10. NAME OF FATHER: Carl M. Wrensted

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: Thamma Borgen

13. BIRTHPLACE OF MOTHER (State or Country): Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Wrensted
(Address) Pocatello Ida

15. Filed 5/11 1921 — J. Young, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 11 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from December 1920 to March 11 1921 that I last saw him alive on March 11th 1921, and that death occurred on the date stated above, at 7 A.M.

The CAUSE OF DEATH* was as follows:
Cancer of the stomach
(Duration) 1 yrs. ..... mos. ..... ds.
Contributory (Secondary) none
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.
March 11th 1921 (Address) Pocatello Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mt View Cemetery — DATE OF BURIAL: 3/13 1921

20. UNDERTAKER: H. H. Tracker — ADDRESS: Pocatello Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
MAY 9 - 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Bannock
City of POCATELLO IDAHO
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 28
Primary Registration District No. 2-161
(No. 402 N Lincoln Ave St.)

File No. 33403
Registered No. 3538
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William Louis Deutsch

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Dec (Month) 12 (Day) 1915 (Year)

7. AGE: 5 Yrs. 2 Mos. 28 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Nebraska

10. NAME OF FATHER: William E Deutsch

11. BIRTHPLACE OF FATHER (State or Country): Omaha Nebraska

12. MAIDEN NAME OF MOTHER: Pauline Elsasser

13. BIRTHPLACE OF MOTHER (State or Country): Omaha Nebraska

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wm E Deutsch
(Address) POCATELLO. IDAHO

15. Filed Mar 12 1921
J. H. Young
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar (Month) 10 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Accidental Drowning

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) S S Ferguson Coroner M. D.
3-12- 1921 (Address) Pocatello Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 1 yrs. ..... mos. ..... days. In the State 1 yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence Omaha Neb.

19. PLACE OF BURIAL OR REMOVAL: Mt View Cem
DATE OF BURIAL: 3/13 1921

20. UNDERTAKER: H. L. McHAN
ADDRESS: POCATELLO. IDAHO

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 28
Primary Registration District No. 2161
File No. 33704
Registered No. 3538

RECEIVED
MAY 9 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Bannock
City of Pocatello (If outside limits, give township) Ward or Precinct 920 W Lewis St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sarah Elizabeth Hailey
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	married

6. DATE OF BIRTH: October (Month) 15 (Day) 1860 (Year)

7. AGE: 62 Yrs. 4 Mos. 25 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Georgia

10. NAME OF FATHER: Jim Taylor

11. BIRTHPLACE OF FATHER (State or Country): Georgia

12. MAIDEN NAME OF MOTHER: Mary Fuller

13. BIRTHPLACE OF MOTHER (State or Country): Georgia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) James R. Hailey
(Address) POCATELLO, IDAHO

15. Filed Nov 12 1921 J. H. Young Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 3- (Month) 10 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jany 25 1920 to Mch 10 1921, that I last saw her alive on Mch 10 1921, and that death occurred on the date stated above, at 3 P M.

The CAUSE OF DEATH* was as follows:
Angina pectoris
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Acute myocarditis
..... (Duration) ..... yrs. 2 mos. ..... ds.

(Signed) J. C. Kay M. D.
3-12 1921 (Address) Pocatello Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. 4 mos. ..... days. In the State ..... yrs. 4 mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence Ogden Utah

19. PLACE OF BURIAL OR REMOVAL: Ogden Utah — DATE OF BURIAL: Nov 13 1921

20. UNDERTAKER: H. L. McHAN — ADDRESS: POCATELLO. IDAHO

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33765
Registered No. 3539

1. PLACE OF DEATH

Registration District No. 28

Primary Registration District No. 2161

County of Bannock

City of Pocatello (No. 5 miles out of town St.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
MAY 9 - 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME Infant Fouts

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: March (Month) 11 (Day) 1921 (Year)

7. AGE: ____ Yrs. ____ Mos. ____ ds.

IF LESS than 1 day how many 6 hrs. or ____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Pocatello Ida

10. NAME OF FATHER: L. O. Fouts

11. BIRTHPLACE OF FATHER (State or Country): Illinois

12. MAIDEN NAME OF MOTHER: Helen Rapes

13. BIRTHPLACE OF MOTHER (State or Country): Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) L. O. Fouts

(Address) Pauline Ida

15. Filed 3/12 1921

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 11 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 11 1921, to Mar 11 1921, that I last saw her alive on Mar 11 1921, and that death occurred on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:

Premature birth

(Duration) ____ Yrs. ____ mos. ____ ds.

Contributory (Secondary)

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) Carl W Clark M. D.

3-12-1921 (Address) Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days

6 hours

Where was disease contracted if not at place of death?

Former or usual residence: Pocatello Ida

19. PLACE OF BURIAL OR REMOVAL: Mt View — DATE OF BURIAL: Mar 12 1921

20. UNDERTAKER: M. Hanson Undertaking Co. — ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED MAY 5 1921 BUREAU OF STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 28

Primary Registration District No. 2141

File No. 3837 6

Registered No. 3940

County of Bannock

City of Pocatello (No. 709 E. Fremont St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Eris Jane Lorina Nomen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Infant (Write the word.)

6. DATE OF BIRTH: February (Month) 26 (Day) 1920 (Year)

7. AGE: 1 Yrs. — Mos. 16 ds.

IF LESS than 1 day: how many ... hrs. or ... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Pocatello Ida.

10. NAME OF FATHER: Robert Nomen

11. BIRTHPLACE OF FATHER (State or Country): Kentucky

12. MAIDEN NAME OF MOTHER: Christina McNew

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mr. Robert Nomen

(Address) Pocatello

15. Filed 5/14 1921

J. R. Young
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 12 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 6" 1921, to Mar 12" 1921, that I last saw h.r. alive on Mar 9" 1921, and that death occurred on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia from Whooping Cough

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary) ...

(Duration) ... yrs. ... mos. ... ds.

(Signed) H. D. Austin M. D.

May 14 1921 (Address) Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain View Cem. — DATE OF BURIAL: May 14 1921

20. UNDERTAKER: Schumacher & Kelly — ADDRESS: Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 383707
Registered No. 5547

1. PLACE OF DEATH

County of Bannock
City of POCATELLO. IDAHO
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 28
Primary Registration District No. 2161
235 E. Garfield St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Elizabeth Adella Dentz

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female white

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widow

6. DATE OF BIRTH: March 6, 1859 (Month) (Day) (Year)

7. AGE: 62 Yrs. — Mos. 7 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House Keeper
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Pennsylvania

10. NAME OF FATHER: Name not Known - Hunter

11. BIRTHPLACE OF FATHER (State or Country): Not Known

12. MAIDEN NAME OF MOTHER: Elizabeth Rogers

13. BIRTHPLACE OF MOTHER (State or Country): Not Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Dean. W. Dentz
(Address) POCATELLO. IDAHO

15. Filed Mar 14 1921 — J. B. Young, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 14 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from after death 19 March 14, 1921 to 19 9 a.m.
that I last saw her alive on Mar 14 1921,
and that death occurred on the date stated above, at 5:30 a. M.
The CAUSE OF DEATH* was as follows:
Myocarditis - Endocarditis

(Duration) 1 Yrs. 3 mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) O. R. Magee M. D.
Mar 18 1921 (Address) Kahl Bldg

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death — yrs. — mos. 7 days. In the State yrs. mos. 7 days
Where was disease contracted if not at place of death?
Former or usual residence Los Angeles, Cal.

19. PLACE OF BURIAL OR REMOVAL: Los Angeles Cal. DATE OF BURIAL: Mar 16 1921

20. UNDERTAKER: H. L. McHAN ADDRESS: Pocatello, Ida.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH — RECEIVED MAY 6 1921 BUREAU OF VITAL STATISTICS

County of Bannock — Registration District No. 28 — Primary Registration District No. 2161

City of Pocatello — (If outside limits of city or village, write the word "No") — Ward No. — (Street and No. of hospital, if in one, otherwise write St.) — Certificate No. 3933708 — Registered No. 3542

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Infant Lindeman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number. St. Anthony Hospital

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6. DATE OF BIRTH: March 14th 1921 (Month) (Day) (Year)

7. AGE: Born Yrs. Mos. ds. — IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work:
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: James Lindeman

11. BIRTHPLACE OF FATHER (State or Country): U.S.

12. MAIDEN NAME OF MOTHER: Christine Dymack

13. BIRTHPLACE OF MOTHER (State or Country): Nebr.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) James Lindeman
(Address) 531 S. Main

15. Filed 3/16 1921 — J. M. Young, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar 14th 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 14th 1921 to Mar 14th 1921 that I last saw him alive on Mar 14th 1921 and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:
Heart trouble - Incomplete
Chronic foramen Ovale -

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) H A Castle M. D.
Mar 16 1921 (Address) Pocatello Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Pocatello Idaho — DATE OF BURIAL: Mar 16 1921

20. UNDERTAKER: Schuerman Bros — ADDRESS: City

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED (illegible)
MAY 9 - (illegible)
BUREAU OF (illegible)

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33709
Registered No. 3543

1. PLACE OF DEATH

County of Bannock
City of Pocatello
(No. 741 N. 8th St.)
Registration District No. 28
Registration District No. 2161

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary B. Julio

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: Italian
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Feb 23 1920
(Month) (Day) (Year)

7. AGE: 1 Yrs. 0 Mos. 22 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: /
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Charlie Julio

11. BIRTHPLACE OF FATHER (State or Country): Italy

12. MAIDEN NAME OF MOTHER: Colonna, Maciocia

13. BIRTHPLACE OF MOTHER (State or Country): Italy

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Charlie Julio
(Address) 741 N. 8th St

15. Filed 3/16 1921
J. P. Young
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 15 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mch 10 1921, to Mch 15 1921, that I last saw h[illegible] alive on Mch 15 1921, and that death occurred on the date stated above, at 3P M.

The CAUSE OF DEATH* was as follows: Broncho pneumonia

(Duration) ... Yrs. ... mos. 8 ds.

Contributory (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) N. J. Howard M. D.

3/16 1921 (Address) Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain View — DATE OF BURIAL: March 17 1921

20. UNDERTAKER: Chamberlain Hall — ADDRESS: Pocatello Idaho

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

RECEIVED
MAR - 1921
BUREAU OF VITAL STATISTICS

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 28
Primary Registration District No. 8161
File No. 3541
Registered No. 3544

1. PLACE OF DEATH
County of Bannock
City of Pocatello (If outside limits, give township) Taft Annex (St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ruth Ann Coleman
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Infant

6. DATE OF BIRTH: January (Month) 2 (Day) 1921 (Year)

7. AGE: — Yrs. 2 Mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Pocatello Ida

10. NAME OF FATHER: John W Coleman

11. BIRTHPLACE OF FATHER (State or Country): Illinois

12. MAIDEN NAME OF MOTHER: Wilhelmina Hedin

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John W Coleman
(Address) Pocatello

15. Filed 3/18 1921
J Mauney, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 17 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3-15 1921 to 3-16 1921
that I last saw her alive on 3-16 1921
and that death occurred on the date stated above, at 12:50 P M.
The CAUSE OF DEATH* was as follows:
Acute Meningitis

(Duration) ..... Yrs. ..... mos. 3 ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D C Kay M. D.
3/18 1921 (Address) Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain View Cem — DATE OF BURIAL: Mar 19 1921
20. UNDERTAKER: Schumacher & Hall — ADDRESS: Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
MAY 5 -
BUREAU OF STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3933711
Registered No. 3345

Registration District No. 28
Primary Registration District No. 2161

1. PLACE OF DEATH
County of Bannock
City of Pocatello (No. 407 So. Arthur St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Quinn

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6. DATE OF BIRTH: July (Month) (Day) 1841 (Year)

7. AGE: 60 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: R.R. Conductor
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: Mike Quinn

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Kate Quinn

13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mary Quinn
(Address) 407 So. Arthur ave

15. Filed May 19 1921 — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 19 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 8 1920, to Mar 19 1921, that I last saw h[illegible] alive on Mar 18 1921, and that death occurred on the date stated above, at 6.45 A.M.
The CAUSE OF DEATH* was as follows: Carcinoma of Stomach

(Duration) 5 Yrs. mos. ds.
Contributory (Secondary) Hypertrophy of prostate
(Duration) 2 yrs. mos. ds.

(Signed) Thos. F. Moore M. D.
3/19 1921 (Address) Can Bdg Pocatello Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 37 yrs. — mos. — days. In the State 37 yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence Illinois

19. PLACE OF BURIAL OR REMOVAL: Mt View Cemetery — DATE OF BURIAL: May 21 1921
20. UNDERTAKER: McHan Undertaking Co — ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED
MAY 5 1921
BUREAU OF VITAL STATISTICS
STATE OF IDAHO

CERTIFICATE OF DEATH

28

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2141
Primary Registration District No.
File No. 38712
Registered No. 3544

1. PLACE OF DEATH

County of Bannock
City of Pocatello (Usual Residence) General Hospital

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James Kimball Hadley

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH: April (Month) 13 (Day) 1919 (Year)

7. AGE: 5 Yrs. 11 Mos. 7 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry, business or establishment in which employed (or employer): At Home

9. BIRTHPLACE (State or Country): Pocatello Idaho

10. NAME OF FATHER: Ether Richard Hadley

11. BIRTHPLACE OF FATHER (State or Country): Swan Lake Idaho

12. MAIDEN NAME OF MOTHER: Lenny Mary Carlson

13. BIRTHPLACE OF MOTHER (State or Country): Clifton Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ether Hadley
(Address) Pocatello

15. Filed 3/22 1921

Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 20 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 6 1920, to March 20 1921, that I last saw him alive on Mch. 20 1921, and that death occurred on the date stated above, at 4:30 P.M.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia

(Duration) 1 Yrs. ..... mos. ..... ds.

Contributory (Secondary) Lobar Pneumonia

(Duration) ..... yrs. ..... mos. 1 ds.

(Signed) J. M. Spangler M. D.

3-22-1921 (Address) Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain View — DATE OF BURIAL: Mch 22 1921

20. UNDERTAKER: Schumacher & Hall — ADDRESS: Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 28

County of Bannock

Primary Registration District No. 2161

City of POCATELLO, IDAHO (No. 912 N. 9th ave St.)

File No. 3933713

Registered No. 3548

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Susie Ernst.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

RECEIVED MAY 5 1921 BUREAU OF STATISTICS

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6. DATE OF BIRTH: October 9 (Month) (Day) 1867 (Year)

7. AGE: 53 Yrs. 5 Mos. 14 ds.

IF LESS than 1 day how many..... hrs. or..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Pensylvania

10. NAME OF FATHER: George Williams

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Susie Hennegan

13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) George A Ernst
(Address) 912 N. 9th ave Pocatello

15. Filed May 24 1921 J P Young Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 23 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 15 1921, to March 23 1921, that I last saw her alive on March 20 1921, and that death occurred on the date stated above, at 11 A. M.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

.....(Duration) .....Yrs. 2 mos. 4 ds.

Contributory (Secondary)

.....(Duration) .....yrs. .....mos. .....ds.

(Signed) A M Newton M. D.

March 24 1921 (Address) Pocatello, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 20 yrs. ..... mos. ..... days. In the State 20 yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence Bonanza, Idaho.

19. PLACE OF BURIAL OR REMOVAL: Pocatello Ida. DATE OF BURIAL: Mar 26 1921

20. UNDERTAKER: H. L. McHAN ADDRESS: POCATELLO, IDAHO

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED MAR 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3833714
Registered No. 3149

1. PLACE OF DEATH

Registration District No. 28
County of Bannock Primary Registration District No. 2161
City of Pocatello (Institution: General Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Matilda Truelock Green

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: May 12 (Month) (Day) 1913 (Year)

7. AGE: 7 Yrs. 10 Mos. 14 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: child
(b) General nature of industry, business or establishment in which employed (or employer): at school

9. BIRTHPLACE (State or Country): Mc Cammon Ida.

10. NAME OF FATHER: B. F. Green

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Matilda Truelock Mary

13. BIRTHPLACE OF MOTHER (State or Country): Woodruff Ida.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) B. F. Green
(Address) Mc Cammon

15. Filed 3/26 1921 J. R. Green Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 24 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 7 1921, to March 26 1921, that I last saw h[illegible] alive on March 26 1921 and that death occurred on the date stated above, at 1:10 P.M.

THE CAUSE OF DEATH was as follows: Chronic Interstitial Nephritis Uremic Poisoning

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.

March 26 1921 (Address) Pocatello Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mc Cammon Ida. DATE OF BURIAL: 3/28 1921

20. UNDERTAKER: Schumacher & Hall ADDRESS: Pocatello

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 28
Primary Registration District No. 2141
File No. 3933715
Registered No. 3550

1. PLACE OF DEATH
County of Bannock
City of Pocatello (If outside limits, give township) County Poor farm (If in hospital or institution, give its name instead of street and number.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED MAY 9 1932 BUREAU OF VITAL STATISTICS

2. FULL NAME Frank Warkulat

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word): Single

6. DATE OF BIRTH: Not Known (Month) (Day) (Year)

7. AGE: 33 Yrs. Mos. ds. — guess to County Infirmary — IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Sheep herder
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: Workulat

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: not Known

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Sommers
(Address) County Infirmary Pocatello

15. Filed May 28 1921 — J. L. Sommers, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 26 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 19 21, to March 26 19 21, that I last saw h. alive on March 26 19 21, and that death occurred on the date stated above, at 5.30 A.M.

The CAUSE OF DEATH* was as follows:
Tuberculosis Lungs
(Duration) Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) Fred Dewey M. D.
March 26 19 21 (Address) Pocatello Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. 4 mos. days. In the U. S. a State 10 yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence Germany

19. PLACE OF BURIAL OR REMOVAL: Mt View Cem — DATE OF BURIAL: May 28 1921

20. UNDERTAKER: A. L. McClain — ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33716
Registered No. 3557

1. PLACE OF DEATH
County of Bannock
City of Pocatello (No. 9 N. 2nd St.)
If death occurs away from usual residence, give facts called for under special information.

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BUREAU OF VITAL STATISTICS

Registration District No. 28
Primary Registration District No. 2141

2. FULL NAME George Parris

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Indian
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.):
6. DATE OF BIRTH: Feb 13 - 1921 (Month) (Day) (Year)
7. AGE: Yrs. 1 Mos. 16 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work:
(b) General nature of industry, business or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Idaho
10. NAME OF FATHER: Mike Parris
11. BIRTHPLACE OF FATHER (State or Country): Idaho
12. MAIDEN NAME OF MOTHER: Lizzie Tatsa
13. BIRTHPLACE OF MOTHER (State or Country): Idaho
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Mike Parris
(Address) 614 N 2nd
15. Filed 5/29 1921 J R Young Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 24 1921 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from 3/29 1921, to 3/29 1921, that I last saw him alive on 3/29 1921, and that death occurred on the date stated above, at 5 P.M.
The CAUSE OF DEATH* was as follows:
Bronchi Pneumonia
(Duration) ..... Yrs. ..... mos. 2 ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) J R Young M. D.
5/29 1921 (Address) Pocatello

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain View — DATE OF BURIAL: May 30 1921
20. UNDERTAKER: J Greenwell — ADDRESS: City

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

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FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 28
Primary Registration District No. 7161
File No. 3933717
Registered No. 3552

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BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Bannock
City of Pocatello (If outside limits, give township) 532 So 2nd Ave (Street and No. or R. F. D. No.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Infant of Mr & Mrs Charles Green
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: March (Month) 27 (Day) 1921 (Year)

7. AGE: Yrs. Still Born Mos. ds.
IF LESS than 1 day how many 0 hrs. or 6 min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Pocatello

10. NAME OF FATHER: Chas Green

11. BIRTHPLACE OF FATHER (State or Country): Penn

12. MAIDEN NAME OF MOTHER: Belva Pearl Mathews

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Peggy Gilbert
(Address) 532 S 2nd Ave Pocatello

15. Filed 5/9 1921 J. H. Young Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 27 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 27 1921, to March 27 1921, that I last saw her alive on March 27 1921, and that death occurred on the date stated above, at 9 12 M.

The CAUSE OF DEATH* was as follows:
Still born
(Duration) Yrs. mos. ds.
Contributory (Secondary)
(Duration) Yrs. mos. ds.

(Signed) S C Ray M. D.
3/27 1921 (Address) Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: W. L. View cemetery — DATE OF BURIAL: 3/29 1921

20. UNDERTAKER: P. L. D. Parker — ADDRESS: 3/29/21

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

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FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33718
Registered No. .....

1. PLACE OF DEATH. Registration District No. 55
County of Bear Lake Primary Registration District No. .....
City of St Charles (No. .... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Hannah Trantrum.

RECEIVED MAY 9 1921 BUREAU OF STATISTICS

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): widow
6. DATE OF BIRTH. Sept (Month) 80 (Day) 1828 (Year)
7. AGE: 93 Yrs. ..... Mos. ..... ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: House Wife
(b) General nature of industry, business, or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): Bestachile Sweden
10. NAME OF FATHER: Neld Monsen
11. BIRTHPLACE OF FATHER (State or Country): dos not know
12. MAIDEN NAME OF MOTHER: Elna Person
13. BIRTHPLACE OF MOTHER (State or Country): dont know
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Hannah Olsen
(Address) St Charles Id.
15. Filed March 5 1921 John Mattson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 8 (Day) 1921 (Year)
17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
No Dr in attendes
Died of old age
(Duration) 1 Yrs. ..... mos. ..... ds.
Contributory (Secondary) only ill one day.
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) ..... M. D.
19... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: St Charles Id — DATE OF BURIAL: March 9 1921
20. UNDERTAKER: The family laid her out — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33719

Registered No. .....

RECEIVED
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BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH.

Registration District No. 5-5-

Primary Registration District No. .....

County of Bear Lake

City of Fish Haven (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Frances Stock

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. Jan (Month) 15 (Day) 1837 (Year)

7. AGE: 84 Yrs. 3 Mos. 8 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House Wife
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: Wm Gillson

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Charlotte King

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Charles L. Stock
(Address) Fish Haven Ida

15. Filed April 21 1924 John Mattson Local Registrar

SYMS - YORK CO., PTRS. & RORS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 23 (Day) 1924 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occured on the date stated above, at 1 0 M.
The CAUSE OF DEATH* was as follows:
General debility
.....(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
.....(Duration ..... yrs. ..... mos. ..... ds.
(Signed) ..... M. D.
.....19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Fish Haven Id. DATE OF BURIAL: Apr 26 1924

20. UNDERTAKER ADDRESS

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33720

Registered No. 7

1. PLACE OF DEATH

Registration District No. 32

County of Benewah Registration District No. 2049

City of St Maries (Ward) St.)

If death occurs away from usual residence, give facts called for under special information.

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BUREAU OF VITAL STATISTICS

2. FULL NAME Valley Lawn

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH: August (Month) 15 (Day) 1844 (Year)

7. AGE: ....Yrs. ....Mos. ....ds.

IF LESS than 1 day how many 10 hrs. or ....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: H

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): St Maries Ida

10. NAME OF FATHER: Roy C Lawn

11. BIRTHPLACE OF FATHER (State or Country): Wash

12. MAIDEN NAME OF MOTHER: Libran J Hendrickson

13. BIRTHPLACE OF MOTHER (State or Country): Colo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Roy C Lawn

(Address) St Maries Ida

15. Filed April 16 1921

H E Hunt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 15 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 14 1921, to Apr 14 1921, that I last saw her alive on Apr 14 1921, and that death occurred on the date stated above, at 8 P M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ....Yrs. ....mos. ....ds.

Contributory (Secondary) Premature Birth

(Duration) ....yrs. ....mos. ....ds.

(Signed) H E Hunt M. D.

Apr 16 1921 (Address) St Maries Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs. ....mos. ....days. In the State ....yrs. ....mos. ....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Woodlawn — DATE OF BURIAL: 4/16 1921

20. UNDERTAKER: Mitchell & Menges — ADDRESS: St Maries

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY; PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Benewah — Registration District No. 92

City of St Maries — (No. ... St.) — Primary Registration District No. 2049

File No. 33721

Registered No. 16

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

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MAY 10 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME Geo M McClure

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Male	White	Married (Write the word.)

6. DATE OF BIRTH: Dec (Month) 16 (Day) 1853 (Year)

7. AGE: 68 Yrs. 3 Mos. 20 ds. — IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mass

10. NAME OF FATHER: Luther McClure

11. BIRTHPLACE OF FATHER (State or Country): Mass

12. MAIDEN NAME OF MOTHER: Lydia Fennell

13. BIRTHPLACE OF MOTHER (State or Country): Mass.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Geo M McClure
(Address) St Maries

15. Filed April 5 1921 — H E Hunt, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 5 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 2 1921 to Apr 5 1921 that I last saw h.em alive on Apr 5 1921 and that death occurred on the date stated above, at 10 M.

The CAUSE OF DEATH* was as follows:

Pernicious Anemia

(Duration) 3 Yrs. ... mos. ... ds.

Contributory (Secondary) ... (Duration) ... yrs. ... mos. ... ds.

(Signed) Owen O'Neill M. D.

Apr 5 1921 (Address) St Maries Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs ... mos ... days. In the State ... yrs ... mos ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Woodlawn — DATE OF BURIAL: 4-8 1921

20. UNDERTAKER: H E Hunt Co — ADDRESS: St Maries

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY; PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33722
Registered No. 15

RECEIVED
MAY 10 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
Registration District No. 32
Primary Registration District No. 2049
County of Benewah
City of St. Maries (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Hideko Uyeno
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: Yellow
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Apr. (Month) 1 (Day) 1919 (Year)

7. AGE: 2 Yrs. ..... Mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER S. Uyeno

11. BIRTHPLACE OF FATHER (State or Country) Japan

12. MAIDEN NAME OF MOTHER Some Takahashi

13. BIRTHPLACE OF MOTHER (State or Country) Japan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) S. Uyeno
(Address) St. Maries

15. Filed April 6 1921 H E Hunt
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr. (Month) 4 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 3 1921, to Apr 4 1921, that I last saw her alive on Apr 4 1921 and that death occurred on the date stated above, at 9 P.M.

The CAUSE OF DEATH* was as follows:

Whooping cough

(Duration) ..... Yrs. ..... mos. 10 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

4/6 1921 (Signed) Delonnell M. D.
(Address) St. Maries

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Spokane
DATE OF BURIAL: 4/7 1921

20. UNDERTAKER: H E Hunt Co.
ADDRESS: St Maries

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33723

Registered No. 14

1. PLACE OF DEATH

County of Canewah

City of St Maries

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
MAY 10 1921
BUREAU OF VITAL STATISTICS

Registration District No. 32

Primary Registration District No. 2019

2. FULL NAME Owen Fowler

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: March (Month) 25 (Day) 1885 (Year)

7. AGE: 36 Yrs. — Mos. 8 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housework Jan

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kansas

10. NAME OF FATHER: J. T. Carpenter

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Millie Gieskell

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W W Fowler

(Address) Santa

15. Filed April 5 1921

A E Hunt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 2 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mch 21 1921, to Apr 2 1921, that I last saw h[illegible] alive on Apr 2 1921, and that death occurred on the date stated above, at 10A M.

The CAUSE OF DEATH* was as follows:

Septicemia

(Duration) ..... Yrs. ..... mos. 4 ds.

Contributory (Secondary) Confinement

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D Edmonds M. D.

4/2 1921 (Address) St Maries

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Woodlawn — DATE OF BURIAL: 4-6 1921

20. UNDERTAKER: A E Hunt Co — ADDRESS: St Maries

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33724

Registered No. 37

1. PLACE OF DEATH

Registration District No. 31

County of Benewah

Primary Registration District No.

City of Wenner (No. St.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
MAY 10 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME Pascal Cornelius Lawrence

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	Indian	Infant

6. DATE OF BIRTH: June (Month) 10 (Day) 1919 (Year)

7. AGE: 2 Yrs. 9 Mos. 18 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ford Wash

10. NAME OF FATHER: Felix Cornelius

11. BIRTHPLACE OF FATHER (State or Country): Wash

12. MAIDEN NAME OF MOTHER: Mary Pascal

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mary Pascal

(Address) Wenner Ida

15. Filed April 20 1921 J. L. Bilsan Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 25 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....19...., to ....19....

that I last saw h.... alive on ....19....,

and that death occurred on the date stated above, at ....M.

The CAUSE OF DEATH* was as follows:

Not known. Received no treatment from physician

....(Duration) ....Yrs. ....mos. ....ds.

Contributory (Secondary)

....(Duration) ....yrs. ....mos. ....ds.

(Signed) ....M. D.

....19.... (Address) ....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death....yrs....mos....days. In the State....yrs....mos....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Wenner Ida	April 26 1921
20. UNDERTAKER	ADDRESS
J. Falcon	Wenner

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13725

Registered No. 16

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No. 31

Primary Registration District No.

County of Benewa

City of DeSmet (No.) St.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
MAY 10 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME Marietta Spring

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. 12 (Month) 25 (Day) 1844 (Year)

7. AGE ....Yrs....Mos....ds. IF LESS than 1 day how many....hrs. or ....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Teacher (School)
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Ohio

10. NAME OF FATHER J B Metcalf

11. BIRTHPLACE OF FATHER (State or Country) N. Y.

12. MAIDEN NAME OF MOTHER Pauline Eckman

13. BIRTHPLACE OF MOTHER (State or Country) N. Y

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant)
(Address)

15. Filed April 12 1921 J. L. Brisan Local Registrar

SYMS - YORK CO., PTRS. & SORS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April March 10 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 9 1921, to March 10 1921, that I last saw her alive on March 9 1921, and that death occured on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:
Valvular Heart disease
(Aortic Stenosis)

(Duration) ....Yrs....mos....ds.

Contributory (Secondary)

(Duration) ....Yrs....mos....ds.

4/11 1920 (Signed) J. A. Nelson M. D.
(Address) DeSmet

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death....yrs....mos....days. In the State....yrs....mos....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Tekoa Cemetery. DATE OF BURIAL: 4-12 1921

20. UNDERTAKER: C. L. Schubert ADDRESS: Tekoa

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED
APR 20 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 116
Primary Registration District No. 2155
File No. 33727
Registered No. 3827

1. PLACE OF DEATH.
County of Bingham
City of Sterling
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Esther May Maxwell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH. Feb 10 (Month) (Day) 1921 (Year)
7. AGE ..... Yrs. 1 Mos. 9 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Idaho
10. NAME OF FATHER: Joseph Cannon Maxwell
11. BIRTHPLACE OF FATHER (State or Country): Kansas
12. MAIDEN NAME OF MOTHER: Clemmie May Edwards
13. BIRTHPLACE OF MOTHER (State or Country): Utah
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. C. Maxwell
(Address) Sterling Idaho
15. Filed Mch 19 21 Marian Kinna Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mch (Month) 19 (Day) 21 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Mch 18 21, to Mch 19 21, that I last saw h[er] alive on Mch 19 21, and that death occured on the date stated above, at 3P M.
The CAUSE OF DEATH* was as follows:
Hydrocephalus
(Duration) X Yrs. 1 mos. 2 ds.
Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) M. C. Maxwell M. D.
3/19 21 (Address) Cleveleen Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Springfield Ida — DATE OF BURIAL: Mch 20 1921
20. UNDERTAKER: Friends — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BORS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33728

Registered No. 51

1. PLACE OF DEATH.

Registration District No. 116

County of Bingham Primary Registration District No. 2185

City of Pingree (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
APR 20 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME Dale Paul

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. March 6 1921 (Month) (Day) (Year)

7. AGE: ..... Yrs. ..... Mos. 15 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: William Paul

11. BIRTHPLACE OF FATHER (State or Country): Oklahoma

12. MAIDEN NAME OF MOTHER: Sarah Johns

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William Paul

(Address) Pingree Ida

15. Filed March 25 1921 M. McMackin Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 25 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 16 1921, to March 25 1921, that I last saw h— alive on March 16 1921 and that death occured on the date stated above, at 10 A. M.

The CAUSE OF DEATH* was as follows:

Marasmus, —

(Duration) ..... Yrs. ..... mos. 19 ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) M. McMackin M. D.

3/25 1921 (Address) Aberdeen Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Springfield Ida — DATE OF BURIAL: March 26 1921

20. UNDERTAKER: Friends — ADDRESS: —

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33329
Registered No. 52

1. PLACE OF DEATH.
Registration District No. 116
Primary Registration District No. 2151
County of Bingham
City of Springfield (If outside limits, give township) St.)

RECEIVED
APR 2 0 1921
BUREAU OF VITAL STATISTICS

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ernest Lowell McDaniel

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH. Feb (Month) 12 (Day) 1920 (Year)
7. AGE: 1 Yrs. 1 Mos. 16 ds. IF LESS than 1 day how many ....hrs. or ....min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work....
(b) General nature of industry, business, or establishment in which employed (or employer)....
9. BIRTHPLACE (State or Country) Idaho -
10. NAME OF FATHER Clarence McDaniel
11. BIRTHPLACE OF FATHER (State or Country) Idaho 3/29
12. MAIDEN NAME OF MOTHER Emma Theresa Reece
13. BIRTHPLACE OF MOTHER (State or Country) Idaho
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Clarence McDaniel
(Address) Springfield Ida
15. Filed Mch 29 21 Mamie Kissinger Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mch 28 21 (Month) (Day) 191 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Mch 23 191 21, to Mch 28 191 21, that I last saw h in alive on Mch 28 191 21 and that death occured on the date stated above, at 4 P M.
The CAUSE OF DEATH* was as follows:
Whooping Cough
(Duration) Yrs. mos. 28 ds.
Contributory (Secondary) Bronchopneumonia
(Duration yrs. mos. 10 ds.
(Signed) Mamie Kissinger M. D.
(Address) Blackfoot Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?....
Former or usual residence ....

19. PLACE OF BURIAL OR REMOVAL: Springfield Ida — DATE OF BURIAL: Mch 30 21
20. UNDERTAKER: Friends — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SVMS - YORK CO., PTRS. & BORS. 24658

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 121

County of Bingham Primary Registration District No. 2194

City of Blackfoot (No. R F D 2 St.)

File No. 33730

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Kirwan

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Sing. (Write the word.)

6. DATE OF BIRTH: Dec (Month) 17 (Day) 1912 (Year)

7. AGE: 8 Yrs. 2 Mos. 15 ds.

IF LESS than 1 day how many..... hrs. or.....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: In school.

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Edward J Kirwan

11. BIRTHPLACE OF FATHER (State or Country): Ill

12. MAIDEN NAME OF MOTHER: Christine Bojack

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E. E. Kuyper

(Address) Blackfoot Idaho R2.

15. Filed Mar 5 1921

Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 2nd (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased ~~from~~ March 2nd 1921, to ..... 19..... that I last saw ~~him~~ alive on March 2nd 1921 and that death occurred on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

Fall from horse

Internal injuries to abdomen

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. O. Hamptain M. D.

3/3 1921 (Address) Blackfoot Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Riverside Shoshone — DATE OF BURIAL: 3-5 1921

20. UNDERTAKER: E J Rick — ADDRESS: Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33731
Registered No. 34

RECEIVED
APR 21 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH. Registration District No. 121
County of Bingham Primary Registration District No. 2194
City of Blackfoot (If outside limits, give township) Idaho Insane Asylum St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mrs Sarah Jones

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married
6. DATE OF BIRTH. (Month) (Day) 1883 (Year)
7. AGE: 38 Yrs. Mos. ds. IF LESS than 1 day how many hrs. or min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Utah
10. NAME OF FATHER: James Parkinson
11. BIRTHPLACE OF FATHER (State or Country): England
12. MAIDEN NAME OF MOTHER: Jeanette Harris
13. BIRTHPLACE OF MOTHER (State or Country): Utah
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Records Idaho Insane asylum Blackfoot Idaho
(Address) by Juliana L Greer clerk
15. Filed Mar 5 1921 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 3rd (Day) 1921 (Year)
17. I HEREBY CERTIFY, That I attended deceased from March 13th 1919 to March 3rd 1921, that I last saw h er alive on March 3rd 1921, and that death occured on the date stated above, at 8 P M.
The CAUSE OF DEATH* was as follows:
Gastritis
(Duration) Yrs. mos. 9 ds.
Contributory (Secondary) Chronic dementia
(Duration) yrs. mos. ds.
(Signed) C H Coover M. D.
3/3 1921 (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death. 10 yrs. 10 mos. 26 days. In the State. 14 yrs. mos. days
Where was disease contracted if not at place of death? Dont Know
Former or usual residence Mc Cammon, Idaho

19. PLACE OF BURIAL OR REMOVAL: Portage Ut — DATE OF BURIAL: 0 March
20. UNDERTAKER: Ed L Eglin — ADDRESS: Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

BYNG - YORK CO., PTRS. & BDRS. 24652

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33732

Registered No. 7

RECEIVED
APR 27 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH. Registration District No. 7 21

County of Bingham Primary Registration District No. 2142

City of Blackfoot No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Johnny Hughes

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Aug (Month) 17 (Day) 1914 (Year)

7. AGE: 7 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none.
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: Charles Hughes

11. BIRTHPLACE OF FATHER (State or Country): Indiana

12. MAIDEN NAME OF MOTHER: Mary Velie

13. BIRTHPLACE OF MOTHER (State or Country): Indiana.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) .....

15. Filed Mar 7 1921 ..... Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mch. (Month) 5 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 1921, to Mch 5 1921, that I last saw h[illegible] alive on Mch 5 1921, and that death occured on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:
Valvular Heart Disease
Mytial Insufficiency

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Rheumatism

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. J. Summers M. D.

3 7 1921 (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Groveland Cemetery | DATE OF BURIAL: March 1921

20. UNDERTAKER: E J Funk | ADDRESS: Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33733
Registered No.

1. PLACE OF DEATH

Registration District No. 121
Primary Registration District No. 1027
County of Bingham
City of Blackfoot (No. 686 So Main St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

APR 21 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME Elanine Robertson

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: ~~Single~~ (Write the word.)

6. DATE OF BIRTH: March (Month) 9 (Day) 1921 (Year)

7. AGE: \ Yrs. \ Mos. \ ds.
IF LESS than 1 day how many \ hrs. or 15 min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: C. Clifford Robertson

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Gwyn Williams

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. Clifford Robertson
(Address) Blackfoot, Idaho

15. Filed Mar 10 1921 Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 9 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 9 1921, to Mar 9 1921, that I last saw her alive on Mar 9 1921, and that death occurred on the date stated above, at 8:50 P.M.

The CAUSE OF DEATH* was as follows:

(Instrumental)
Protracted Delivery 1
(Duration) Yrs. mos. ds.
Contributory (Secondary) Contracted prior
(Duration) yrs. mos. ds.

(Signed) W W Beck M. D.
3/10 1921 (Address) Blackfoot, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Grove City Cem. DATE OF BURIAL: March 12 1921

20. UNDERTAKER: Eddy & Lee ADDRESS: Blackfoot

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bingham Registration District No.

City of Arco (No. St.) Primary Registration District No.

File No. 33734

Registered No.

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Eva Shutt.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F	W.	

6. DATE OF BIRTH: July (Month) 24 (Day) 1914 (Year)

7. AGE: 7 Yrs. 7 Mos. 21 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ida.

10. NAME OF FATHER: Jacob. Shutt

11. BIRTHPLACE OF FATHER (State or Country): Ida.

12. MAIDEN NAME OF MOTHER: Edith Dawson.

13. BIRTHPLACE OF MOTHER (State or Country): Mich

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Jacob. Shutt.
(Address): Arco

15. Filed March 16 1921 Mrs Nalen E. Patrick Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar (Month) 15 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3/13/ 1921, to 3/15 1921
that I last saw h[illegible] alive on 3/15 19.....
and that death occurred on the date stated above, at 4 a M.
The CAUSE OF DEATH* was as follows:
Bronchio Pneumonia

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) F M Cannon M. D.

19..... (Address) Arco

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Grove City Cem.	19.....

20. UNDERTAKER: Ed. L. Eglin ADDRESS: Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK ▶ THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 1007
File No. 33736
Registered No. 479

1. PLACE OF DEATH
County of Bingham
City of Blackfoot
(No. 60 Judicial 9 Myers St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs Adelia Bybee

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F	W	Widowed

6. DATE OF BIRTH: June (Month) 22 (Day) 1836 (Year)

7. AGE: 84 Yrs. 8 Mos. 17+ ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Canada

10. NAME OF FATHER: Myron Higley

11. BIRTHPLACE OF FATHER (State or Country): Connecticut

12. MAIDEN NAME OF MOTHER: Priscilla Hubbard

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Dora Turner
(Address) Blackfoot Idaho

15. Filed Mar 18 1921
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 18 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mch 13 1921, to Mch 18 1921, that I last saw h.er alive on Mch 17 1921, and that death occurred on the date stated above, at 6:20 A.M.

The CAUSE OF DEATH* was as follows:

Spinal Haemorrhage

(Duration) ..... Yrs. ..... mos. 4 ds.
Contributory (Secondary) Old age
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Joseph B Davis M. D.
3/18 1921 (Address) Blackfoot Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Idaho Falls
DATE OF BURIAL: 3/20 1921

20. UNDERTAKER: E J Funk
ADDRESS: Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED APR 24 BUREAU OF STATISTICS

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33737
Registered No. 42

1. PLACE OF DEATH. County of Bingham City of Blackfoot (If outside limits, give township) Registration District No. ..... Primary Registration District No. ..... No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Hannah Mare

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. (Month) (Day) (Year): 1881

7. AGE: 40 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Not known

11. BIRTHPLACE OF FATHER (State or Country): Not known

12. MAIDEN NAME OF MOTHER: Not known

13. BIRTHPLACE OF MOTHER (State or Country): Not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Records of Idaho Temple By: Martha E. Light Worker
(Address) Blackfoot, Ida

15. Filed ..... 191.....
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
March (Month) 19 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 12 1919, to March 19 1921, that I last saw her alive on March 19 1921 and that death occured on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

Heart Disease

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Mitral Valve Lesion with Dilatation

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Dr. N. J. Power M. D.

8-19 1924 (Address) Blackfoot, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 6 yrs. 9 mos. 11 days. In the State 12 yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? Not known
Former or usual residence Idaho Falls, Idaho

19. PLACE OF BURIAL OR REMOVAL: Idaho Falls — DATE OF BURIAL ..... 191.....

20. UNDERTAKER: Cliff Hayes — ADDRESS Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & STNRS. 24659

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED
APR 21 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 2194
File No. 33738
Registered No. 43

1. PLACE OF DEATH
County of Bingham
City of Blackfoot (No. Reed Lane St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Doris Irene Turner
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: August 21 (Month) (Day) 1919 (Year)

7. AGE: 1 Yrs. 7 Mos. 1 ds. IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho Falls Idaho

10. NAME OF FATHER: Joseph Moroni Turner

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Lula Clark

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. A. Turner
(Address) Blackfoot Idaho

15. Filed Mar 23 1921
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 22 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 13 1921, to March xx 1921, that I last saw her alive on March xx 1921 and that death occurred on the date stated above, at 3P M.
The CAUSE OF DEATH* was as follows:

Broncho Pneumonia
(Duration) ... Yrs. ... mos. ... ds.
Contributory (Secondary) Measles
(Duration) ... yrs. ... mos. 7 ds.

(Signed) W W Beck M. D.
3/23 1921 (Address) Blackfoot, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Grove City Cemetery | DATE OF BURIAL: Mar 24 1921
20. UNDERTAKER: Ed L Egli | ADDRESS: Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33739

Registered No. 42

RECEIVED
APR 21 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH. Registration District No. 121

County of Bingham Primary Registration District No. 2194

City of Blackfoot (If outside limits, give township) St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mina Reed

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. (Month) (Day) 1873 (Year)

7. AGE: 48 Yrs. — Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: Dont Know

11. BIRTHPLACE OF FATHER (State or Country): Dont Know

12. MAIDEN NAME OF MOTHER: Dont Know

13. BIRTHPLACE OF MOTHER (State or Country): Dont Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Records of Idaho Insane asylum Blackfoot Idaho
(Address) By Julius Thuer, Clerk

15. Filed March 25 1921 Mrs Nadine E. Petrie Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 23 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 17th 1921, to March 23rd 1921, that I last saw her alive on March 23rd 1921, and that death occured on the date stated above, at 5 a. M.

The CAUSE OF DEATH* was as follows:
Exhaustion due to Pyelitis
Ejected, Auto Infection

(Duration) Yrs. mos. 6 ds.

Contributory (Secondary) —
(Duration) Yrs. — mos. — ds.

(Signed) C. N. Brown M. D.
3/23 1921 (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. 6 days. In the State. 13 yrs. ... mos. ... days
Where was disease contracted if not at place of death? Dont Know
Former or usual residence Hagerman Idaho

19. PLACE OF BURIAL OR REMOVAL: Hagerman Id Rt — DATE OF BURIAL: 3-25 1921

20. UNDERTAKER: E T Peck — ADDRESS: Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & RBRS. 24658

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33740-

Registered No. 45

1. PLACE OF DEATH

County of Bingham

City of

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
APR 21 1921
BUREAU OF VITAL STATISTICS

Registration District No.

Primary Registration District No.

(No.) 2½ (St.) Miles West of Moreland

2. FULL NAME Elmer Wallace Loebsack

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH: Oct 12 (Month) (Day) 1919 (Year)

7. AGE: 1 Yrs. 5 Mos. 7 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Tabor Idaho

10. NAME OF FATHER: George H Loebsack

11. BIRTHPLACE OF FATHER (State or Country): Russia

12. MAIDEN NAME OF MOTHER: Ida Grim

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) George H Loebsack
(Address) Tabor, Idaho.

15. Filed March 29 1921 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 24 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Suffocation caused by the overturning of a load of hay

(Accidental) (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Ed L. Egli Coroner M. D.

3/25 1921 (Address) Blackfoot Bingham Co Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Moreland Cemetery	Mar 30 1921

20. UNDERTAKER	ADDRESS
Ed L Egli	Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

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MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33741

Registered No. 46

1. PLACE OF DEATH

County of Bingham Registration District No. 121

City of Blackfoot (If not in city give township) Primary Registration District No. 1007

STATISTICS 3 Park St (If in hospital, institution or camp, give its NAME instead of street and number.) St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Eskel Alvord

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: June (Month) 10 (Day) 1887 (Year)

7. AGE: 33 Yrs. 9 Mos. 15 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Henry Blair

11. BIRTHPLACE OF FATHER (State or Country): New York State

12. MAIDEN NAME OF MOTHER: Anna Nastrom

13. BIRTHPLACE OF MOTHER (State or Country): Michigan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jon Edmond Alvord

(Address) Blackfoot Idaho

15. Filed March 25 1921 Mrs Nalen E. Peterson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 25 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 8 1921, to March 25 1921, that I last saw h.er alive on March 24 1921, and that death occurred on the date stated above, at 10.40 A.M.

The CAUSE OF DEATH* was as follows:

Diffuse Nephritis (Chronic)

(Duration) 4 Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) W W Beck M. D.

3/25 1921 (Address) Blackfoot, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Riverside cemetery — DATE OF BURIAL: March 26 1921

20. UNDERTAKER: E J Peck — ADDRESS: Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 2194
File No. 33742
Registered No. 47

1. PLACE OF DEATH
County of Bingham
City of Blackfoot
(No. R F D 2-1 Rum St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lelah Marie Madsen
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Nov (Month) 28 (Day) 1919 (Year)

7. AGE: 1 Yrs. 3 Mos. 29 ds.
IF LESS than 1 day: how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: P R Madsen

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Martha Petersen

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) P. R. Madsen
(Address)

15. Filed March 28 1921 Mrs. Nalen E. Watson Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 27 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 15 1921 to March 27 1921 that I last saw h. alive on March 27 1921 and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:
Pneumonia (Bronchial)
Nephritis (acute)

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) measles.
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. J. Lemmon M. D.
3/28 1921 (Address) Blackfoot Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Groveland, Idaho | DATE OF BURIAL: March 29 1921

20. UNDERTAKER: E J Funk | ADDRESS: Blackfoot

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 3374

Registered No.

1. PLACE OF DEATH

County of Bingham — Registration District No. 121

City of Blackfoot — Primary Registration District No. 2194

(Thomas — St.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED APR 21 1921 BUREAU OF VITAL STATISTICS

2. FULL NAME Frances Louise Crofts

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Dec (Month) 8 (Day) 1889 (Year)

7. AGE: 31 Yrs. 3 Mos. 21 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: At home

(b) General nature of industry, business or establishment in which employed (or employer): Housewife

9. BIRTHPLACE (State or Country): Orderville, Utah

10. NAME OF FATHER: Enos P. Fackrell

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Louise Fisher

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Enos P. Fackrell

(Address) Thomas.

15. Filed March 29 1921 Mrs Nalie E. Petrie Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 28 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 19 1920 to March 28 1921 that I last saw h.er alive on Dec 20 1920 and that death occurred on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Rt Breast

(Duration) 1 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W W Beck M. D.

Mar 29 1921 (Address) Blackfoot, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Thomas Riverside — DATE OF BURIAL: Mar 30 1921

20. UNDERTAKER: Ed L Egli — ADDRESS: Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33745
Registered No. [illegible]

1. PLACE OF DEATH
County of Bingham Registration District No. 121
City of Blackfoot Primary Registration District No. 1097
(If outside city limits, give township) (No. ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Delos Griffith Hale

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Sept. (Month) 19 (Day) 1902 (Year)

7. AGE: 18 Yrs. 6 Mos. 9 ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Perry Idaho

10. NAME OF FATHER: Orock C. Hale

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Elizabeth A Seamons

13. BIRTHPLACE OF MOTHER (State or Country): Hyde Park Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Orock C Hale
(Address) Blackfoot RD #1

15. Filed Mar 31 1921 Mrs. Ruth E. Fuller Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 28 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 25 1921 to March 28 1921, that I last saw him alive on March 28 1921, and that death occurred on the date stated above, at 11.45 M.
The CAUSE OF DEATH* was as follows:

Bowel Obstruction +
General Peritonitis
(Duration) ... Yrs. ... mos. 10 ds.
Contributory (Secondary) Appendicitis. Operated on 7th day of disease
(Duration) ... yrs. ... mos. 10 ds.

(Signed) W W Beck M. D.
Mar 31 1921 (Address) Blackfoot, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Riverside Cemetery — DATE OF BURIAL: Mar 31 1921
20. UNDERTAKER: Ed L Eyli — ADDRESS: Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-18

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33746
Registered No. 37

1. PLACE OF DEATH. APR 21 1921
BUREAU OF VITAL STATISTICS
Registration District No. 121
Primary Registration District No. 2194
County of Bingham
City of Blackfoot (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME George A. Hardy

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): widower
6. DATE OF BIRTH. March (Month) 23 (Day) 1853 (Year)
7. AGE: 67 Yrs. 11 Mos. 12 ds. IF LESS than 1 day how many ..... hrs. or ..... min.
8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): Some Eastern State
10. NAME OF FATHER: Dont Know
11. BIRTHPLACE OF FATHER (State or Country): Dont Know
12. MAIDEN NAME OF MOTHER: Dont Know
13. BIRTHPLACE OF MOTHER (State or Country): Dont Know
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Records Idaho Insane Asylum
(Address) Blackfoot Idaho
By James L Greer
15. Filed March-6 1921 Mrs Nadine E. Pat
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 5th (Day) 1921 (Year)
17. I HEREBY CERTIFY, That I attended deceased from February 5 1921, to March 5th 1921, that I last saw him alive on March 4th 1921, and that death occured on the date stated above, at 6.15 P.M.
The CAUSE OF DEATH* was as follows:
Septicaemia
(Duration) — Yrs. 1 mos. — ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) C. N. Gowen M. D.
3/6 1921 (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death. ..yrs. 1 mos. —days. In the State 15 yrs. —mos. —days
Where was disease contracted if not at place of death? Dont Know
Former or usual residence Shelley, Idaho

19. PLACE OF BURIAL OR REMOVAL: Asylum Cemetery — DATE OF BURIAL: 3/5/21 191
20. UNDERTAKER: C. J. Wright — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & STRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33747
Registered No. 52

1. PLACE OF DEATH. Registration District No. 121

County of Bingham Primary Registration District No. 2194

City of Blackfoot (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED APR 21 1921 BUREAU OF VITAL STATISTICS

2. FULL NAME Eda A. Bryant

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1862 (Year)

7. AGE: 59 Yrs. — Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Dont Know

11. BIRTHPLACE OF FATHER (State or Country): Dont Know

12. MAIDEN NAME OF MOTHER: Dont Know

13. BIRTHPLACE OF MOTHER (State or Country): Dont Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Records of Idaho Insane Asylum
(Address) Blackfoot Idaho
By Julius L Greer

15. Filed March 12 1921 Mrs Nadie E. Patterson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 11th 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 12th 1919 to March 11 1921, that I last saw her alive on March 11th 1921, and that death occured on the date stated above, at 11 a M.

The CAUSE OF DEATH* was as follows:
Exhaustion of Inanition
due to Chronic mania

(Duration) — Yrs. 1 mos. — ds.

Contributory (Secondary) .....
(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) C. N. Corn M. D.
3/11 1921 (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 9 yrs. 8 mos. 24 days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? Dont Know
Former or usual residence Thomas, Idaho Bingham County

19. PLACE OF BURIAL OR REMOVAL: Asylum Cemetery — DATE OF BURIAL: 3/12 1921

20. UNDERTAKER: C. F. Wright — ADDRESS: .....

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SVMB - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33748
Registered No. 53

1. PLACE OF DEATH.
County of Bingham
City of Blackfoot Ida (No. ....., ... St.)
Registration District No. 121
Primary Registration District No. 2194
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Richard Oliver

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): widower
6. DATE OF BIRTH. ~~March~~ ~~18th~~ ~~1848~~ (Month) (Day) (Year)
7. AGE: 73 Yrs. — Mos. — ds. IF LESS than 1 day how many ..... hrs. or ..... min.
8. OCCUPATION
(a) Trade, profession or particular kind of work: Tailor
(b) General nature of industry, business, or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): England
10. NAME OF FATHER: Dont Know
11. BIRTHPLACE OF FATHER (State or Country): Dont Know
12. MAIDEN NAME OF MOTHER: Dont Know
13. BIRTHPLACE OF MOTHER (State or Country): Dont Know
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Records of Idaho Insane Asylum Blackfoot Idaho
(Address) By Julius L Graer, clerk.
15. Filed March 18 1921 Mrs Nelle E Pabst Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 18th (Day) 1921 (Year)
17. I HEREBY CERTIFY, That I attended deceased from March 13 1919, to March 18th 1921, that I last saw him alive on March 17th 1921, and that death occured on the date stated above, at 5 a. M.
The CAUSE OF DEATH* was as follows:
Apoplexy due to Sclerosis
.....(Duration) ..... Yrs. ..... mos. 1 ds.
Contributory (Secondary) Chronic dementia
.....(Duration) 7 yrs. 8 mos. 5 ds.
(Signed) C A Hoover M. D.
3/18 1921 (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death. 1 yrs. 8 mos. 5 days. In the State 23 yrs. — mos. ..... days
Where was disease contracted if not at place of death? Dont Know
Former or usual residence Pocatello Idaho

19. PLACE OF BURIAL OR REMOVAL: Asylum Cemetery — DATE OF BURIAL: 3/18 1921
UNDERTAKER: C. G. Wright — ADDRESS:

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & STRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 2194
File No. 33749
Registered No. 54

1. PLACE OF DEATH.

County of Bingham
City of Blackfoot (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME David J. Hann

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): widower

6. DATE OF BIRTH. December (Month) 13th (Day) 1844 (Year)

7. AGE: 76 Yrs. 3 Mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): (Old Soldier)

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Dont Know

11. BIRTHPLACE OF FATHER (State or Country): Dont Know

12. MAIDEN NAME OF MOTHER: Dont Know

13. BIRTHPLACE OF MOTHER (State or Country): Dont Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Records of Idaho Insane Asylums
(Address) Blackfoot Idaho
By Julius L Green Clerk

15. Filed March 29 1921 Mrs Nellie E. Pate Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 28th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 21st 1921, to March 28th 1921, that I last saw h~~im~~ alive on March 27th 1921, and that death occured on the date stated above, at 7:30 A.M.

The CAUSE OF DEATH* was as follows:
Exhaustion of Paychosis Epileptic

(Duration) ..... Yrs. ..... mos. 7 ds.

Contributory (Secondary)

(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) C. A. Hoagne M. D.

3/28 1921 (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. 7 days. In the State. 10 yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? Dont Know

Former or usual residence: Idaho Soldiers Home Boise Idaho

19. PLACE OF BURIAL OR REMOVAL: Asylum Cemetery — DATE OF BURIAL: 3/29 191

20. UNDERTAKER: C. J. Hughes — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24658

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 32750
Registered No.

1. PLACE OF DEATH — RECEIVED MAY 9 - 1921 BUREAU OF VITAL STATISTICS
Registration District No. 85
Primary Registration District No. 2185
County of Bonner
City of Priest river (St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Carl J. Lythman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widowed (Write the word.)

6. DATE OF BIRTH: Dec 31 1846 (Month) (Day) (Year)

7. AGE: 75 Yrs. 3 Mos. 27 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Carpenter
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER: ~~Unknown~~ Gustav Lythman

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Not known

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) [signature]
(Address) Priest River Ida.

15. Filed May 9 1921 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 27 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 10 1920, to April 27 1921 that I last saw him alive on April 26 1921, and that death occurred on the date stated above, at 3.20 P.M.
The CAUSE OF DEATH* was as follows:

Chronic Cystitis

(Duration) ..... Yrs. 10 mos. ..... ds.

Contributory (Secondary) Hypertrophic Prastate

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [signature] M. D.

28 April 1921 (Address) Priest River, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Priest River — DATE OF BURIAL: April 29 21

20. UNDERTAKER: [illegible] — ADDRESS: Bonners Ferr.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

RECEIVED MAY Idaho

PLACE OF DEATH

Washington State Board of Health

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Record No. 33751

Registered No.

County of Bonner

City or Town of Newport

Registration Dist No. ..... No. ....., ...
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2. FULL NAME Geneva Yelsie Ayers

(a) Residence No. ..... St.;
(Usual place of abode)

(b) If non-resident, give city or town, and state .....

(c) How long in Registration Dist. ..... yrs. ..... mos. ..... ds.; how long in U. S. if of foreign birth ..... yrs. ..... mos. ..... ds.

Personal and Statistical Particulars

3. Sex	4. Color or Race	5. Single, Married, Widowed or Divorced (Write the word)
female	White	single

6. (a) If married, widowed, or divorced:
Husband of .....
or
Wife of .....

6. Date of birth: Feb (Month) 14 (Day) 1921 (Year)

7. Age: ..... yrs. 1 mos. 18 ds. If less than one day ..... hrs. ..... or min.

8. Occupation of deceased:
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. Birthplace (City or town) .....
(State or Country) Idaho

PARENTS

10. Name of Father Clarence W.
11. Birthplace of Father (City or town) (State or Country) Mich
12. Maiden name of Mother Nellie McIntosh
13. Birthplace of Mother (City or town) (State or Country) Wash.

14. Informant Clarence W.
Address Newport Ida.

15. Filed ..... 1921 ..... Registrar

Medical Certificate of Death

16. Date of death April 1 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 13, 1921, to April 1, 1921
that I last saw her alive on April 1, 1921
and that death occurred on the date stated above, at 12 45 m.
(State the disease causing death, or, in deaths from violent causes, state: (1) Means and nature of injury; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL).
The CAUSE OF DEATH was as follows:

READ DETAILS ON OTHER SIDE

(Primary) Whooping Cough
(See 1 and 3 other side)

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Poorly nourished.
(See 2 other side)

(Duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at the place of death? .....

(a) Did an operation precede death? ..... Date of .....

(b) Was there an autopsy? .....

(c) What test confirmed diagnosis? .....

(Signed) Dr. V. C. Cleveland M. D.

April 2, 1921 Address Newport.

19. Place of Burial, Cremation or Removal: Newport. Date of Burial: April 2, 1921

20. Undertaker: William Davis Address: Newport.

I HEREBY CERTIFY, upon honor, That I have made the effort but was unable to secure answers to questions ..... (Insert numbers of unanswered questions)

(Signature of Undertaker)

V. S. No. 1—30M—3-20

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33752
Registered No. 31

RECEIVED
APR 21 1927
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Bonneville — Registration District No. 73
City of Ida Falls — Primary Registration District No. 21-0
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Peter Anderson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH: April (Month) 14 (Day) 1870 (Year)

7. AGE: 50 Yrs. 11 Mos. 0 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER: Andrew Anderson

11. BIRTHPLACE OF FATHER (State or Country): Sweden.

12. MAIDEN NAME OF MOTHER: Sarah Peterson

13. BIRTHPLACE OF MOTHER (State or Country): Sweden.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Peterson
(Address) R.D. 1 Ririe

15. Filed Dec 29 1927 — Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 13 (Day) 1927 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 14 1927, to Mar 13 1927, that I last saw him alive on Mar 7 1927, and that death occurred on the date stated above, at 2a M.

The CAUSE OF DEATH* was as follows:
Carcinoma - inoperable stomach
(Duration) ? Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C Townsend M. D.
3/18 1927 (Address) Idaho Falls Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: New Sweden — DATE OF BURIAL: 3/18 1927

20. UNDERTAKER: C Edmundson — ADDRESS: Ida Falls

McKinnard

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33753
Registered No. 30

RECEIVED
APR 21 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
Registration District No. 73
Primary Registration District No. 21 V-D
County of Bonneville
City of Idaho Falls (If outside limits, give township) Gen. Hosp. St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Fredrick R. O'Brien
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH: April (Month) 8 (Day) 1887 (Year)

7. AGE: 33 Yrs. 11 Mos. 16 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Linotype Operator
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: James C. O'Brien

11. BIRTHPLACE OF FATHER (State or Country): N. Y.

12. MAIDEN NAME OF MOTHER: Eliza McDonald

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ted Crabtree
(Address) Idaho Falls

15. Filed Mar. 29 19 21 [signature] Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 25 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar. 16 1921, to March 25 1921, that I last saw h.im alive on March 25 1921 and that death occurred on the date stated above, at 6 P M.

The CAUSE OF DEATH* was as follows:
Acute suppurative Pancreatitis.
(Duration) ..... Yrs. ..... mos. 24 hrs ..... ds.
Contributory (Secondary) Suppuration Peptic ulcer
(Duration) ..... yrs. ..... mos. 9 ..... ds.

(Signed) H. D. Hurtin M. D.
3/25 1921 (Address) Idaho Falls Id.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence Ship

19. PLACE OF BURIAL OR REMOVAL: Des Moines, Iowa
DATE OF BURIAL: 3/28 1921

20. UNDERTAKER: C. E. Dunwoody
ADDRESS: Ida Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33754

1. PLACE OF DEATH

County of Bonneville RECEIVED Registration District No. 73

City of Idaho Falls APR 21 1921 Primary Registration District No. 21 N-0

(No. , St.)

Registered No. 29

If death occurs away from usual residence, give facts called for under special information. BUREAU OF VITAL STATISTICS

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ralph Fern Newman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH: Dec (Month) 10 (Day) 1904 (Year)

7. AGE: 16 Yrs. 2 Mos. 10 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Milo Idaho

10. NAME OF FATHER: Albert D Newman

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Julia Anderson

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A.D. Newman
(Address) RD 2 Rigby Ida

15. Filed Mar 29 1921 C.E. Linnard Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 20 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feby 28 1921 to March 20 1921, that I last saw h.im alive on March 20 1921, and that death occurred on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Ray Fisher M. D.

3/21 1921 (Address) Rigby Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Milo Idaho	3/23 1921
20. UNDERTAKER	ADDRESS
C E Linnard	Ida Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED APR 21 19[illegible]
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33755

Registered No. 22

1. PLACE OF DEATH. Registration District No. 73

County of Bonneville Primary Registration District No. 2170

City of Idaho Falls (If not in city give village or township) Ward or Precinct No. Chamberlain St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Infant Hill

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. (Month) Dec (Day) 8 (Year) 1920

7. AGE: Yrs. ..... Mos. 23 ds. ..... IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho Falls Ida.

10. NAME OF FATHER: R J Hill

11. BIRTHPLACE OF FATHER (State or Country): Idaho Falls

12. MAIDEN NAME OF MOTHER: Martha Eaton

13. BIRTHPLACE OF MOTHER (State or Country): Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Reuben J Hill
(Address) Idaho Falls Ida

15. Filed Mr 22 1921 C Hammond Local Registrar

SYMS - YORK CO., PTRS. & STRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (Month) Jan (Day) 10 (Year) 1921

17. I HEREBY CERTIFY, That I attended deceased from Dec 8 1920, to Jan 10 1921, that I last saw him alive on Jan 8 1921, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Pyloric Stenosis.

from birth (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Harry L. Williams M. D.

1/16 1921 (Address) Idaho Falls, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rose Hill Cem

DATE OF BURIAL: Jan 11 1921

20. UNDERTAKER: Duffy & Hay

ADDRESS: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

Dr. Wilson

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED
APR 21 19
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 2130
File No. 33756
Registered No. 22

1. PLACE OF DEATH
County of Bonner
City of Idaho (No.) General Hospital St.),
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary Jefferys

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married
6. DATE OF BIRTH. Sept 3, 1877 (Month) (Day) (Year)
7. AGE: 43 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Home wife
(b) General nature of industry, business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Mo.
10. NAME OF FATHER: Lewis Igo,
11. BIRTHPLACE OF FATHER (State or Country): Dont Know.
12. MAIDEN NAME OF MOTHER: Lizzie Johnson,
13. BIRTHPLACE OF MOTHER (State or Country): ~~Dont~~ Mo
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Wm Jefferys.
(Address) Ned Bluewender,
15. Filed Mar 22 1921 C Kinnard Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. 23, 1921 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from Feb. 23 1921, to Feb. 23 1921, that I last saw h Sr alive on Feb. 23 1921, and that death occured on the date stated above, at 1:30 P.M.
The CAUSE OF DEATH* was as follows:
Died from burns received when a stove exploded
(Duration) ..... Yrs. ..... mos. 6hrs, ds.
Contributory (Secondary)
(Duration ..... Yrs. ..... mos. ..... ds.
(Signed) Harry L. Wilbaux M. D.
2/26 1921 (Address) Idaho Falls, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rose Hill Idaho Falls — DATE OF BURIAL: Feb 26 1921
20. UNDERTAKER: Sheff & Hayes — ADDRESS: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

Dr. Wilson

SYMS - YORK CO., PTRS. & STRS. 24658

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
APR 22 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33757
Registered No. 26

1. PLACE OF DEATH
County of Bannock Registration District No. 73
Primary Registration District No. 2150
City of R D 4 - Ida Dale (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Udora Foy Sant
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Infant

6. DATE OF BIRTH: January (Month) 27 (Day) 1921 (Year)

7. AGE: 0 Yrs. 0 Mos. 28 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: A. G. Sant

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Mabel J. Harris

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A G Sant
(Address) R D 4 Ida Dale

15. Filed Mar 21 1921 C E Turner Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feby (Month) 22 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at 5 P M.
The CAUSE OF DEATH* was as follows:

Pneumonia

..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary): Prematurity
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C E Clem M. D.
Mar 19 21 (Address) Lehman Bldg

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Arimon, Ida — DATE OF BURIAL: 3/25 1921

20. UNDERTAKER: C E Greenwood — ADDRESS: Ida Dale

Dr Clem.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

RECEIVED APR 6 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3375 8
Registered No. 21

1. PLACE OF DEATH
County of Bonneville Registration District No. 73
City of Idaho Falls Primary Registration District No. 21N-0
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Rosa Jane Garner
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Sep. (Month) 11 (Day) 1886 (Year)

7. AGE: 34 Yrs. 7 Mos. 1 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: at Home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: W. E. Hope

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Lucy Higley

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. L. Garner
(Address) R 4 - City

15. Filed Mar 21 1921 C. Kinnear Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 17 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from MARCH 11' 1921, to MARCH 12'21 19....., that I last saw h..or.... alive on MARCH 12'21 19....., and that death occurred on the date stated above, at 7a M.

The CAUSE OF DEATH* was as follows:
HEART BLOCK (ACUTE DILATATION)
INCIDENT TO LABOR

.....(Duration) .....Yrs.....mos.....ds.
Contributory (Secondary) CHRONIC ANATOMIC HEART LESION
VALVULAR INSUFFICIENCY
.....(Duration) MANY yrs.....mos.....ds.

(Signed) [signature] M. D.
3/14/1921 (Address) IDAHO FALLS, IDAHO.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State .....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Idaho Falls	3/18 19 21
20. UNDERTAKER	ADDRESS
C. Townsend	Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY; PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

Per Comet

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
APR 5 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 73

County of Bannock Primary Registration District No. 2110

City of Idaho Falls (or Town) St.)

File No. 33759

Registered No. 24

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Etta May Allen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Female	White	Married (Write the word.)

6. DATE OF BIRTH: Feby (Month) 17 (Day) 1886 (Year)

7. AGE: 35 Yrs. 0 Mos. 20 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Fillmore, Ut.

10. NAME OF FATHER: Virgil Baldwin

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Mary E. McLatchie

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Engnt Frank Allen
(Address) Montevieu, Ida

15. Filed Mar 21 1921 [signature] Local Registrar
L. Wilson

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 9 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 13 1921, to March 9 1921, that I last saw h.er alive on March 9 1921 and that death occurred on the date stated above, at 3.30 P.M.

The CAUSE OF DEATH* was as follows:
Pneumonia, from the bowels and
Puerperal Septicaemia

(Duration) ..... Yrs. ..... mos. 7 ds.
Contributory (Secondary) Puerperal Septicaemia
(Duration) ..... yrs. ..... mos. 35 ds.

(Signed) Harry L. Wilson M. D.
3/10 1921 (Address) Idaho Falls Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Idaho Falls	3/11 1921

20. UNDERTAKER: B G Dinwoody ADDRESS Ida Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3376
Registered No. 23

RECEIVED
APR 21 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
Registration District No. 73
Primary Registration District No. 2170
County of Bonneville
City of Idaho Falls (If outside limits, give township.) St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Gene Francis Wells

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Male	White	Infant (Write the word.)

6. DATE OF BIRTH: Oct (Month) 9 (Day) 1919 (Year)

7. AGE: 1 Yrs. 5 Mos. 22 ds. IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER J F Wells

11. BIRTHPLACE OF FATHER (State or Country) Ohio

12. MAIDEN NAME OF MOTHER Vera Wiggins

13. BIRTHPLACE OF MOTHER (State or Country) Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J F Wells
(Address) City

15. Filed Mar 21 1921 [illegible] Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jany (Month) 31 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 27 1921 to Jan 31 1921 that I last saw h[illegible] alive on 31 Jan. 1921 and that death occurred on the date stated above, at 11-55 P M.

The CAUSE OF DEATH* was as follows:
Pneumonia
(Duration) ... Yrs. ... mos. 12 ds.
Contributory (Secondary) Fever
(Duration) ... yrs. ... mos. ... ds.

(Signed) [illegible] M. D.
Jan 31 1921 (Address) Idaho Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Idaho Falls	Jan 2 1921
20. UNDERTAKER	ADDRESS
C E Linnwood	Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
MAR 21 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bonneville Registration District No. 73

Primary Registration District No. 21 N-0

File No. 33761

City of Idaho Falls (No. ..... St.)

Registered No. 22

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Still Taylor

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: July (Month) 1 (Day) 1887 (Year)

7. AGE: 33 Yrs. 7 Mos. 8 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Rigby, Ida

10. NAME OF FATHER: George Still

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Delia Harmon

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Geo Still

(Address) Rigby, Ida

15. Filed Mar 21 1921 C. E. Kinnaird Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feby (Month) 9 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 14 1920, to Feb 9 1921, that I last saw h.r alive on Feb 9 1921, and that death occurred on the date stated above, at 9 P M.

The CAUSE OF DEATH* was as follows:

Pleurisy

(Duration) 1 Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.

2/17 1921 (Address) Idaho Falls, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rigby, Ida — DATE OF BURIAL: 2/17 1921

20. UNDERTAKER: B. Dunwoody — ADDRESS: Idaho Falls

Dr. Clint

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

RECEIVED APR 2 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH — Registration District No. 73
County of Bannock — Primary Registration District No. 2170
City of Dona (No. ..... St.)
File No. 33762
Registered No. 21

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Antone albert Patelzick

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Infant

6. DATE OF BIRTH — Nov (Month) 22 (Day) 1920 (Year)

7. AGE — 0 Yrs. 2 Mos. 26 ds. — IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business or establishment in which employed (or employer) —

9. BIRTHPLACE (State or Country) Dona, Ida

10. NAME OF FATHER W. J. Patelzick

11. BIRTHPLACE OF FATHER (State or Country) Idaho

12. MAIDEN NAME OF MOTHER Polly Collier

13. BIRTHPLACE OF MOTHER (State or Country) Mont.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. J. Patelzick
(Address) Dona, Ida

15. Filed Nov 21 1921 — Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH — Febry (Month) 17 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at 1230 P. M.
The CAUSE OF DEATH* was as follows:

Pneumonia

no physician

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas Turnbull M. D.
2/17 1921 (Address) Idaho Falls Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Dona, Ida	2/19 1921

20. UNDERTAKER	ADDRESS
E. E. Hunnicutt	Idaho Falls

Note

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
APR 21 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33763
Registered No. 20

1. PLACE OF DEATH
County of Bonneville Registration District No. 73
Primary Registration District No. 2170
City of Iona St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Henry Stothard

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Dec 6 1862 (Month) (Day) (Year)

7. AGE: 58 Yrs. 2 Mos. 19 ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farming
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: Henry Stothard

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Mary Ann Crane

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Mrs A Wolf
(Address): Iona Ida

15. Filed Mar. 21 1921 Wm Townsend Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feby 25 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ... 19..., to ... 19...,
that I last saw h... alive on ... 19...,
and that death occurred on the date stated above, at 4 P.M.
The CAUSE OF DEATH* was as follows:
Paralytic Stroke
No physician for one Year
(Duration) ... Yrs. ... mos. ... ds.
Contributory (Secondary)
(Duration) ... yrs. ... mos. ... ds.
(Signed) Wm Townsend M. D.
2/26 1921 (Address) Idaho Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Iona Ida
DATE OF BURIAL: 2/28 1921

20. UNDERTAKER: B. C. Linnoway
ADDRESS: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
APR 21 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 73

County of Bonneville — Primary Registration District No. 2176

City of Idaho Falls (St.)

File No. 33764

Registered No. 19

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ollie Brosier

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH: Aug. (Month) 6 (Day) 1846 (Year)

7. AGE: 74 Yrs. 5 Mos. 6 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Stone Idaho

10. NAME OF FATHER: C W Brosier

11. BIRTHPLACE OF FATHER (State or Country): Michigan

12. MAIDEN NAME OF MOTHER: Effie Teague

13. BIRTHPLACE OF MOTHER (State or Country): North Carolina

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C W Brosier
(Address) R.F.D. 3 Box 45

15. Filed Mar 14 1921 — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Month March 13 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 12 1921, to March 13 1921
that I last saw h~~im~~ alive on March 13 1921,
and that death occurred on the date stated above, at 5 P.M.
The CAUSE OF DEATH* was as follows:
Whooping Cough

(Duration) ..... Yrs. ..... mos. 14 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H Dorfner M. D.
March 14 1921 (Address) Idaho Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Rest Haven Cem.	Mar 16 1921

20. UNDERTAKER: Sam — ADDRESS: —

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

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SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33765
Registered No. 1 A

RECEIVED
APR 21 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Bonneville Registration District No. 73
City of Ida Falls (No. ..... St.) Primary Registration District No. 12 10

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Harriet Thomas

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widowed

6. DATE OF BIRTH: Apr. (Month) 24 (Day) 1847 (Year)

7. AGE: 73 Yrs. 10 Mos. 9 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: at Home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Alabama

10. NAME OF FATHER: Thomas Lendbreck

11. BIRTHPLACE OF FATHER (State or Country): Alabama

12. MAIDEN NAME OF MOTHER: ? Powell

13. BIRTHPLACE OF MOTHER (State or Country): Alabama

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Mary C Baird
(Address) R.D. 1 - City

15. Filed Mar 8 1921 — Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 5 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 5 1921, to Mar 5 1921, that I last saw her alive on Mar 5 1921, and that death occurred on the date stated above, at 10 A M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. P. Shupe M. D.

19 ..... (Address) Ida Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Ogden, Ut — DATE OF BURIAL: 3/8 1921

20. UNDERTAKER: E Edenwooley — ADDRESS: Ida Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

RECEIVED
APR 21 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 2170
File No. 33766
Registered No. 17

1. PLACE OF DEATH.
County of Bonneville
City of Idaho Falls (If outside limits, give township) 34 7 22 St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Fred Wagner.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Don't Know (Month) (Day) 1 (Year)

7. AGE About 75 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Stone Mason.
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Austria

10. NAME OF FATHER: Don't Know.

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) A W Leed
(Address) Idaho Falls

15. Filed May 1 1921 [signature] Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 22. (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Senility.
.....
.....
.....
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) I S Rogers M. D.
19... (Address) Idaho Falls Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rose Hill Idaho Falls | DATE OF BURIAL: Jan 25 1921

20. UNDERTAKER: Jeff C Haynes | ADDRESS: Idaho Falls Ida

Dr. Rogers

FORM V. S. No. 5-25 M. 1-16-13

APR 21 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33768
Registered No. 17

1. PLACE OF DEATH. Registration District No. 73
County of Bonneville Registration District No. 2170
City of Idaho Falls (No. 555 Chamberlain St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Emma Jane Ferguson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Dec (Month) 24 (Day) 1920 (Year)

7. AGE: Yrs. 1 Mos. 7 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho Falls Ida

10. NAME OF FATHER: Roy Ferguson.

11. BIRTHPLACE OF FATHER (State or Country): Mo.

12. MAIDEN NAME OF MOTHER: ?

13. BIRTHPLACE OF MOTHER (State or Country): ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Roy Ferguson
(Address) Idaho Falls,

15. Filed May 1 1921 [signature] Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 9 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2-8-1921, to 2-9-1921, that I last saw h-- alive on 2-9-1921 and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) [signature] M. D.

19.... (Address) Idaho Falls Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rose Hill Idaho Falls
DATE OF BURIAL: 7/10 1921

20. UNDERTAKER: Siff Hayes
ADDRESS: Idaho Falls

Dr. Hostetler

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

RECEIVED MAY 10 1921 BUREAU OF VITAL STATISTICS

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 79

County of Boundary Primary Registration District No. 3156

File No. 33769

City of Indian Valley (or Village, or Township) St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Pierre Cudraeu

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Red

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: April (Month) 2 (Day) 1921 (Year)

7. AGE: ... yrs. ... mos. ... ds.

IF LESS than 1 day how many ... hrs. or ... mins.: 3 hrs.

8. OCCUPATION
(a) Trade, profession or particular kind of work: ~
(b) General nature of industry business, or dstablishment in which employed (or employer): ~

9. BIRTHPLACE (State or Country): Boundary Co. Idaho.

10. NAME OF FATHER: Pierre Cudraeu

11. BIRTHPLACE OF FATHER (State or Country): Bonners Ferry, Ida.

12. MAIDEN NAME OF MOTHER: Magdalene Francois

13. BIRTHPLACE OF MOTHER (State or Country): Bonners Ferry Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Murrett S. Fisher
(Address) Bonners Ferry, Ida

15.

Filed ... 191 ... Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: April (Month) 2 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ... 191..., to ... 191..., that I last saw h... alive on ... 191..., and that death occurred on the date stated above, at ... M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

... (Duration) ... yrs. ... mos. ... ds.

Contributory (Secondary)

... (Duration) ... yrs. ... mos. ... ds.

(Signed) ... M. D.

... 19... (Address) ...

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Indian cemetery

DATE OF BURIAL: April 2 1921

20. UNDERTAKER: Ira Adams

ADDRESS: Bonners Ferry Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

RECEIVED MAY 16 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33770
Registered No.

1. PLACE OF DEATH. Registration District No. 79
County of Boundary Primary Registration District No. 3156
City of Bonners Ferry (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Don W Robinson

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH: Unknown (Month) 1 (Day) (Year)

7. AGE: about 60 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *mins.*

8. OCCUPATION
(a) Trade, profession or particular kind of work: Trackwalker
(b) General nature of industry business, or dstablishment in which employed (or employer): G. N. Ry. Co.

9. BIRTHPLACE (State or Country): Unknown

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C B Stookey
(Address) Bonners Ferry Ida

15.
Filed Apr. 4th 1921. E E Fry, Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Apr. (Month) 3 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar. 23rd. 1921, to Apr. 3rd 1921, that I last saw him alive on Apr. 3rd 1921, and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:
Senile gangrene of leg.

(Duration) ..... yrs. ..... mos. 7 ds.
Contributory (Secondary) Arterio sclerosis.
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E E Fry M. D.
4/4 1921. (Address) Bonners Ferry, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. 10 days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence Sonia, Idaho.

19. PLACE OF BURIAL OR REMOVAL: Bonners Ferry Ida | DATE OF BURIAL: Apr. 5 1921

20. UNDERTAKER: C B Stookey | ADDRESS: Bonners Ferry Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

RECEIVED MAY 10 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33771
Registered No.

1. PLACE OF DEATH.
Registration District No. 79
Primary Registration District No. 315-6
County of Boundary
City of Bonners Ferry (No. , St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Linus Benjamin Monday Wells

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	W	Single

6. DATE OF BIRTH: March (Month) 11 (Day) 1907 (Year)

7. AGE: 14 yrs. — mos. 25 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Scholar
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Colorado

10. NAME OF FATHER: A. E. Wells

11. BIRTHPLACE OF FATHER (State or Country): Wyo.

12. MAIDEN NAME OF MOTHER: Adda Bellows

13. BIRTHPLACE OF MOTHER (State or Country): Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. A. E. Wells
(Address) Bonners Ferry Ida

15. Filed April 6th 1921. E E Fry Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Apr (Month) 5 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar. 22 nd 1921, to Apr. 5 - 1921, that I last saw h im alive on Apr. 4th 1921, and that death occurred on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:
Mitral and aortic insufficiency.

(Duration) 2 yrs. mos. ds.
Contributory (Secondary) Whooping cough -
(Duration) yrs. mos. ds.

(Signed) E E Fry M. D.
4/6/1921 (Address) Bonners Ferry, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. 7 days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death?
Former or usual residence Bonners Ferry, Ida.

19. PLACE OF BURIAL OR REMOVAL: Bonners Ferry Ida — DATE OF BURIAL: Apr 7 1921

20. UNDERTAKER: C Hookey — ADDRESS: Bonners Ferry Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
MAY 10 1921
BUREAU OF STATISTICS

1. PLACE OF DEATH. Registration District No. 79
County of Boundary Primary Registration District No. 5156
City of Bonners Ferry (If outside limits, give township) St.)
File No. 33772
Registered No.
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Klinger

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH: Unknown (Month) 1 (Day) (Year)

7. AGE: about 100 yrs. mos. ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Unknown
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Unknown

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant)
(Address)

15. Filed Apr. 9 1921 E E Frazier Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: April (Month) 9 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191..., that I last saw h... alive on ..... 191..., and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Homicide
Head severed from body by Train
(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E. E. Saunders Coroner
4/9/1921 (Address) Bonners Ferry Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Bonners Ferry Ida — DATE OF BURIAL: Apr. 11 1921

20. UNDERTAKER: [illegible] — ADDRESS: Bonners Ferry

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

GYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33773
Registered No.

RECEIVED
MAY 16 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH. Registration District No. 79.
County of Boundary Primary Registration District No. 715-6
City of Bonners Ferry (If outside city limits, give township) St.)
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Denis Moricee

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH: January (Month) 16 (Day) 1906 (Year)

7. AGE: 15 yrs. 2 mos. 21 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: School Boy
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Washington

10. NAME OF FATHER: J. A. Moricee

11. BIRTHPLACE OF FATHER (State or Country): Ontario, Canada

12. MAIDEN NAME OF MOTHER: Mat Browning

13. BIRTHPLACE OF MOTHER (State or Country): Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. A. Moricee
(Address) Naples

15.
Filed Mar. 11th 1921 E E Fry Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March (Month) 9 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 2nd 1921, to March 9 1921, that I last saw him alive on March 9 1921, and that death occurred on the date stated above, at 12.10 P.M.

The CAUSE OF DEATH* was as follows:
Tuberculas meningetis

(Duration) yrs. mos. 7 ds.
Contributory (Secondary) Influenza
(Duration) yrs. mos. 14 ds.

(Signed) E E Fry M. D.
Mar 9 1921 (Address) Bonners Ferry

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: McArthur, Ida — DATE OF BURIAL: Mar. 12 1921

20. UNDERTAKER: O. R. Stookey — ADDRESS: Bonners Ferry

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 79

County of Boundary Registration District No. 2156

City of Bonners Ferry (No. ..... St.)

File No. 33774

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Clara Abraham Sweet

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	W	Married

6. DATE OF BIRTH: Nov (Month) 22 (Day) 1880 (Year)

7. AGE: 40 yrs. 3 mos. 29 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Teamster
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Mich

10. NAME OF FATHER: William Henry Sweet

11. BIRTHPLACE OF FATHER (State or Country): Mich.

12. MAIDEN NAME OF MOTHER: Polly Matilda Gilbert

13. BIRTHPLACE OF MOTHER (State or Country): Mich

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. A. Sweet
(Address) Bonners Ferry Ida

15. Filed Mar. 28 - 1921. E E Fry Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March (Month) 24 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191..., that I last saw h..... alive on ..... 191..., and that death occurred on the date stated above, at 11 P M.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis

(Duration) 3 yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Randolph Davis M. D.
March 29 1921 (Address) Bonners Ferry, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Bonners Ferry Ida — DATE OF BURIAL: Mar 27 1921

20. UNDERTAKER: C R Stookey — ADDRESS: Bonners Ferry

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33775
Registered No.

RECEIVED
MAY 9 - 1921
BUREAU OF VITAL STATISTICS
STATE OF IDAHO

1. PLACE OF DEATH
County of Butte District No. 59
Primary Registration District No. 2129
City of Moore (No.) St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elmer Charles Morgan
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Oct. (Month) 7 (Day) 1884 (Year)

7. AGE: 36 Yrs. 6 Mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Grand Forks, Utah

10. NAME OF FATHER: David Morgan

11. BIRTHPLACE OF FATHER (State or Country): Wales

12. MAIDEN NAME OF MOTHER: Elizabeth Prior

13. BIRTHPLACE OF MOTHER (State or Country): Wales.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Ruby J Morgan
(Address) Moore, Ida.

15.
Filed ..... 19 .....
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr. (Month) 12 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 2 1921 to 4-12-1921 that I last saw him alive on 4-12-1921 and that death occurred on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ..... Yrs. ..... mos. 12 ds.

Contributory (Secondary) Pleurisy Lues,

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A M Cameron M. D.

4/12/1921 (Address) Arco, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Grand Forks, Utah
DATE OF BURIAL: 4/15/1921

20. UNDERTAKER: L. L. Ogle
ADDRESS: Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH 59

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33776
Registered No.

RECEIVED
MAY 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
Registration District No.
County of Butte
Primary Registration District No. 2129
City of Arco (No. St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Edwin Shaw

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (or Widowed)

6. DATE OF BIRTH: Mar. 16 1871 (Month) (Day) (Year)

7. AGE: 50 Yrs. 1 Mos. 1 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: Wm Shaw

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: unknown

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mattie Shaw
(Address) arco

15. Filed 4/18/21 19.... F. M. Cannon Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr 17, 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3-1- 1921, to 4-17- 1921 that I last saw him alive on 4-17- 1921 and that death occurred on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(Duration) Yrs. 6 mos. ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed) F. M. Cannon M. D.

4/17 1921 (Address) arco

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: arco — DATE OF BURIAL: 4/18/1921

20. UNDERTAKER: Hall Bros — ADDRESS: arco

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33777
Registered No.

1. PLACE OF DEATH
County of Butte
City of Arco (St.)
If death occurs away from usual residence, give facts called for under special information.

RECEIVED MAY 4 1921 BUREAU OF VITAL STATISTICS

Registration District No.
Primary Registration District No.

2. FULL NAME German Grant Long
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Mar 17, 1902 (Month) (Day) (Year)

7. AGE: 19 Yrs. 1 Mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: High School
(b) General nature of industry, business or establishment in which employed (or employer): student.

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Orrie Long

11. BIRTHPLACE OF FATHER (State or Country): Arkansas

12. MAIDEN NAME OF MOTHER: Elora Marshall

13. BIRTHPLACE OF MOTHER (State or Country): Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Orrie Long
(Address): Arco

15. Filed, 5/21/ 1921
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr. 19 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 16 1921 to Apr. 19 1921
that I last saw him alive on Apr. 19 1921
and that death occurred on the date stated above, at 12:15 M.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of Stomach
(Duration) ..... Yrs. ..... mos. 3 ds.
Contributory (Secondary): Myocarditis
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) P. M. Cannon M. D.
4/19/1921 (Address) Arco Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Arco, Ida
DATE OF BURIAL: 4/20/1921

20. UNDERTAKER: Long
ADDRESS: Arco

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33778
Registered No.

Registration District No. 58d
Primary Registration District No. 2138
(No. St.)

RECEIVED
MAY 7 19
BUREAU

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Camas
City of Corral

2. FULL NAME No Name

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): single

6. DATE OF BIRTH: April (Month) 11d (Day) 1921 (Year)

7. AGE: ....Yrs. ....Mos. 0 ds.
IF LESS than 1 day how many ....hrs. or 20 min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Camas Co; Idaho.

10. NAME OF FATHER: Charles Clarence Barrow

11. BIRTHPLACE OF FATHER (State or Country): Pa.

12. MAIDEN NAME OF MOTHER: Laura Lloyd.

13. BIRTHPLACE OF MOTHER (State or Country): Pa.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Charles C Barrow
(Address) Corral, Idaho

15. Filed 4-17 1921 L Wilencheck Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 11d (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 11d 1921, to April 11d 1921 that I last saw h[illegible] alive on April 11d 1921 and that death occurred on the date stated above, at 6.50a M.

The CAUSE OF DEATH* was as follows:

Atelectasis.

....(Duration) ....Yrs. ....mos. ....ds.

Contributory (Secondary)

....(Duration) ....yrs. ....mos. ....ds.

(Signed) L Wilencheck M. D.

4-17 1921 (Address) Fairfield, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs. ....mos. ....days. In the State ....yrs. ....mos. ....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL ....19....

20. UNDERTAKER | ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33779

Registration District No. 7
Primary Registration District No. 2002
Registered No.

RECEIVED
MAY 10 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Canyon
City of Nampa (Ward, St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Eldora Mae Martin
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.):

6. DATE OF BIRTH: Apr (Month) 12 (Day) 1924 (Year)

7. AGE: — Yrs. — Mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: V
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Cecil Martin

11. BIRTHPLACE OF FATHER (State or Country): Ida

12. MAIDEN NAME OF MOTHER: Elsie Maloney

13. BIRTHPLACE OF MOTHER (State or Country): Montana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Maloney
(Address) Nampa Ida

15. Filed May 10 1921 Pearle Dodds Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr (Month) 19 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 12 1921 to April 19 1921 that I last saw her alive on April 19 1921, and that death occurred on the date stated above, at 10 P.M.
The CAUSE OF DEATH* was as follows:
Pneumonia

(Duration) ..... Yrs. ..... mos. 6 ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J H Murray M. D.
4/20 1921 (Address) Nampa Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Nampa Ida — DATE OF BURIAL: Apr 20 1921

20. UNDERTAKER: F K Robinson — ADDRESS: Nampa

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Mum

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

RECEIVED
MAY 10 1921
BUREAU OF VITAL STATISTICS

Registration District No. 7
Primary Registration District No. 2004
File No. 33780
Registered No.

County of Canyon
City of Melba (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Alva Cramer #1

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): single

6. DATE OF BIRTH: April 17 1921 (Month) (Day) (Year)

7. AGE: 0 Yrs. 0 Mos. 0 ds.
IF LESS than 1 day how many 25 hrs. or 30 min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business or establishment in which employed (or employer): none

9. BIRTHPLACE (State or Country): Melba, Id. Canyon Co.

10. NAME OF FATHER: William Jasper Cramer

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Persis Luella Tanner

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): William J Cramer
(Address): Melba Idaho

15. Filed May 13 1921 Pearl Dodds
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 18 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 17 1921, to April 18 1921, that I last saw h.im alive on April 18 1921, and that death occurred on the date stated above, at 11:30 A.M.

The CAUSE OF DEATH* was as follows:

Prematurity - 6½ mo.

(Duration) 0 Yrs. 0 mos. 0 ds. 30 min

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Samuel A Swayne M. D.

19 (Address) Melba, Id.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Melba Cemetery
DATE OF BURIAL: 4-18-1921

20. UNDERTAKER: none
ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
MAY 10 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 2006
File No. 3378[illegible]
Registered No.

1. PLACE OF DEATH
County of Canyon
City of Melba
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Baby Cramer ##2
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: April (Month) 17 (Day) 1921 (Year)

7. AGE: 0 Yrs. 0 Mos. 0 ds.
IF LESS than 1 day how many 0 hrs. or 10 min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business or establishment in which employed (or employer): none

9. BIRTHPLACE (State or Country): Melba, Ida. Canyon Co.

10. NAME OF FATHER: William Jasper Cramer

11. BIRTHPLACE OF FATHER (State or Country): [illegible] Utah

12. MAIDEN NAME OF MOTHER: Perais Luella Tanner

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) William J. Cramer
(Address) Melba Idaho

15. Filed May 10 1921 Pearle Dodds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 17 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 17 1921, to April 17 1921, that I last saw him alive on April 17 1921, and that death occurred on the date stated above, at 10:40 P.M.

The CAUSE OF DEATH* was as follows:
Prematurity, — 6½ mo.
Evisceration
10 min.
(Duration) 0 Yrs. 0 mos. 0 ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Samuel A Swayne M. D.
19..... (Address) Melba, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Melba Cemetery
DATE OF BURIAL: 4-18 1921

20. UNDERTAKER: None
ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-A—25 M. 1-19.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 2006
File No. 33782
Registered No.

1. PLACE OF DEATH

County of Canyon RECEIVED
City of Nampa MAY 10 (No. , St.)
BUREAU OF VITAL STATISTICS

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Charles Mack Parker

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	white	Married

6. DATE OF BIRTH: May (Month) 2 (Day) 1853 (Year)

7. AGE: 68 Yrs. Mos. ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Samuel Parker

11. BIRTHPLACE OF FATHER (State or Country): Penn

12. MAIDEN NAME OF MOTHER: Mary Loomis

13. BIRTHPLACE OF MOTHER (State or Country): N Jersey

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Roy S Parker
(Address) Nampa Rt

15. Filed May 10 1921 Pearle Dodds Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 5 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 29 1921 to May 5 1921 that I last saw him alive on May 5 1921, and that death occurred on the date stated above, at 10 20 AM.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy -
Hemiplegia

(Duration) Yrs. mos. 6 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) J H Murray M. D.

5/5 1921 (Address) Nampa Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Boise Valley Cem	5/6 1921
20. UNDERTAKER	**ADDRESS**
Fred L Robinson	Nampa

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33783

Registered No.

RECEIVED
MAY 10 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Canyon — Primary Registration District No. 2006 — Local Registration District No. 7

City of Nampa (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Frank Bradley

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Male	White	Single (Write the word.)

6. DATE OF BIRTH: Dec 1 (Month) ..... (Day) 1913 (Year)

7. AGE: 7 Yrs. 5 Mos. 19 ds. — IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Elmore Co. Idaho

10. NAME OF FATHER Ira Bradley

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Gertrude E Boyntn
(Address) Nampa, Idaho

15. Filed May 10 1921 Pearle Dodds Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 20 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 19 1921, to April 21 1921, that I last saw him alive on April 19 1921, and that death occurred on the date stated above, at 7 A. M.

The CAUSE OF DEATH* was as follows:

Tuberculosis

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) T.B. Meningitis

(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) Wm. R. Jones M. D.

May 4 1921 (Address) Nampa Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Nampa Ida	4/22 1921

20. UNDERTAKER	ADDRESS
F K Robinson	Nampa

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

7

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED MAY 10 1921 VITAL

Registration District No. 7
Primary Registration District No. 2004
File No. 33784
Registered No.

1. PLACE OF DEATH
County of Canyon
City of Nampa (No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Violet V Butt
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: May (Month) 18 (Day) 1893 (Year)

7. AGE: 28 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ida

10. NAME OF FATHER: Cole

11. BIRTHPLACE OF FATHER (State or Country): Boston Mass

12. MAIDEN NAME OF MOTHER: unknown

13. BIRTHPLACE OF MOTHER (State or Country): "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Lois Butt
(Address) Nampa, Ida.

15. Filed May 10 1921 Pearl Dodds Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr (Month) 11 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1920, to 4-7 1921 that I last saw h[er] alive on 4-7 1921, and that death occurred on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:

Dilitation of heart

(Duration) Yrs. 1 mos. ds.

Contributory (Secondary) Lesite infection - hereditary

(Duration) from a yr Constit mos. ds.

(Signed) H E Robinson M. D.

5-12 1921 (Address) Nampa

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Nampa Ida
DATE OF BURIAL: Apr 14 1921

20. UNDERTAKER: F K Robinson
ADDRESS: Nampa

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33785

Registered No.

1. PLACE OF DEATH

County of Canyon

City of Nampa (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 7

Primary Registration District No. 2011a

RECEIVED
MAY 10 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME Carol Lee

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Unknown ..... 1 (Month) (Day) (Year)

7. AGE: 64 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Canada

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Dr. Boyntes

(Address) Nampa Ida Co

15. Filed May 10 1921 Pearle Dodds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apl 27 (Month) ..... 27 (Day) ..... 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 9 1918, to Apl 27 1921, that I last saw her alive on Apl 27 1921, and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows: Chronic tuberculosis of lungs

(Duration) 3 Yrs. 2 mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Dr. Boyntes M. D.

4-27-1921 (Address) Nampa Ida Co

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 2 yrs. 10 mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? Nampa Ida Co

Former or usual residence Nampa Ida Co

19. PLACE OF BURIAL OR REMOVAL: Nampa Ida — DATE OF BURIAL: Apr 29 1921

20. UNDERTAKER: J K Robinson — ADDRESS: Nampa

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33786
Registered No.

1. PLACE OF DEATH

Registration District No. 7
Primary Registration District No. 2006

County of Canyon
City of Nampa (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
MAY 10 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME Wm. J. Bingaman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: April (Month) 29 (Day) 1877 (Year)

7. AGE: 44 Yrs. ..... Mos. 1 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kansas

10. NAME OF FATHER: William Bingaman

11. BIRTHPLACE OF FATHER (State or Country): Tenn

12. MAIDEN NAME OF MOTHER: Susan Ferguson

13. BIRTHPLACE OF MOTHER (State or Country): Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Basil Bingaman
(Address) Nampa Idaho

15. Filed May 10 1921 Pearle Dodds
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 30 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Called at time of death 19..... to 19.....
that I last saw h..... alive on ..... 19.....
and that death occurred on the date stated above, at 11:40 A.M.
The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis

(Duration) 12 Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. H. Murray M. D.
4/30 1921 (Address) Nampa Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Nampa Ida — DATE OF BURIAL: May 1 1921

20. UNDERTAKER: H. H. Robertson — ADDRESS: Nampa

Nampa

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33787

1. PLACE OF DEATH

Registration District No.

County of Canyon

Primary Registration District No. 8 10 K

City of Nampa (No. , St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

RECEIVED MAY 10 1921 BUREAU OF VITAL STATISTICS

2. FULL NAME John Ellis Marvin

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	

6. DATE OF BIRTH: Jan (Month) 17 (Day) 1850 (Year)

7. AGE: 71 Yrs. Mos. ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): N. Y.

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): "

12. MAIDEN NAME OF MOTHER: "

13. BIRTHPLACE OF MOTHER (State or Country): "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Louise Marvin
(Address) Nampa Ida.

15. Filed May 9 1921 Pearle Dodds Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 5 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 1920, to May 5 1921, that I last saw h[illegible] alive on May 5 1921, and that death occurred on the date stated above, at 3 40 P.M.

The CAUSE OF DEATH* was as follows:
Valvular heart disease and arterio-sclerosis

(Duration) one Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) George R. Proctor M. D.

5/6 1921 (Address) Nampa, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Nampa Idaho	5/8 1921
20. UNDERTAKER	**ADDRESS**
F. R. Robinson	Nampa Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33788
Registered No.

1. PLACE OF DEATH

Registration District No.
Primary Registration District No. 1 Dec

County of Canyon
City of Nampa (No. St.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
MAY 10 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME Ivana M. Smith

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Oct (Month) 28 (Day) 1902 (Year)

7. AGE: 19 Yrs. 6 Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kansas

10. NAME OF FATHER: Geo. D. Collins

11. BIRTHPLACE OF FATHER (State or Country): Ill

12. MAIDEN NAME OF MOTHER: Mary A. Hall

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) N. A. Smith
(Address) 1410 N 20 Boise Ida.

15. Filed May 10 1921 Pearle Dreier Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr (Month) 28 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apl. 20 - 1921 to Apl-28- 1921 that I last saw h[e] alive on Apl-27- 1921 and that death occurred on the date stated above, at 7 A. M.
The CAUSE OF DEATH* was as follows:
Pulmonary tuberculosis
(Duration) 1 Yrs. — mos. — ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) F. B. Smith M. D.
5/4 1921 (Address) Nampa Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Joplin Cem. near Meridian — DATE OF BURIAL: Apl 30 1921
20. UNDERTAKER: F. K. Johnson — ADDRESS: Nampa Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Smith

FORM V. S. No. 5-A—25 M. 1-19.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

RECEIVED
MAY 10 1921
BUREAU OF VITAL STATISTICS

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 1006
File No. 33789
Registered No.

1. PLACE OF DEATH
County of Canyon
City of Nampa (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William A Shupe

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word.): Married

6. DATE OF BIRTH
..... (Month) ..... (Day) 1 (Year)

7. AGE 57 ~~65~~ Yrs. 3 Mos. 7 ds.
IF LESS than 1 day how many..... hrs. or.....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wash

10. NAME OF FATHER: E Shupe

11. BIRTHPLACE OF FATHER (State or Country): Wis

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs V Jacobs
(Address) Nampa Ida

15. Filed May 10 1921 Pearle Dodds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Apr (Month) 11 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 7 1921, to Apr 11 1921, that I last saw him alive on Apr 11 1921, and that death occurred on the date stated above, at 10 M.

The CAUSE OF DEATH* was as follows:
Malpractice by Mrs Fosve Nampa Idaho
(Peritonitis from ruptured gall bladder
(Duration) 7 Yrs. X mos. 9 ds.
Contributory (Secondary) Gall stones
(Duration) 2 yrs. X mos. X ds.

(Signed) Horace C Baldwin M. D.
4/14 1921 (Address) Nampa Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Nampa Ida — DATE OF BURIAL: apr 14 1921

20. UNDERTAKER: F K Robinson — ADDRESS: Nampa

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

189-23

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 1556
File No. 33790
Registered No.

1. PLACE OF DEATH

County of Canyon RECEIVED
City of Nampa MAY 10 1921 (No. ..... St.)
BUREAU OF VITAL STATISTICS

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Juserial Bollschein

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Fem	white	Widow

6. DATE OF BIRTH ..... (Month) ..... (Day) 1843 (Year)

7. AGE 78 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Housekeeper
(b) General nature of industry, business or establishment in which employed (or employer) (Retired)

9. BIRTHPLACE (State or Country) Indiana

10. NAME OF FATHER Anthony Baldwin

11. BIRTHPLACE OF FATHER (State or Country) Indiana

12. MAIDEN NAME OF MOTHER Stephenson

13. BIRTHPLACE OF MOTHER (State or Country) Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Fred Davis
(Address) Nampa Ida

15. Filed May 10 1921 Pearle Dodds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH ..... Apr (Month) ..... 9 (Day) ..... 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mch 2nd 1921, to April 9 1921, that I last saw h.e.r. alive on Apr 8 1921, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Mitral Regurgitation
..... (Duration) ..... Yrs. — mos. — ds.
Contributory (Secondary) Acute Rheumatism
..... (Duration) 1 yrs. 6 mos. — ds.
(Signed) Lee N Shilton M. D.
..... 19..... (Address) Nampa Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Nampa Ida	4/11 1921
20. UNDERTAKER	ADDRESS
F K Robinson	Nampa

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33791

1. PLACE OF DEATH

Registration District No. 7

County of Canyon

Primary Registration District No. 1052

City of Nampa (No. ..... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

RECEIVED
MAY 10 1921
BUREAU OF VITAL STATISTICS
STATE OF IDAHO

2. FULL NAME Inger Julum

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Fem	white	Married

6. DATE OF BIRTH: Oct (Month) ..... (Day) 1875 (Year)

7. AGE: 45 Yrs. 5 Mos. ..... ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Minn

10. NAME OF FATHER M. Thorgenson

11. BIRTHPLACE OF FATHER (State or Country) Norway

12. MAIDEN NAME OF MOTHER Espeng

13. BIRTHPLACE OF MOTHER (State or Country) Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ole Julum
(Address) Nampa Ida

15. Filed May 13 1921 Pearle Dodds Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr (Month) 24 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 6 1921 to Apr 23 1921 that I last saw her alive on Apr 23 1921 and that death occurred on the date stated above, at 9 A. M.

The CAUSE OF DEATH* was as follows:
Mitral regurgitation
..... (Duration) ..... Yrs. 2 mos. ..... ds.
Contributory (Secondary) Acute Inflammatory Rheumatism
..... (Duration) ..... yrs. 1 mos. ..... ds.

(Signed) H. P. Ross M. D.
Apr 24 1921 (Address) Nampa Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Nampa Ida	Apr 28 1921
20. UNDERTAKER J. K. Robinson	ADDRESS Nampa

Ross

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33792
Registered No.

1. PLACE OF DEATH

County of Canyon RECEIVED
City of Nampa MAY 10 1921 (No. 32 ch + 23 ave 9 St.)
BUREAU OF VITAL STATISTICS

Registration District No. 7
Primary Registration District No. 1306

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Hazel Vera Mullinex

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Apr (Month) 30 (Day) 1907 (Year)

7. AGE: 14 Yrs. 7 Mos. 9 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Nevada

10. NAME OF FATHER: R. M. Mullinex

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Jessie Hunt

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R. M. Mullinex
(Address) Nampa Ida

15. Filed April 9 1921 Pearl Dodds Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 9 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 8th 1921, to May 8th 1921, that I last saw her alive on May 8th 1921, and that death occurred on the date stated above, at 3:45 P.M.

The CAUSE OF DEATH* was as follows:
Acute Endocarditis

(Duration) Yrs. 3 mos. — ds.
Contributory (Secondary) Acute Hypermia of Liver
(Duration) yrs. 1 mos. ds.

(Signed) Leo W Chilton M. D.
19 (Address) Nampa, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Nampa Ida — DATE OF BURIAL: May 10 1921

20. UNDERTAKER: H. E. Robinson — ADDRESS: Nampa Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A--25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33793

Registered No.

1. PLACE OF DEATH

County of Canyon

City of Nampa (No. St.)

Registration District No. 7

Primary Registration District No. 1006

RECEIVED
MAY 10
BUREAU OF VITAL STATISTICS

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary E Tuttle

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Fem	white	Married

6. DATE OF BIRTH: Oct (Month) 28 (Day) 871 (Year)

7. AGE: 49 Yrs. 6 Mos. 12 ds. (Oct 28 struck out)

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Calif

10. NAME OF FATHER: Daughtery

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chas W. Tuttle
(Address) Nampa Ida

15. Filed May 10 1921 Pearle Dodds Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 8 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from At Time of Death to May 8 1921 that I last saw h[illegible] alive on May 8 1921, and that death occurred on the date stated above, at 8 A. M.

The CAUSE OF DEATH* was as follows:

Apoplexy.
Previous partial
paralysis

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J H Murray M. D.

5/9 1921 (Address) Nampa Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Kohlerlawn Cem	May 10 1921
20. UNDERTAKER	ADDRESS
F K Robinson	Nampa Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33794

Registered No. 7

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

RECEIVED
MAY 10 1927
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH.

Registration District No. 3

Primary Registration District No. 1007

County of Canyon

City of Parma (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James M. Cason

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. August (Month) 15 (Day) 1850 (Year)

7. AGE: 76 Yrs. 11 Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Insurance Agent
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: Do not know

11. BIRTHPLACE OF FATHER (State or Country): Do not know

12. MAIDEN NAME OF MOTHER: Do not Know

13. BIRTHPLACE OF MOTHER (State or Country): .....

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Clarence O. Cason
(Address) Parma Idaho

15.
Filed 5/8 1927 Ruth Gadsby Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24853

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 16 (Day) 1927 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar. 27 1927, to Apr. 16 1927, that I last saw him alive on Apr. 15 1927, and that death occured on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:
Angina Pectoris

(Duration) about Yrs. mos. 3 0 ds.

Contributory (Secondary) Bronchial Asthma about

(Duration 5 yrs. mos. ds.

(Signed) W. W. Mulder M. D.

Apr. 16 1927 (Address) Parma, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL ~~OR REMOVAL~~: Parma Ida — DATE OF BURIAL: Apr 17 1927

20. UNDERTAKER: Reckham Fun Co — ADDRESS: Parma

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED MAY 10 1921 BUREAU OF [illegible]

CERTIFICATE OF DEATH 3

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33795

Registered No. 8

1. PLACE OF DEATH.

Registration District No. .....

County of Canyon

Primary Registration District No. 2007

City of Parma (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Henry Morris Huffman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS.

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
W	M	S

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE Stillborn ..... Yrs. ..... Mos. ..... ds. IF LESS than 1 day how many 3 hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Canyon Co

10. NAME OF FATHER C. M Huffman

11. BIRTHPLACE OF FATHER (State or Country) Neb.

12. MAIDEN NAME OF MOTHER Bessie M Barker

13. BIRTHPLACE OF MOTHER (State or Country) Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C M Huffman

(Address) .....

15. Filed 5/8 1921 Lulu Waldron Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 1 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1 1921, to May 1 1921, that I last saw h... alive on May 1 1921, and that death occured on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:

Premature separation of Placenta
with Forcep extraction

3 hrs.
(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Chas. O. Allen M. D.

5/2 1921 (Address) Parma, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF ~~BURIAL OR REMOVAL~~	DATE OF BURIAL
Caldwell Ida	May 3 1921
20. UNDERTAKER	ADDRESS
Peckham Funeral	

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24853

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
APR 13 19
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH — Registration District No. 9
County of Canyon — Primary Registration District No. 9007
City of Notus — No. ..... St.) — File No. 33796
Registered No. 7

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Shepherd Reed Sayre

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6. DATE OF BIRTH: Sept 25 (Month) (Day) 1843 (Year)

7. AGE: 77 Yrs. 5 Mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Minister
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Illinois.

10. NAME OF FATHER: Thos. B. Sayre

11. BIRTHPLACE OF FATHER (State or Country): Maryland

12. MAIDEN NAME OF MOTHER: Hanna Shepherd

13. BIRTHPLACE OF MOTHER (State or Country): Don't know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Sarah M Sayre
(Address) Notus Ida.

15. Filed March 9 1921 Lulu Waldrop
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 8 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 19 1920, to March 8 1921
that I last saw him alive on Feb. 28 1921,
and that death occurred on the date stated above, at 4:15 A.M.
The CAUSE OF DEATH* was as follows:
Bright's disease of the kidneys
(Duration) over 5 Yrs. ..... mos. ..... ds.
Contributory (Secondary) Hypostatic
(Duration) several yrs. ..... mos. ..... ds.
(Signed) Chas. B. Allen M. D.
3/9 1921 (Address) Parma, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Roswell — DATE OF BURIAL: Mar 9 1921

20. UNDERTAKER: Peckham — ADDRESS: Caldwell

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33797
Registered No. 5

RECEIVED
APR 15 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH. Registration District No. 3
County of Canyon. Primary Registration District No. 2007
City of 4 Miles N Parma (Ward) St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Harriet Isabel Foulds.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: May (Month) 19 (Day) 1860 (Year)

7. AGE: 60 yrs. 9 mos. 21 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife.
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: Watson Kennedy.

11. BIRTHPLACE OF FATHER (State or Country): Scotland.

12. MAIDEN NAME OF MOTHER: Laura Hills

13. BIRTHPLACE OF MOTHER (State or Country): Vermont.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant)
(Address)

15. Filed 3/17 1921 Lulu Malcho Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Mar (Month) 12 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 1920, to Mar 12 1921 that I last saw her alive on Mar 11 1921 and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:
Hepatic Carcinoma.

(Duration) ..... yrs. 9 mos. ..... ds.
Contributory (Secondary) Carcinoma Uterine
(Duration) 1 yrs. 6 mos. ..... ds.

(Signed) J. J. Barazin M. D.
3/14/1921 (Address) Nyssa Ore

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Fruit Parma Ida — DATE OF BURIAL: Mch. 15 1921

20. UNDERTAKER: Peckham Fur Co — ADDRESS: Parma Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33798
Registered No. 6

1. PLACE OF DEATH.

RECEIVED
APR 13 1921
BUREAU OF VITAL STATISTICS

Registration District No. 8
Primary Registration District No. 2007
County of
City of (No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Virginia Seiber,

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Infant.

6. DATE OF BIRTH. July (Month) 16 (Day) 1920 (Year)

7. AGE: ....Yrs. ....Mos. 8 ds. 10

IF LESS than 1 day how many ....hrs. or ....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work....
(b) General nature of industry, business, or establishment in which employed (or employer)....

9. BIRTHPLACE (State or Country) Roswell Idaho.

10. NAME OF FATHER W. H. Seiber,

11. BIRTHPLACE OF FATHER (State or Country) Tofaz, Mo. Douglas Co.

12. MAIDEN NAME OF MOTHER Lillye Bell McCoy.

13. BIRTHPLACE OF MOTHER (State or Country) Chadwick Christian Co.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) W. H. Seiber
(Address) Roswell Idaho.

15. Filed 3-29 1921 Lulu Waldrop Local Registrar

SYMS - YORK CO., PTRS. & SONS. 24853

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mar. (Month) 26 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 1 1921, to Mar 26 1921, that I last saw h alive on Mar 26 1921, and that death occured on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:

Nephritis.

(Duration) Yrs. 6 mos. ds.

Contributory (Secondary) Selen Calitis

(Duration) yrs. 1 mos. ds.

(Signed) A. M. Mitchell M. D.

3-29 1921 (Address) Parma Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death....yrs....mos....days. In the State....yrs....mos....days

Where was disease contracted if not at place of death?....

Former or usual residence ....

19. PLACE OF BURIAL OR ~~REMOVAL~~: Roswell — DATE OF BURIAL: March 27 1921

20. UNDERTAKER: Peckham Fun Co — ADDRESS: Parma

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH. 33799

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. RECEIVED

Registration District No. 120

County of Ada MAY 3 1921 Primary Registration District No. 2199

City of Boise BUREAU OF VITAL STATISTICS No. ..... St.)

File No. XVII

Registered No. 13

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME James Whitby

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Feb (Month) 16 (Day) 1921 (Year)

7. AGE: ....Yrs. 1 ....Mos. —ds. IF LESS than 1 day how many.....hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Joseph Reid

11. BIRTHPLACE OF FATHER (State or Country): Wash

12. MAIDEN NAME OF MOTHER: Liza Sorenson

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant): Joseph Reid
(Address): Boise Ida

15. Filed Apr 20 1921 — N. W. Wilson, Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 16 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 191..., to ....., 191...,
that I last saw h... alive on ....., 191...,
and that death occured on the date stated above, at .....M.
The CAUSE OF DEATH* was as follows:

Unknown — no medical attendance (premature birth)

.....(Duration) .....Yrs.....mos.....ds.

Contributory (Secondary)

.....(Duration) .....yrs.....mos.....ds.

3/17 1921 (Signed) N. W. Wilson M. D.
(Address) Boise Ada

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Marsing, Id. DATE OF BURIAL: 3/17 1921

20. UNDERTAKER: J. P. Gurney ADDRESS: Marsing Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
MAY 3 19..
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH. Registration District No. 120 33800
County of Cassia Primary Registration District No. 2199 File No. XVII
City of Oakley St.) Registered No. 12

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Richard Mallard

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. March 6 1924 (Month) (Day) (Year)

7. AGE ..... Yrs. 11 Mos. 25 ds. IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Oakley Idaho

10. NAME OF FATHER John Mallard

11. BIRTHPLACE OF FATHER (State or Country) Idaho

12. MAIDEN NAME OF MOTHER Ella Halverson

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) John Mallard
(Address) Oakley Idaho

15. Filed 4/25 1924 [illegible] Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 1 1924 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 24 1924, to March 1 1924, that I last saw h[illegible] alive on March 1 1924, and that death occured on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) Yrs. mos. 6 ds.

Contributory (Secondary)

(Duration yrs. mos. ds.

3/2 1924 (Signed) [illegible] M. D.
(Address) [illegible]

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL, OR REMOVAL: Oakley Idaho — DATE OF BURIAL: 3/4 1924

20. UNDERTAKER: B.P. Adams — ADDRESS: Oakley Id

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

33301

City of Churchill BUREAU OF VITAL STATISTICS ..... St.) Registered No. 10

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Parley Edwin Poulton

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PH should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact staten of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. February 1 1921 (Month) (Day) (Year)

7. AGE ..... Yrs. ..... Mos. 2 ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... None

(b) General nature of industry, business, or establishment in which employed (or employer)..... None

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER George Richard Poulton

11. BIRTHPLACE OF FATHER (State or Country) Idaho

12. MAIDEN NAME OF MOTHER Lela Todd

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George Poulton

(Address) Churchill

15. Filed 4/25 1921 A. A. Nielsen Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH February 3 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feby 1 1921, to Feby 3 1921, that I last saw him alive on Feby 1 1921, and that death occured on the date stated above, at 330 P.M.

The CAUSE OF DEATH* was as follows:

Congenital Atelectasis

..... (Duration) ..... Yrs. ..... mos. 2 ..... ds.

Contributory (Secondary) Prematurity

..... (Duration ..... Yrs. ..... mos. ..... ds.

(Signed) Jesse L. Rams M. D.

2/3 1921 (Address) Oakley Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Oakley Idaho — DATE OF BURIAL: 2/5 1921

20. UNDERTAKER: By Ramsey — ADDRESS: Oakley Idaho

FORM V. S. No. 5-25 M. 1-16-18

CERTIFICATE OF DEATH.

33802

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. RECEIVED
County of Canyon MAY 5 BUREAU OF VITAL STATISTICS
City of Caldwell
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 120
Primary Registration District No. 2199
(No. ..... St.)

File No. 2449
Registered No. 9

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Charles Frederick Yaeoby

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married
6. DATE OF BIRTH. June 6 1846 (Month) (Day) (Year)
7. AGE: 74 Yrs. 8 Mos. 3 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Germany
10. NAME OF FATHER: Carl Yaeoby
11. BIRTHPLACE OF FATHER (State or Country): Germany
12. MAIDEN NAME OF MOTHER: not known
13. BIRTHPLACE OF MOTHER (State or Country): Germany
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs C Yaeoby
(Address) Caldwell
15. Filed Apr 20 1921 W. E. Rhea Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: February 11 1921 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from February 8 1921, to Feby 11 1921, that I last saw h was alive on Feby 8 1921, and that death occured on the date stated above, at 10 P. M.
The CAUSE OF DEATH* was as follows:
Lobar pneumonia
(Duration) ..... Yrs. ..... mos. 4 ds.
Contributory (Secondary) Arteriosclerosis
(Duration) ? yrs. ..... mos. ..... ds.
(Signed) Jesse L Rhea M. D.
2/12 1921 (Address) Caldwell Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Caldwell Ida — DATE OF BURIAL: 2/14 1921
20. UNDERTAKER: Bp Harper — ADDRESS: Boise, Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

BYRNS - YORK CO., PTRS. & BDRS. 24658

(63)

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH. 33803

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 130

Primary Registration District No. 2199

File No. X411

Registered No. 14

County of Cassia

City of Oakley (No. St.)

If death occurs away from usual residence, give facts called for under special information.

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BUREAU OF VITAL STATISTICS

2. FULL NAME Ernest Worthington

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): Widowed

6. DATE OF BIRTH. April (Month) 30 (Day) 1 (Year)

7. AGE 7 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Farmer

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) England

10. NAME OF FATHER Ishabod Worthington

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER Priscilla Leyton

13. BIRTHPLACE OF MOTHER (State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Ishabod Worthington

(Address) Oakley Idaho

15. Filed 4/25 1921 W. W. Jackson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March (Month) 28 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 28 1921, to March 28 1921, that I last saw h[illegible] alive on March 21 1921, and that death occured on the date stated above, at 8 A. M.

The CAUSE OF DEATH* was as follows:

Cholecystitis

(Duration) 3 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) W. W. Jackson M. D.

3/28 19..... (Address) Oakley Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Oakley Idaho | DATE OF BURIAL: April 2 1921

20. UNDERTAKER: [illegible] | ADDRESS: Oakley Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STNRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

33804

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. XIII

Registered No. 11

RECEIVED
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BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH. Registration District No. 123

County of Cassia Primary Registration District No. 2199

City of Oakley (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Nelson Price

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. Jan (Month) 29 (Day) 1897 (Year)

7. AGE: ..... Yrs. 24 Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... /
(b) General nature of industry, business, or establishment in which employed (or employer)...

9. BIRTHPLACE (State or Country): Idaho Oakley

10. NAME OF FATHER: Royal Price

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Julia Horne

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Royal Price
(Address) Oakley Idaho

15. Filed 4/25 1921 M. M. Sheldon Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 28 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 26 1921, to Feb 28 1921, that I last saw h... alive on Feb 26 1921, and that death occured on the date stated above, at 8-9 M.

The CAUSE OF DEATH* was as follows:

Pertussis

(Duration) ..... Yrs. ..... mos. 28 ds.

Contributory (Secondary)

(Duration ..... Yrs. ..... mos. ..... ds.

(Signed) M. M. Sheldon M. D.

4/28 1921. (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Oakley Id | DATE OF BURIAL 4/1 1921

20. UNDERTAKER By Adams | ADDRESS Oakley Id

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

6Y1M8 - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-12 M. 6-15-17.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Cassia Registration District No. 47

City of Burley Primary Registration District No. 2196

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

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State of Idaho BOARD OF HEALTH Bureau of Vital Statistics

File No. 33805

Registered No. 396

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Arthur Earl Bartunek

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Sept (Month) 11 (Day) 1907 (Year)

7. AGE 13 Yrs. 5 Mos. 23 ds.

IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: schoolboy
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Ora. Nebr

10. NAME OF FATHER Paul Bartunek

11. BIRTHPLACE OF FATHER (State or Country) Bohemia

12. MAIDEN NAME OF MOTHER Alice Ledvina

13. BIRTHPLACE OF MOTHER (State or Country) Wahoo Nebr

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Paul Bartunek
(Address) Burley Ida

15. Filed Apr. 18 1921 Dr. J. C. Patterson Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March (Month) 6 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 5 1921 to March 6 1921 that I last saw him alive on March 6 1921 and that death occurred on the date stated above, at 4:30 P.M.

The CAUSE OF DEATH* was as follows:
Streptococcic Throat
(Vincent's Angina)
(Duration) .... Yrs. .... mos. .... ds.

Contributory (Secondary) .....
(Duration) .... Yrs. .... mos. .... ds.

(Signed) P. V. Barta M. D.
19.... (Address) Burley, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the State....yrs....mos....days

Where was disease contracted if not at place of death?

Former or usual residence Burley Ida

19. PLACE OF BURIAL OR REMOVAL Pleasant Hill Cemetery — DATE OF BURIAL Mar. 7 1921

20. UNDERTAKER Rierdan & Rierdan — ADDRESS Burley Ida

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33806

Registered No. #97

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BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH.

County of Cassia — Primary Registration District No. 117 — Subdistrict No. 2196

City of Burley (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Kermit McEwen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. April 30 (Month) (Day) 1918 (Year)

7. AGE: 6 Yrs. 10 Mos. 23 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: W. R. McEwen

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Pearlee Griffith

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W. R. McEwen

(Address) Burley Ida

15. Filed Apr. 18 1921 Dr. J. C. Patterson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar. (Month) 23 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 23 1921, to March 23 1921, that I last saw him alive on March 23 1921, and that death occured on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:

Accident

Runaway

Pathology - Ruptured Liver

— (Duration) — Yrs. — mos. — ds.

Contributory (Secondary)

(Duration — yrs. — mos. — ds.

(Signed) W. A. Bragg M. D.

19 (Address) Burley Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Pleasant View Cemetery — DATE OF BURIAL: Mar 25 1921

20. UNDERTAKER: Rudwall — ADDRESS: Burley Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STNRS. 24653

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

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BUREAU OF VITAL STATISTICS

Registration District No. 117
Primary Registration District No. 2196
File No. 33807
Registered No. 29

County of Cassia
City of Burley (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME J. W. Walters

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Divorced

6. DATE OF BIRTH: Month Unknown (Month) (Day) 1838 (Year)

7. AGE: 83 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Janitor
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ill.

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): "

12. MAIDEN NAME OF MOTHER: "

13. BIRTHPLACE OF MOTHER (State or Country): "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) L. B. Talleyly
(Address) Burley Ida.

15. Filed 3/29/21 19.... Dr. J. C. Pettibone Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar. 28- 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar. 1 - 1921, to Mar. 29 1921
that I last saw h.... alive on Mar. 29. 1921
and that death occurred on the date stated above, at 6 P.M.
The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G. H. Jasper M. D.
3/29 1921 (Address) Burley Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Fairmont Neb. — DATE OF BURIAL: April 2 - 1921

20. UNDERTAKER: L. B. Talleyly — ADDRESS: Burley Ida.

Homestead

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH RECEIVED APR 28 1921 BUREAU OF STATISTICS

Registration District No. 147
Primary Registration District No. 2196
File No. 33808
Registered No. 49

County of Cassia
City of Declo (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Violet Savage.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Single

6. DATE OF BIRTH

April (Month) 4 (Day) 1895 (Year)

7. AGE 25 Yrs. 11 Mos. 27 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work At Home.
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Elba Ida.

10. NAME OF FATHER Joseph Savage.

11. BIRTHPLACE OF FATHER (State or Country) Utah.

12. MAIDEN NAME OF MOTHER Jane Babbott.

13. BIRTHPLACE OF MOTHER (State or Country) Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) M. K. Savage.
(Address) Declo Ida.

15. Filed Apr 18 1921 D. J. C. Patterson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 31 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 10 1921 to March 31 1921 that I last saw her alive on March 31 1921 and that death occurred on the date stated above, at 11:30 M.

The CAUSE OF DEATH* was as follows:

Tuberculosis

(Duration) Yrs. 7 mos. ds.

Contributory (Secondary) ✓

(Duration) yrs. mos. ds.

(Signed) P. T. Story M. D.

Apr. 19 1921 (Address) Burley-Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Elba Ida.	April 2. 1921.
20. UNDERTAKER	ADDRESS
L. B. Facer.	Burley. Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
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BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 117
Primary Registration District No. 216
File No. 33809
Registered No. 300

County of Cassia
City of Burley (No. 714 N. Almo Ave. St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William Kees.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Nov. 27 1885
(Month) (Day) (Year)

7. AGE: 35 Yrs. 3 Mos. 17 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Butcher
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Germany.

10. NAME OF FATHER: Carl Georg Kees.

11. BIRTHPLACE OF FATHER (State or Country): Germany.

12. MAIDEN NAME OF MOTHER: Unknown.

13. BIRTHPLACE OF MOTHER (State or Country): Germany.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Fred Wahl.
(Address): Twin Falls Ida.

15. Filed Apr. 18 1921 P. J. C. Patterson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 16 1921.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Gun Shot Wound In Head.
By An Unknown Hand.

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) L. B. Beesley - Coroner - M. D.
3/20/1921. (Address) Burley Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Ida. DATE OF BURIAL: 3/19/1921.

20. UNDERTAKER: L. B. Beesley. ADDRESS: Burley Ida.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

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BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33810
Registered No. 499

1. PLACE OF DEATH
Registration District No. 117
Primary Registration District No. 2,96
County of Cassia
City of Burley (No. N. Schodden St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Reva Richardson.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (write the word.)

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1 (Year)

7. AGE: 6 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Alma Idaho.

10. NAME OF FATHER: Willard Richardson.

11. BIRTHPLACE OF FATHER (State or Country): Utah.

12. MAIDEN NAME OF MOTHER: Annie Cohon.

13. BIRTHPLACE OF MOTHER (State or Country): Alma Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Annie Richardson.
(Address) Burley Ida.

15. Filed Apr. 18 1921 Dr. J. C. Patterson Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 27 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 26 1921, to March 27 1921 that I last saw h.. alive on March 27 1921, and that death occurred on the date stated above, at 9 a. M.

The CAUSE OF DEATH* was as follows:
Paralysis following
Pulmonary Hemorrhage

(Duration) ..... Yrs. 1 mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. C. Patterson M. D.
3-27 1921 (Address) Burley, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Burley Idaho. DATE OF BURIAL: March 27 1921

20. UNDERTAKER: L. B. Tracy. ADDRESS: Burley Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33811

RECEIVED
MAY 7 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH.
Registration District No. 121
Primary Registration District No. 2203
County of Clark
City of Dubois (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Octave Roberts Burnside

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: June (Month) 2 (Day) 1914 (Year)

7. AGE: 1 yrs. 10 mos. 28 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At home
(b) General nature of industry business, or dstablishment in which employed (or employer): none

9. BIRTHPLACE (State or Country): Dubois Idaho

10. NAME OF FATHER: Arthur G Burnside

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Myrtle G Hawkins

13. BIRTHPLACE OF MOTHER (State or Country): Colorado

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Arthur G Burnside
(Address) Dubois Idaho

15. Filed April 30 1921 C E Jones M D
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: April (Month) 30 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 17, 1921, to April 30 1921, that I last saw h alive on April 30 1921, and that death occurred on the date stated above, at 4:30 P.M.

The CAUSE OF DEATH* was as follows:

Flea-Cerebro

(Duration) ..... yrs. ..... mos. 2 0 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C E Jones M. D.
4/30 1921 (Address) Dubois Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Dubois Idaho
DATE OF BURIAL: May 2 1921

20. UNDERTAKER: None
ADDRESS: —

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

GYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3812
Registered No. 12

1. PLACE OF DEATH
County of Clearwater
City of Orofino (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

RECEIVED
MAY 7 1921
BUREAU OF VITAL STATISTICS

Registration District No. 9
Primary Registration District No. 2.68

2. FULL NAME Edwin W Blake

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
male	white	married

6. DATE OF BIRTH June (Month) 15 (Day) 839 (Year)

7. AGE 81 Yrs. 8 Mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Canada

10. NAME OF FATHER — Blake

11. BIRTHPLACE OF FATHER (State or Country) Vermont

12. MAIDEN NAME OF MOTHER Brown

13. BIRTHPLACE OF MOTHER (State or Country) New H.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ed Blake
(Address) Orofino Idaho

15. Filed May 3 19 21 J M Faulk Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 2 (Day) 19 21 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h.. alive on ..... 19.....,
and that death occurred on the date stated above, at 4 P.M.
The CAUSE OF DEATH* was as follows:

Brights disease

(Duration) 2 Yrs. ..... mos. ..... ds.
Contributory (Secondary) old age
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Faulk M. D.
May 3 1921 (Address) Orofino Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Weisman Cemo — DATE OF BURIAL May 19 21

20. UNDERTAKER C W Blake — ADDRESS Orofino Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

Form V. S. No. 5 20M.1-16-19

RECEIVED
MAY 7
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 99
County of Clearwater Primary Registration District No. 2168
City of Orofino, Idaho (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

File No. 33813
Registered No. 13
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Rose

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: About (Month) 1 (Day) 1846 (Year)

7. AGE: About 75 yrs. ~ mos. ~ ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Scotland

10. NAME OF FATHER: ?

11. BIRTHPLACE OF FATHER (State or Country): ?

12. MAIDEN NAME OF MOTHER: ?

13. BIRTHPLACE OF MOTHER (State or Country): ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. W. Atteberry
(Address) Orofino, Idaho

15.
Filed May 17 1921
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March (Month) 17th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 12, 1911 to March 17th 1921, that I last saw h im alive on March 16th 1921 and that death occurred on the date stated above, at 3:25 A.M.

The CAUSE OF DEATH* was as follows:
Arteria Sclerosis
Unknown (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Insanity
Unknown (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) John W. Greene M. D.
3/18 1921 (Address) Orofino, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 9 yrs. 7 mos. 6 days. In the State about 9 yrs. 7 mos. 9 days.
Where was disease contracted if not at place of death? Unknown
Former or usual residence Came from Moscow, Idaho.

19. PLACE OF BURIAL OR REMOVAL: Northern Idaho Sanitarium Cemetery Grave #15 Row 4 new addition.
DATE OF BURIAL: March 20 1921

20. UNDERTAKER: P. M. Johnson
ADDRESS: Orofino, Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

RECEIVED MAY 7 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

33814

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 90

County of Clearwater Primary Registration District No. 268 File No.

City of Orofino (If not in limits, give township) St.) Registered No. 14

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Annie Elizabeth Cochran

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH: About (Month) (Day) 1853 (Year)

7. AGE: About 68 yrs. ✓ mos. ✓ ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer): Housekeeping

9. BIRTHPLACE (State or Country): America

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. W. Atteberry
(Address) Orofino, Idaho

15. Filed May 21 191 J. M. Fairley Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March (Month) 21st (Day) 1921 (Year) ~~191~~

17. I HEREBY CERTIFY, That I attended deceased from August 26th ~~191~~ 1920, to March 21st ~~191~~ 1921; that I last saw h or alive on March 21st ~~191~~ 1921, and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis,

(Duration) yrs. mos. ds.

Contributory (Secondary) Insanity

(Duration) Unknown yrs. mos. ds.

(Signed) J. Kurrle Jimerson M. D.

Mar. 21 ~~19~~ 1921 (Address) Orofino, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.) about

At place of death ✓ yrs. 6 mos. 23 days. In the State 24 yrs. ✓ mos. ✓ days.

Where was disease contracted if not at place of death?

Former or usual residence Orofino, Idaho

19. PLACE OF BURIAL OR REMOVAL: Lewiston Idaho | DATE OF BURIAL: Mar 23 1921

20. UNDERTAKER: Bobb and Snee | ADDRESS: Orofino Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

GYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

RECEIVED
MAY 7 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 90
Primary Registration District No. 2168
File No. 33815
Registered No. 15

County of Clearwater,
City of Orofino, (St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Kate Miller,

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)
Female	White	Married,

6. DATE OF BIRTH: About (Month) 1 (Day) 1872 (Year)

7. AGE: About 49 yrs. ---- mos. ---- ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *mins.*

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife,
(b) General nature of industry business, or dstablishment in which employed (or employer): General House Work,

9. BIRTHPLACE (State or Country): Ireland,

10. NAME OF FATHER: Unknown,

11. BIRTHPLACE OF FATHER (State or Country): Unknown,

12. MAIDEN NAME OF MOTHER: Unknown,

13. BIRTHPLACE OF MOTHER (State or Country): Unknown,

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. H. Atteberry
(Address) Orofino, Idaho.

15. Filed April 26 1921 J. M. Gaily Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
April twenty-five, 1921, ##########
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 21, 1909, ####, to April 25, 1921 ####
that I last saw h er alive on April 25, 1921 ####
and that death occurred on the date stated above, at 11:00 A.M.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
(Duration) Unknown, yrs. mos. ds.
Contributory (Secondary) Insanity,
(Duration) Unknown, yrs. mos. ds.

(Signed) [illegible] M. D.
(Address) Orofino, Idaho.
Apr. 26## 1921,

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 11 yrs. 11 mos. 5 days. In the State 14 yrs. ##### #####
Where was disease contracted if not at place of death? Unknown,
Former or usual residence Wallace, Idaho.

19. PLACE OF BURIAL OR REMOVAL: Sanitarium Cemetery | DATE OF BURIAL: April 27 1921

20. UNDERTAKER: Boles and Son | ADDRESS: Orofino Ida

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

GYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33816
Registered No. 16

1. PLACE OF DEATH. Registration District No. 93
Primary Registration District No. 2168
County of Clearwater.
City of Orofino. (No. ..... St.)

RECEIVED
MAY 7 1921
BUREAU OF VITAL STATISTICS

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Eliza J. Powers.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White,
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.): Married,
6. DATE OF BIRTH: About ---------- 1856 (Month) (Day) (Year)
7. AGE: About 65 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *min?*
8. OCCUPATION
(a) Trade, profession or particular kind of work: House Wife,
(b) General nature of industry business or establishment in which employed (or employer): General House Work,
9. BIRTHPLACE (State or Country): Ohio, at Mansfield,
10. NAME OF FATHER: Unknown,
11. BIRTHPLACE OF FATHER (State or Country): Unknown,
12. MAIDEN NAME OF MOTHER: Unknown,
13. BIRTHPLACE OF MOTHER (State or Country): Unknown,
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. W. Attaberry
(Address) Orofino, Idaho.
15. Filed April 27 1921. J. Midaugh Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: April, Twenty-sixth, 1921, (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from April 16th, 1919 to April 26, 1921 that I last saw her alive on April 26th, 1921, and that death occurred on the date stated above, at 10:10 A.M.
The CAUSE OF DEATH* was as follows:
General Paresis,
(Duration) Unknown yrs. ..... mos. ..... ds.
Contributory (Secondary) Insanity,
(Duration) Unknown yrs. ..... mos. ..... ds.
(Signed) John W. Stevens M. D.
Apr. 26, 1921
(Address) Orofino, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death Two yrs. No mos. Eleven ds. In the State Ten yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? Unknown,
Former or usual residence St. Maries, Benewah County, Ida.

19. PLACE OF BURIAL OR REMOVAL: Coeur d'Alene
DATE OF BURIAL ..... 191...
20. UNDERTAKER: Bobo & Son
ADDRESS: Orofino

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5 20M.1-16-12

RECEIVED
MAY 1 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33817

Registered No. 17

1. PLACE OF DEATH.
County of Clearwater Registration District No. 90
City of Orofino (No. ..... St.) Registration District No. 2168

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Angeline Dresser

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)
Female	White	Widowed

6. DATE OF BIRTH: July (Month) 18 (Day) 1839 (Year)

7. AGE: 81 yrs. 7 mos. 12 ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mass

10. NAME OF FATHER: Elliott Braley

11. BIRTHPLACE OF FATHER (State or Country): ✓

12. MAIDEN NAME OF MOTHER: ✓

13. BIRTHPLACE OF MOTHER (State or Country): ✓

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Victor Dresser
(Address) Orofino Idaho

15. Filed May 1 1921 J M Stanley Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: April (Month) 30 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 23 1921, to April 30 1921, that I last saw h[illegible] alive on April 30 1921, and that death occurred on the date stated above, at 8 P.M.

The CAUSE OF DEATH* was as follows:

Acute Indigestion

(Duration) ..... yrs. ..... mos. 8 ds.

Contributory (Secondary) Angina Pectoris

(Duration) ..... yrs. ..... mos. 8 ds.

(Signed) J M Stanley M. D.
4/30 1921 (Address) Orofino Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF ~~BURIAL OR~~ REMOVAL: Lewiston Ida — DATE OF BURIAL: ? 191

20. UNDERTAKER: Babb & Son — ADDRESS: Orofino Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED MAY 6 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 16

County of Lemhi Primary Registration District No. 2153

City of Macksay (If outside limits, give township) St.)

File No. 33818

Registered No.

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Charles Dennis LaFever

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: Wh

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. 1 (Month) 29 (Day) 1876 (Year)

7. AGE: 45 Yrs. 2 Mos. 16 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Rancher -
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Mah

10. NAME OF FATHER Charles Lafever

11. BIRTHPLACE OF FATHER (State or Country) Canada

12. MAIDEN NAME OF MOTHER Felicia Dennis -

13. BIRTHPLACE OF MOTHER (State or Country) Iowa.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Chas. LaFever Sr.
(Address) Macksay - Ida.

15. Filed 5 7 5 1921 R. Monroe Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 4 (Month) 16 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 28 1921, to April 16 1921, that I last saw him alive on April 16 1921 and that death occured on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Gastric Haemorrhage -

(Duration) 4 Yrs. 1 mos. ds.

Contributory (Secondary) Gastric Ulcer

(Duration 5 yrs. mos. ds.

(Signed) A. P. Richards M. D.

4/18 1921 (Address) Macksay Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Macksay Idaho — DATE OF BURIAL ..... 191....

20. UNDERTAKER — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 16

County of Butte RECEIVED Primary Registration District No. 2153 File No. 33819

City of Arco MAR 1921 St.) Registered No.

If death occurs away from usual residence, give facts called for under special information. BUREAU OF VITAL STATISTICS

2. FULL NAME Andreas Lamont Aiscle

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
m	Wh	Single

6. DATE OF BIRTH. June (Month) 25 (Day) 1913 (Year)

7. AGE 7 Yrs. 9 Mos. 25 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... School boy
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Logan Utah

10. NAME OF FATHER Andreas Aiscle

11. BIRTHPLACE OF FATHER (State or Country) Germany

12. MAIDEN NAME OF MOTHER Josephine Pardington

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Father
(Address) Arco Idaho

15. Filed 5-5 1921 R. Nowell Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March (Month) 20 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3/13/21 1921, to 3/20/21 1921, that I last saw him alive on 3/13/21 1921, and that death occured on the date stated above, at 11:30 A.M.

The CAUSE OF DEATH* was as follows:

Chronic Endo carditis.

(Duration) 3 Yrs. mos. ds.

Contributory (Secondary) Cardiac dilatation

(Duration yrs. mos. 14 ds.

(Signed) A. P. Richards M. D.

3/20 1921 (Address) Macray Idaho

*State the DISEASE CAUSING DEATH; or ~~in deaths from~~ VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL 191
20. UNDERTAKER	ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

BYRNE - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2119
Primary Registration District No. 27
File No. 958821
Registered No. 27

RECEIVED
MAY 7 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Franklin
City of Dayton (St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary E. Smith

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: May 14 (Month) (Day) 1874 (Year)

7. AGE: 47 Yrs. 10 Mos. 25 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer): U

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Thomas Davis

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Martha Callan

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Arthur E. Smith
(Address) Dayton Idaho.

15. Filed May 5 1921 Dan Quelch Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April 8 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 19 1921, to April 8 1921, that I last saw h.. alive on April 8 1921, and that death occurred on the date stated above, at 10:20 P. M.

The CAUSE OF DEATH* was as follows:

Hypostatic Congestion due to a dynamic state + weakened heart action

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Was convalescing from acute Bronchitis (Duration) ..... yrs. ..... mos. 21 ds.

(Signed) Curtis Hand M. D.
4/9 1921 (Address) Preston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Dayton Idaho
DATE OF BURIAL: Apr. 11 1921

20. UNDERTAKER: W. A. Skidmore
ADDRESS: Preston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration district No. 89
County of Fremont RECEIVED Primary Registration District No. 32
City of Teton APR 2 (No. 92 St.)
File No. 3822
Registered No. 32

If death occurs away from usual residence, give facts called for under special information.

BUREAU OF VITAL STATISTICS

2. FULL NAME Grace M. Johnston Curtis

If death occurred in a hospital, institution, or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Married

6. DATE OF BIRTH. September 4 1896
(Month) (Day) (Year)

7. AGE 24 Yrs. 6 Mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE
(State or Country) Teton, Idaho.

10. NAME OF FATHER Jacob Johnston

11. BIRTHPLACE OF FATHER
(State or Country) Salt Lake city, Utah

12. MAIDEN NAME OF MOTHER Sarah Bird

13. BIRTHPLACE OF MOTHER
(State or Country) Weyedon, Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Jacob Johnston.
(Address) Teton, Idaho.

15. [illegible]

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
March 28 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 27 1921, to March 28 1921
that I last saw h[illegible] alive on March 28 1921
and that death occured on the date stated above, at 3:50 A.M.
The CAUSE OF DEATH* was as follows:
Post Partum Eclampsia

(Duration) ..... Yrs. ..... mos. .....

Contributory (Secondary)
(Duration) 5 Yrs. ..... mos.

(Signed) J. Frank Watkins M.D.
March 29 1921 (Address) Driggs Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL
[illegible] | [illegible] 21

[illegible]

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33823
Registered No.

1. PLACE OF DEATH

County of Fremont Registration District No. 99
Primary Registration District No. 2177
City of St anthony (No. St.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
APR 27 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME Lavina M. Parnell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: married (Write the word.)

6. DATE OF BIRTH: 9 (Month) 11 (Day) 1895 (Year)

7. AGE: 25 Yrs. 7 Mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: mother
(b) General nature of industry, business or establishment in which employed (or employer): housekeeping

9. BIRTHPLACE (State or Country): utah

10. NAME OF FATHER: Robert M. Hall

11. BIRTHPLACE OF FATHER (State or Country): utah

12. MAIDEN NAME OF MOTHER: Hannah M Hall

13. BIRTHPLACE OF MOTHER (State or Country): utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Grant Parnell
(Address) St anthony Ida

15. Filed Apr 10 1921 W Brent Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 3 (Month) 26 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 5 1921 to 3-26 1921 that I last saw her alive on 3-26 1921 and that death occurred on the date stated above, at 10 30 M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... Yrs. 2 mos. 7 3 ds.

Contributory (Secondary) Myelitis

(Duration) ..... yrs. 2 mos. 23 ds.

(Signed) J M Clay M. D.

3-26-1921 (Address) St anthony Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Parker DATE OF BURIAL: 3-29-1921

20. UNDERTAKER: Taylor-Ellerson ADDRESS: St anthony Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
APR 27 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 99
Primary Registration District No. 2177
File No. 33824
Registered No.

1. PLACE OF DEATH
County of Fremont
City of St Anthony (No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Vern Hammond

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): single

6. DATE OF BIRTH: Nov (Month) 25 (Day) 1920 (Year)

7. AGE: Yrs. 3 Mos. 27 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Fremont

10. NAME OF FATHER: Robert L Hammond

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Rena Kerr

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Robert Hammond
(Address) St. Anthony Idaho

15. Filed Apr 10 1921
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar (Month) 22 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 25 1920, to Mar 21 1921, that I last saw her alive on 21 1921, and that death occurred on the date stated above, at 4 A.M.
The CAUSE OF DEATH* was as follows:
marasmus

(Duration) Yrs. 3 mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) J W McGary M. D.
3/22 1921 (Address) St Anthony Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: St Anthony
DATE OF BURIAL: 3/22 1921

20. UNDERTAKER: Taylor Ellison Undtg Co.
ADDRESS: St. Anthony Ida
W M Hansen

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED
APR 27 1921
BUREAU OF STATISTICS

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Fremont — Registration District No. 9 9

City of St. Anthony, Ida. — Primary Registration District No. 2 1 7

(No. ..... , ... St.)

File No. 33825

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Constantine Myers.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Male	White	Single

(Write the word.)

6. DATE OF BIRTH: March 6th-2I (Month) (Day) 1 (Year)

7. AGE: ..... Yrs. ..... Mos. 7 ds. — IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) None

9. BIRTHPLACE (State or Country) St. Anthony, Ida.

10. NAME OF FATHER: Fred Myers

11. BIRTHPLACE OF FATHER (State or Country): Russia.

12. MAIDEN NAME OF MOTHER: Mary Scheaur

13. BIRTHPLACE OF MOTHER (State or Country): Russia.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Fred Myers
(Address) St Anthony, Ida.

15. Filed Apr 10 1921 — W Blunt, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: MarchI3th-2I 19 ..... (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ——— 19..... to ——— 19....., that I last saw h— alive on ——— 19....., and that death occurred on the date stated above, at A. M. The CAUSE OF DEATH* was as follows:

Congenital (unknown)

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. Frank Hatkins, M. D.

March 19I4th-2I (Address) St. Anthony, Id a

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL ..... 19.....

20. UNDERTAKER | ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Fremont. Registration District No. 99

City of Wilford (No. ....., ... St.) Primary Registration District No. 277

File No. 33826

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
APR 27 1921
BUREAU OF VITAL STATISTICS

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Baby Wickham

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: March 23-"2I. (Month) (Day) 1 (Year)

7. AGE: .....Yrs. .....Mos. .....ds.

IF LESS than 1 day how many ..... hrs. or 20 min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work ----------

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Ida.

10. NAME OF FATHER: VernonH. Wickham

11. BIRTHPLACE OF FATHER (State or Country): Ida.

12. MAIDEN NAME OF MOTHER: May Rasband

13. BIRTHPLACE OF MOTHER (State or Country): Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Vernon H. Wickham

(Address) .....

15. Filed Apr 11 19 21 .....
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar. 23-2I. (Month) (Day) 19..... (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19....., to ..... 19....., that I last saw h..... alive on ..... 19....., and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Premature birth
Utero Gestation six haf months

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. Frank Watkins M. D.

Mar. 24th-21 19 (Address) St Anthony, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL ..... 19.....

20. UNDERTAKER | ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33827
Registered No. 20

1. PLACE OF DEATH. RECEIVED
Registration District No. ~~100~~ - 99
County of Madison APR 27 1921 Primary Registration District No. 2179
City of Rexburg BUREAU OF VITAL STATISTICS (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.
2. FULL NAME Zola Bell Willard
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH: February xx 1921 (Month) (Day) (Year)
7. AGE: — yrs. — mos. 16 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: nil
(b) General nature of industry business, or dstablishment in which employed (or employer): nil
9. BIRTHPLACE (State or Country): Idaho
10. NAME OF FATHER: Charles L Willard
11. BIRTHPLACE OF FATHER (State or Country): Utah
12. MAIDEN NAME OF MOTHER: Marvilla Riggs
13. BIRTHPLACE OF MOTHER (State or Country): Idaho
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Charles L Willard
(Address) .....
15. Filed Apr 10 1921 W Elliott Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March 8 1921 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191..., that I last saw h..... alive on ..... 191..., and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Pneumonia
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) James Gray M. D.
19.... (Address) St. Anthony

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL ..... 191...

20. UNDERTAKER: John R Phillips | ADDRESS: Ryburg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO. STRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
APR 27 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH. Registration District No. 99
County of Fremont Primary Registration District No. 2177
City of Newdale (No. St.)
File No. 33828
Registered No.
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.
2. FULL NAME George P. Simpson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH: March 3 (Month) (Day) 1856 (Year)

7. AGE: 65 yrs. 0 mos. 4 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: George B. Simpson

11. BIRTHPLACE OF FATHER (State or Country): America

12. MAIDEN NAME OF MOTHER: Nancy Henderson

13. BIRTHPLACE OF MOTHER (State or Country): Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mary E. Simpson
(Address) Newdale

15. Filed Apr 11 1921 W. S. Wright Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March 7 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 21 1921 to March 7 1921, that I last saw h[illegible] alive on March 7 1921 and that death occurred on the date stated above, at 3 A. M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 14 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. Frank Matthews M. D.

March 8th 1921 (Address) St Anthony Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Newdale	3/9 1921

20. UNDERTAKER	ADDRESS
W. A. Harris	Rexburg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTGS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33829

Registered No.

RECEIVED
APR 27 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 99

Primary Registration District No. 177

County of Fremont

City of St. Anthony (If outside limits of city or village, give township) (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lorenzo Jeffs

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: September 14th 1842 (Month) (Day) (Year)

7. AGE: 58 Yrs. 6 Mos. 17 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Rancher

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: Williams Jeffs

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Emma Summers

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Harriett Jeffs

(Address) Parker Idaho

15. Filed Apr 10 1921 W Durrant Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 7th 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3/7/1921, to 3/7/1921, that I last saw him alive on 3/7/1921, and that death occurred on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Cardiac failure

(Duration) two Yrs. two mos. two ds.

Contributory (Secondary) Indigestion acute

(Duration) ..... yrs. ..... mos. few ds.

(Signed) Frank Heaney M. D.

3 10 1921 (Address) St Anthony Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Parker Cemetery — DATE OF BURIAL: Mar 11th 1921

20. UNDERTAKER: Taylor Eberson Undtg Co. By W. M. Robinson — ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 99

Primary Registration District No. 2177

File No. 33830

Registered No.

County of Fremont

City of St Anthony (No. St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

RECEIVED
APR 27 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME Silva Mary Hobbs

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Feb (Month) 11 (Day) 1921 (Year)

7. AGE: Yrs. Mos. 16 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Raymond H. Hobbs

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Minnie McCarthey

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ernest W Hobbs

(Address) St Anthony R 7D # 2

15. Filed Nov 10 1921

W D Wurst
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb 27 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 25 1921, to Feb 27 1921, that I last saw h.me alive on Feb 26 1921, and that death occurred on the date stated above, at 8 P M.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia.

(Duration) Yrs. mos. 5 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. Frank Watkins M. D.

1921 (Address) St Anthony Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Wilford, Ida.

DATE OF BURIAL 1921

20. UNDERTAKER: David R Young

ADDRESS Rexburg Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
APR 27 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 99

Primary Registration District No. 7117

File No. 33831

County of Bonneville

City of St. Anthony (or Village, or Township, or Precinct, and St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Howard Alla Coulson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH: Jan (Month) 19 (Day) 1921 (Year)

7. AGE: 1 Yrs. 0 Mos. ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ida

10. NAME OF FATHER: Alla Coulson

11. BIRTHPLACE OF FATHER (State or Country): Texas

12. MAIDEN NAME OF MOTHER: Pearl Howard

13. BIRTHPLACE OF MOTHER (State or Country): Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant)
(Address) A. M. Blanchard

15. Filed Mar 10 1921 W Dwire
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feby (Month) 24 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from at No 19..., to time 19...,
that I last saw h... alive on ...19...,
and that death occurred on the date stated above, at ...M.
The CAUSE OF DEATH* was as follows: Bronchial Pneumonia

(Duration) ...Yrs...mos...ds.
Contributory (Secondary)
(Duration) ...yrs...mos...ds.
(Signed) W Dwire M. D.
...19... (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death...yrs...mos...days. In the State...yrs...mos...days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mary Ville | DATE OF BURIAL: 26 1921

20. UNDERTAKER: None | ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33832
Registered No.

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BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Fremont. Registration District No. 49

City of St. Anthony (No. ..... St.) Primary Registration District No. 2177

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Theodora A. Daniels

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Male	White	Married (Write the word.)

6. DATE OF BIRTH: August (Month) 24th (Day) 1876 (Year)

7. AGE: 45 Yrs. 5 Mos. 30 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Engineer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Theodora Daniels

11. BIRTHPLACE OF FATHER (State or Country): Ill.

12. MAIDEN NAME OF MOTHER: Sarah E. Spaulding

13. BIRTHPLACE OF MOTHER (State or Country): Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Isabel N. Daniels
(Address) St. Anthony, Idaho

15. Filed Mar 10 1921 W. D. West Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: February (Month) 23rd (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 22 1921, to Feb 23rd 1921, that I last saw h. alive on Feb 23rd 1921, and that death occurred on the date stated above, at 5.20 P. M.

The CAUSE OF DEATH* was as follows:
Chronic cardiac Valvular disease
Nephritis, chronic Interstitial
(Duration) Unknown. Yrs. mos. ds.
Contributory (Secondary) Acute Uremia.
(Duration) yrs. mos. 1 ds.

(Signed) J. Frank Watkins M. D.
Feb 25 1921 (Address) St. Anthony Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence Rexburg, Idaho

19. PLACE OF BURIAL OR REMOVAL: St. Anthony, Idaho | DATE OF BURIAL: Feb 26th 1921

20. UNDERTAKER: Taylor Chesen Undtg Co. By W. M. Hansen | ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3383

RECEIVED
APR 27 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Fremont
City of St Anthony (St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 99
Primary Registration District No. 2177

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ralph Miller

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
male	white	single

6. DATE OF BIRTH Feb. 22ond

Feb. (Month) 22 (Day) 1921 (Year)

7. AGE Yrs. 6 Mos. 11 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work infant
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Chas. Conrad Miller

11. BIRTHPLACE OF FATHER (State or Country) Idaho

12. MAIDEN NAME OF MOTHER Nina Stal[illegible]

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) G Harris Miller
(Address)

15. Filed May 10 1921 W D Wood
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Febuary (Month) 22 (Day) 19 21 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 19 1921, to Feb. 22 1921, that I last saw him alive on Feb. 22 1921, and that death occurred on the date stated above, at [illegible] M.
The CAUSE OF DEATH* was as follows:
broncho pneumonia

(Duration) Yrs. mos. 5 ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) W D Wood M. D.
19 (Address) St Anthony Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Walford Ida | DATE OF BURIAL 2 4 1921

20. UNDERTAKER None | ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

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FORM V. S. No. 5-25 M. 1-19.

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BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Fremont

City of St Anthony (If outside limits, give township.) (St.)

Registration District No. 99

Primary Registration District No. 2177

File No. 33834

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Warren Leland Williams

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	white	Single

6. DATE OF BIRTH: Nov (Month) 19 (Day) 1920 (Year)

7. AGE: Yrs. 3 Mos. 2 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Ida

10. NAME OF FATHER Chas Williams

11. BIRTHPLACE OF FATHER (State or Country) Wales

12. MAIDEN NAME OF MOTHER May Knight

13. BIRTHPLACE OF MOTHER (State or Country) Switzerland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Charles Williams
(Address)

15. Filed Mar 10 19 21 W. B. Wix Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feby (Month) 21 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feby 17 1921, to Feby 21 1921, that I last saw h[illegible] alive on Feby 21 1921, and that death occurred on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:
Broncho Pneumonia

(Duration) ..... Yrs. ..... mos. 4 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. B. Wix M. D.

19 ..... (Address) St Anthony Ida

*State the **Disease Causing Death**; or in deaths from **Violent Causes**, state (1) **Means of Injury**; and (2) whether **Accidental, Suicidal or Homicidal.**

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Carlos Ida	2 24 1921
20. UNDERTAKER: None	ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED MAY 3 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No.

Primary Registration District No.

File No. 33835

Registered No.

1. PLACE OF DEATH

County of Fremont

City of Drummond

(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sarah Ann Hecker

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Widowed

6. DATE OF BIRTH April (Month) 16 (Day) 1855 (Year)

7. AGE 66 Yrs. — Mos. 13 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Salt Lake City Utah

10. NAME OF FATHER — Thorneck

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER — Batt

13. BIRTHPLACE OF MOTHER (State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Hathaway

(Address) Drummond Idaho

15.

Filed 19

Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 4 (Month) 29 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4/29/21 to 19

that I last saw h alive on 4/29 1921

and that death occurred on the date stated above, at 10.30 M.

The CAUSE OF DEATH* was as follows:

Acute Indigestion

(Duration) Yrs. mos. 3rd ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) C M Mecham M. D.

4/29 1921 (Address) Ashton Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Dilworth Ida DATE OF BURIAL 5-1 1921

20. UNDERTAKER Lewis Kiser ADDRESS Ashton Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33836
Registered No.

1. PLACE OF DEATH

Registration District No.
(If Registration District No. 6)

County of Gem
City of Ola (St.)

If death occurs away from usual residence, give facts called for under special information.

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APR 14 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME Elizabeth Holbrook

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	married

6. DATE OF BIRTH: June 24 (Month) (Day) 1838 (Year)

7. AGE: 82 Yrs. 8 Mos. 21 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmers wife
(b) General nature of industry, business or establishment in which employed (or employer): farm house work

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: A Mr Burton

11. BIRTHPLACE OF FATHER (State or Country): I do not know

12. MAIDEN NAME OF MOTHER: Do not know

13. BIRTHPLACE OF MOTHER (State or Country): Pennsylvania

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John M Holbrook
(Address) Sweet Ida

15. Filed Mar 20 1921 J. L. Reynolds Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar (Month) 15 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 17 1921, to Mar 15 1921, that I last saw h.r alive on Feb 28 1921, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Mitral lesion of heart

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Burton O Clark M. D.

Mar 16 1921 (Address) Emmett Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Ola	19

20. UNDERTAKER	ADDRESS
Family	

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33837
Registered No.

RECEIVED
APR 14 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
Registration District No.
County of Gem
Primary Registration District No. 6
City of Emmett (No. St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Harriet Dresser
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: widow (Write the word.)

6. DATE OF BIRTH: Mar 28 1841 (Month) (Day) (Year)

7. AGE: 79 Yrs. 10 Mos. 26 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Penn.

10. NAME OF FATHER: Aukenbaur

11. BIRTHPLACE OF FATHER (State or Country): Not Known

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. C. Dresser
(Address) Emmett Idaho

15. Filed Mar 5 1921 J. L. Reynolds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb 24 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 16 1921 to Feby 24 1921 that I last saw hdr alive on Feby 24 1921, and that death occurred on the date stated above, at 5 P M.

The CAUSE OF DEATH* was as follows:
Bronchopneumonia
Following influenza
(Duration) Yrs. 1 mos. ds.
Contributory (Secondary) Chronic nephritis
(Duration) Several yrs. mos. ds.

(Signed) R. N. Cummins M. D.
2/26 1921 (Address) Emmett

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Emmett Idaho
DATE OF BURIAL: 2/26 1921

20. UNDERTAKER: O. L. Buckmun
ADDRESS: Emmett Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33838
Registered No.

1. PLACE OF DEATH
County of Gem
City of Emmett (No. 1 St.)
Registration District No.
Primary Registration District No. 6

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BUREAU OF VITAL STATISTICS

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Dorothy Bernice Lundt

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Infant (Write the word.)

6. DATE OF BIRTH: March 9 1921 (Month) (Day) (Year)

7. AGE: — Yrs. — Mos. 2 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Revillo Lundt

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Florine Murray

13. BIRTHPLACE OF MOTHER (State or Country): Arkansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Revillo Lundt
(Address) Emmett Ida

15. Filed May 11 1921
J. K. Reynolds
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 11 - 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 10 - 1921 to May 11 1921, that I last saw h[illegible] alive on May 10 1921, and that death occurred on the date stated above, at 5 P. M.
The CAUSE OF DEATH* was as follows:
Melena
(Duration) Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) Burton O Clark M. D.
1921 (Address) Emmett Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Emmett Idaho
DATE OF BURIAL: 3/11 1921

20. UNDERTAKER: C D Buckenum
ADDRESS: Emmett Idaho

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MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33839
Registered No.

1. PLACE OF DEATH
County of Gem
City of Emmett (No. ..... St.)
Registration District No. 6
Primary Registration District No.
If death occurs away from usual residence, give facts called for under special information.

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2. FULL NAME Hannah Sorensen
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: widowed (Write the word.)

6. DATE OF BIRTH: Dec (Month) 4 (Day) 1859 (Year)

7. AGE: 61 Yrs. 1 Mos. 1 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Sweeden

10. NAME OF FATHER: Anderson

11. BIRTHPLACE OF FATHER (State or Country): Sweeden

12. MAIDEN NAME OF MOTHER: Not Known

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jesse Sorensen
(Address) Emmett Idaho

15. Filed Jan 20 1921 J. V. Reynolds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. (Month) 5 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 5 1921, to Jan 5 1921, that I last saw her alive on Jan 5 1921, and that death occurred on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:
Chronic Myocarditis

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) R. N. Cummings M. D.
1/7 1921 (Address) Emmett Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Emmett Idaho	1/8 1921
20. UNDERTAKER: O. D. Buckenum	ADDRESS: Emmett Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
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FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33840
Registered No.

1. PLACE OF DEATH
County of Gem
City of Emmett
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 6
Primary Registration District No.
(No. St.)

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BUREAU OF VITAL STATISTICS

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mahala Martin

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: widow (Write the word.)

6. DATE OF BIRTH: Aug 16 1839 (Month) (Day) (Year)

7. AGE: 81 Yrs. 7 Mos. 24 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: unknown

11. BIRTHPLACE OF FATHER (State or Country): "

12. MAIDEN NAME OF MOTHER: "

13. BIRTHPLACE OF MOTHER (State or Country): "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Nellie Jardine
(Address) Emmett Idaho

15.
Filed 4/27 1921
J. L. Reynolds
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr. (Month) 10 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 23, 1921, to Apr 10 1921, that I last saw h[illegible] alive on Mar 23 1921, and that death occurred on the date stated above, at ____ M.

The CAUSE OF DEATH* was as follows: Chronic valvular heart disease

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Burton O Clark M. D.
19 (Address) Emmett Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Emmett Idaho
DATE OF BURIAL: 4/12 1921

20. UNDERTAKER: D Buckmaster
ADDRESS: Emmett Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33841
Registered No.

RECEIVED
MAY 3 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No.
County of
Primary Registration District No. 6
City of (No. St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William Little

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	white	Bachelor

6. DATE OF BIRTH: Dec (Month) 21 (Day) 1865 (Year)

7. AGE: 55 Yrs. 3 Mos. 24 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Scotland

10. NAME OF FATHER: Andrew Little

11. BIRTHPLACE OF FATHER (State or Country): Scotland

12. MAIDEN NAME OF MOTHER: Janet Dalgliesh

13. BIRTHPLACE OF MOTHER (State or Country): Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Walter C. Little
(Address) Emmett, Ida.

15. Filed 4/22 1921 J. L. Reynolds Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr (Month) 15 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 11 1921, to April 15 1921, that I last saw him alive on April 15 1921, and that death occurred on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:
Chronic Valvular Heart disease

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Burton O. Clark M. D.

19 (Address) Emmett Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Emmett Idaho	4/17 1921
20. UNDERTAKER: C. D. Buckner	ADDRESS: Emmett Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

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MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33842
Registered No.

RECEIVED
MAY 3 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Gem
City of Emmett (St.)
Registration District No. 6
Primary Registration District No.
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Rush Von Harten
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widower

6. DATE OF BIRTH: Sept. (Month) 7 (Day) 1850 (Year)

7. AGE: 70 Yrs. 7 Mos. 10 ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Virginia

10. NAME OF FATHER: Anthony Von Harten

11. BIRTHPLACE OF FATHER (State or Country): Maryland

12. MAIDEN NAME OF MOTHER: Phoebe Rush

13. BIRTHPLACE OF MOTHER (State or Country): Penn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W K Von Harten
(Address) Pearl Idaho

15. Filed 4/22 1921
J. A. Reynolds
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr (Month) 17 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 14 1921, to Apr 17 1921, that I last saw h~~im~~alive on Apr 16 1921, and that death occurred on the date stated above, at 4 a. M.

The CAUSE OF DEATH* was as follows:
~~Chronic Interstitial Heart disease~~
Angina Pectoris
(Duration) ... Yrs. ... mos. ... ds.
Contributory (Secondary)
(Duration) ... yrs. ... mos. ... ds.

(Signed) Burton O Clark M. D.
19 (Address) Emmett Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Pearl Idaho	19
20. UNDERTAKER: C D Bucknum	ADDRESS: Emmett Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

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MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33843
Registered No.

Registration District No.
Primary Registration District No. 6

RECEIVED
MAY 3 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Gem
City of Emmett
(No. St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Edgar Fountaine
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): widower

6. DATE OF BIRTH: Feb (Month) 28 (Day) 1861 (Year)

7. AGE: 60 Yrs. 2 Mos. 21 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Canada

10. NAME OF FATHER: Isaac Fountaine

11. BIRTHPLACE OF FATHER (State or Country): Canada

12. MAIDEN NAME OF MOTHER: Adile Barbeau

13. BIRTHPLACE OF MOTHER (State or Country): Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. K. B. Hamelburg
(Address) Baker Ore

15. Filed 4/22 1921
J. D. Reynolds
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr (Month) 19 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 22 1921, to Apr 19 1921, that I last saw him alive on Apr 18 1921, and that death occurred on the date stated above, at 3:20 P.M.
The CAUSE OF DEATH* was as follows:
Angina Pectoris
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Burton A Hoch M. D.
19..... (Address) Emmett Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Emmett Idaho
DATE OF BURIAL: 4/22 1921

20. UNDERTAKER: C. Buckner
ADDRESS: Emmett Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

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FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED
MAY 3 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33844
Registered No.

1. PLACE OF DEATH

County of Elmore
Registration District No. 6
Primary Registration District No.
City of Emmett (or Town) (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME No name

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	W	Infant

6. DATE OF BIRTH Apr (Month) 4 (Day) 1921 (Year)

7. AGE Yrs. Mos. 5 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Emmett Elmore Co. Ida

10. NAME OF FATHER Clyde McClure

11. BIRTHPLACE OF FATHER (State or Country) Oregon

12. MAIDEN NAME OF MOTHER Myrtle Hiamy

13. BIRTHPLACE OF MOTHER (State or Country) Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address) A. H. Hearing

15. Filed 5/11 1921 J. K. Reynolds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Apr (Month) 9 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 4 1921, to Apr 9 1921, that I last saw h... alive on Apr 7 1921, and that death occurred on the date stated above, at 11 P. M.

The CAUSE OF DEATH* was as follows:

Premature birth 6½ mo

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. K. Reynolds M. D.

5/11 1921 (Address) Emmett Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Emmett — **DATE OF BURIAL** Apr 11 1921

20. UNDERTAKER D. Buchanan — **ADDRESS** Emmett

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

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FORM V. S. No. 5-25 M. 1-19.

RECEIVED
MAY 3 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33845
Registered No.

1. PLACE OF DEATH
County of Gem Registration District No.
Primary Registration District No.
City of Emmett (St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William E. Mix
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: widower (Write the word.)

6. DATE OF BIRTH: Nov. 4 1838 (Month) (Day) (Year)

7. AGE: 82 Yrs. 4 Mos. 10 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Physician
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Penn

10. NAME OF FATHER: unknown

11. BIRTHPLACE OF FATHER (State or Country): "

12. MAIDEN NAME OF MOTHER: "

13. BIRTHPLACE OF MOTHER (State or Country): "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Maggie Mrs Davis
(Address) Emmett Idaho

15. Filed 4/16/ 1921 J. L. Reynolds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar. 14 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased ~~from~~ on Mar 14 1921, to 19..., that I last saw h~~im~~ alive on Mar 14 1921, and that death occurred on the date stated above, at 3 P. M.
The CAUSE OF DEATH* was as follows:
Chronic Valvular Heart with Angina Pectoris
(Duration) Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) Burton O. Clark M. D.
Mar 17 1921 (Address) Emmett Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Emmett Idaho
DATE OF BURIAL: 3/15 1921
20. UNDERTAKER: C. D. Buckmun
ADDRESS: Emmett Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
MAY 3 1921
BUREAU OF VITAL STATISTICS

Registration District No.
Primary Registration District No.
File No. 33846
Registered No.

1. PLACE OF DEATH
County of Gem
City of Emmett (Ward) St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Harold Steunenberg

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	white	Infant

6. DATE OF BIRTH ~~Jan~~ Feb 11 1921
(Month) (Day) (Year)

7. AGE ~~Yrs.~~ 1 Mos. 22 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Infant
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Julian Steunenberg

11. BIRTHPLACE OF FATHER (State or Country) Iowa

12. MAIDEN NAME OF MOTHER Frances B. Wood

13. BIRTHPLACE OF MOTHER (State or Country) Wash

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Julian Steunenberg
(Address) Emmett Idaho

15. Filed 4/3 1921 J. L. Reynolds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Apr (Month) 2 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 25 1921, to Apr 2 1921, that I last saw him alive on Apr 2 1921, and that death occurred on the date stated above, at 11 10 A.M.

The CAUSE OF DEATH* was as follows:
Bronchial Pneumonia

(Duration) Yrs. mos. 6 ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) J. L. Reynolds M. D.
4/3 1921 (Address) Emmett

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Caldwell Idaho	4/3 1921

20. UNDERTAKER	ADDRESS
C. R. Buckner	Emmett Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

CERTIFICATE OF DEATH. ✓

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33847

Registered No. .....

RECEIVED
MAY 10 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH.
County of Gooding — Registration District No. 24
City of Gooding (No. ..... St.) — Primary Registration District No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Thomas Eddy Bennett

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Nov. (Month) 9 (Day) 1847 (Year)

7. AGE: 73 Yrs. 4 Mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Lawyer
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ind

10. NAME OF FATHER: Wm Bennett

11. BIRTHPLACE OF FATHER (State or Country): N. C.

12. MAIDEN NAME OF MOTHER: Abigail Neeley

13. BIRTHPLACE OF MOTHER (State or Country): N.Y.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. J. E. Bennett
(Address) Gooding, Idaho

15. Filed 4 — 6 — 1921 — F J Cary MD — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 5 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 2 1921, to April 5 1921, that I last saw him alive on April 5 1921, and that death occured on the date stated above, at 12 30 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage —
Apoplexy —

(Duration) ..... Yrs. ..... mos. 3 ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) L W Cary — M. D.
4/6 1921 (Address) Gooding, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Gooding Cemetery — DATE OF BURIAL: 4-7-1921

20. UNDERTAKER: A E Thompson — ADDRESS: Gooding, Ida

SYMS - YORK CO., PTRS. & BDRS. 24658

Form V. S. No. 5 20M.1-16-12

RECEIVED MAY 10 19.. BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33848
Registered No.

1. PLACE OF DEATH.
Registration District No. 24
County of Gooding
Primary Registration District No.
City of Gooding (No. , St.)
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Clarence R. Beaty.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH
Nov. (Month) 27 (Day) 1903 (Year)

7. AGE
18 yrs. 4 mos. 16 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Rock Co. Colo.

10. NAME OF FATHER
R. F. Beaty

11. BIRTHPLACE OF FATHER
(State or Country) Ohio.

12. MAIDEN NAME OF MOTHER
Helen Nero.

13. BIRTHPLACE OF MOTHER
(State or Country) Wis.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R. F. Beaty
(Address) Grooding Ida.

15.
Filed April 15 1921 F J Cary M.D.
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
April (Month) 13 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 11 1921, to April 13 1921, that I last saw him alive on April 13 1921, and that death occurred on the date stated above, at 9 A. M.

The CAUSE OF DEATH* was as follows:
Traumatic Peritonitis, accidental, being kicked in abdomen by horse.
(Duration) yrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) R. A. Johnston D. C. ~~M. D.~~
4-13-1921 (Address) Gooding, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Denver, Colo —	4-17 1921

20. UNDERTAKER	ADDRESS
A E Thompson	Gooding Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

GYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33849
Registered No.

RECEIVED
MAY 10 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Gooding Registration District No. 24
City of Gooding Primary Registration District No. St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Ussery.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.)
F	W	Single

6. DATE OF BIRTH: Mar (Month) 12 (Day) 1921 (Year)

7. AGE: Yrs. 1 Mos. 2 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Gooding Idaho

10. NAME OF FATHER Tecumseh Ussery

11. BIRTHPLACE OF FATHER (State or Country) Mo.

12. MAIDEN NAME OF MOTHER Mary Colson

13. BIRTHPLACE OF MOTHER (State or Country) Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Tecumseh Ussery
(Address) Gooding Idaho

15. Filed 4-15 1921 H H Gary MD Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr (Month) 14 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....19...., to ....19....,
that I last saw h..... alive on ....19....,
and that death occurred on the date stated above, at ....M.
The CAUSE OF DEATH* was as follows:

Whooping Cough
Pneumonia

(Duration) ....Yrs....mos....ds.
Contributory (Secondary)
(Duration) ....yrs....mos....ds.

(Signed) No Doctor in attendance M. D.
....19.... (Address) ....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Gooding Ida	4 18 1921
20. UNDERTAKER	ADDRESS
A E Thompson	Gooding Ida

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 24
Primary Registration District No.
File No. 33850
Registered No.

RECEIVED
APR 14 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Gooding
City of Gooding (If outside limits of city or village, give township.) (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Truman O Sutphen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Male	White	Widower

6. DATE OF BIRTH: January 15 (Month) (Day) 1858 (Year)

7. AGE: 63 Yrs. 2 Mos. 14 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Merchant- Retired
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER: m. Peter Sutphen

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Mary Hallister

13. BIRTHPLACE OF MOTHER (State or Country): Vermont ~~New York~~

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) T. T. Sutphen
(Address) Gooding, Idaho,

15. Filed 4-13-1921 F J Campbell
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar 29 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 15 1921, to Mar 29 1921, that I last saw him alive on Mar 28 1921, and that death occurred on the date stated above, at noon
The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) Yrs. mos. 14 ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) J H Conrad M. D.
3/29 1921 (Address) Gooding Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Gooding Cemetery — DATE OF BURIAL: 3/31 1921

20. UNDERTAKER: A E Thompson — ADDRESS: Gooding

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 24
Primary Registration District No.
File No. 33851
Registered No.

RECEIVED
APR 14 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Gooding
City of Gooding (St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Frieda Hedwig Wetzel

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (or widowed or divorced)

6. DATE OF BIRTH: March (Month) 10th (Day) 1890 (Year)

7. AGE: 31 Yrs. — Mos. 19 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: Pflueger

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Pflueger

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Leo Wetzel
(Address) Gooding Ida

15. Filed 4-13- 1921 F J Caymond
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 29th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 27 1921, to Mar 29 1921
that I last saw h-er alive on Mar 29 1921
and that death occurred on the date stated above, at 3 P. M.
The CAUSE OF DEATH* was as follows:

Septicaemia (Puerperal)

(Duration) ..... Yrs. ..... mos. 10 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. H. Cromwell M. D.
3/29 1921 (Address) Gooding, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Gooding Ida — DATE OF BURIAL: 3/31 1921

20. UNDERTAKER: A E Thompson — ADDRESS: Gooding

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

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FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
MAY 10 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Idaho
City of Grangeville
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 103
Primary Registration District No. 1001
(No. ..... St.)

File No. 33853
Registered No. 9
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Albert L Cosaud

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: March (Month) 7 (Day) 1867 (Year)

7. AGE: 54 Yrs. 4 Mos. 25 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Raucher. Retired
(b) General nature of industry, business or establishment in which employed (or employer): account of Health

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Steven Cosaud

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Mary Sexton

13. BIRTHPLACE OF MOTHER (State or Country): Tenn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs A L Cosaud
(Address) Grangeville

15. Filed May 1 1921 G. S. Stockton Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 2 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 1 1921, to April 2 1921, that I last saw him alive on March 15 1921, and that death occurred on the date stated above, at 6 P. M.
The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 1 year Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G. S. Stockton M. D.
4/3 1921 (Address) Grangeville Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Prairie View — DATE OF BURIAL: Apr 4 1921

20. UNDERTAKER: G. J. Maugg — ADDRESS: City

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED
MAY 7 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6 33854
Registered No. .....

1. PLACE OF DEATH.
Registration District No. 105
Primary Registration District No. 2183
County of Idaho
City of Cottonwood (If not in incorporated limits, give township) St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Robert M. Welte

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. April (Month) 8 (Day) 1921 (Year)

7. AGE ..... Yrs. ..... Mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: Jacob. Welte

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Cecilia Kopczynski

13. BIRTHPLACE OF MOTHER (State or Country): Kan.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) H B Blake M.D.
(Address) Registrar - Cottonwood Ida.

15. Filed April 12 1921 H B Blake. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 12 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 8 1921, to April 12 1921, that I last saw him alive on April 12 1921 and that death occured on the date stated above, at 12:30 P.M.

The CAUSE OF DEATH* was as follows:
Hemorrhagica Neonatorum.

(Duration) ..... Yrs. ..... mos. 2 ds.
Contributory (Secondary) Unknown
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Wesley F. Orr M. D.
4/12 1921 (Address) Cottonwood, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: R C Cemetery Cottonwood Ida — DATE OF BURIAL: April 13 1921

20. UNDERTAKER: None - buried by relatives — ADDRESS: Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 106
Primary Registration District No. 2184
File No. 33855
Registered No. 109

RECEIVED
APR 14 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH.
County of Idaho
City of Stites (St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sylvester Mahlon Summerhart

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married
6. DATE OF BIRTH. November (Month) 4th (Day) 1862 (Year)
7. AGE: 58 Yrs. 4 Mos. 28 ds.
IF LESS than 1 day how many.....hrs. or .....min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Indiana
10. NAME OF FATHER: Levi Summerhart
11. BIRTHPLACE OF FATHER (State or Country): Ohio
12. MAIDEN NAME OF MOTHER: Rachel Fairchilds
13. BIRTHPLACE OF MOTHER (State or Country): Indiana
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mary R Summerhart
(Address) Stites Ida
15.
Filed March 31 1921 J M Kuhn Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Mar (Month) 30th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 30 1921, to Mar 30 1921, that I last saw h. im alive on Mar 29 1921, and that death occured on the date stated above, at 1150 P M.

The CAUSE OF DEATH* was as follows:
Wagon and Contents rolled on and crushed him to death

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration ..... yrs. ..... mos ..... ds.
(Signed) H W Whitworth M. D.
Mar 31 1921 (Address) Stites Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Near Stites
DATE OF BURIAL: Apr 1 1921
20. UNDERTAKER: Geo Denary
ADDRESS: Lorkin

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 106
Primary Registration District No. 2184
File No. 33856
Registered No. 108

RECEIVED
APR 14 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH.
County of Idaho
City of Kooskia (If death occurs away from usual residence, give facts called for under special information.) St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Emma Hall

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow
6. DATE OF BIRTH. Sep. (Month) 29 (Day) 1837 (Year)
7. AGE: 83 Yrs. 5 Mos. 22 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....
9. BIRTHPLACE (State or Country): Ohio
10. NAME OF FATHER: John Strate
11. BIRTHPLACE OF FATHER (State or Country): ✓
12. MAIDEN NAME OF MOTHER: ✓
13. BIRTHPLACE OF MOTHER (State or Country): ✓
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Emery Micholson
(Address) Kooskia Idaho.
15. Filed March 30 1921 — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 22 (Day) 1921 (Year)
17. I HEREBY CERTIFY, That I attended deceased from March 18 1921, to March 22 1921, that I last saw her alive on March 22 1921, and that death occured on the date stated above, at 8 P M.
The CAUSE OF DEATH* was as follows:
Chronic Interstitial Nephritis
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Arterio Sclerosis
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) J. M. Weber Kraus M. D.
Mch 1921 (Address) Kooskia Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Kooskia Cemetery — DATE OF BURIAL: March 24 1921
20. UNDERTAKER: Geo Feeney — ADDRESS: Kooskia

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33857

Registered No. 107

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

RECEIVED
APR 14 1921
BUREAU OF VITAL STATISTICS

Registration District No. 106

Primary Registration District No. 2184

1. PLACE OF DEATH.
County of Idaho
City of States (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Alfred Wheeler

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Red

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. April (Month) 17th (Day) 1920 (Year)

7. AGE: ..... Yrs. 10 Mos. 19 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Harry Wheeler

11. BIRTHPLACE OF FATHER (State or Country): Oregon

12. MAIDEN NAME OF MOTHER: Ida James

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Parent Wheeler
(Address) Ahsahka Idaho

15. Filed March 30 1921 J M Verbarendt Local Registrar

SYMS - YORK CO., PTRS. & SDRS. 24858

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 8th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 4 1921, to Mar 8 1921, that I last saw him alive on Mar 8 1921, and that death occured on the date stated above, at 3 P M.

The CAUSE OF DEATH* was as follows:
Severe bronchio pneumonia
Cut six teeth
Abscess with sore

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Lungs never cleared

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) H W Wentworth M. D.
Mar 8 1921 (Address) States Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: States — DATE OF BURIAL: Mar 10 1921

20. UNDERTAKER — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 106

Primary Registration District No. 2184

File No. 33858

County of Idaho

City of Kooskia (No. ..... St.)

Registered No. 106

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
APR 14 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME William Pierre Corbett.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Indian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. ✓ (Month) ..... (Day) ..... 1 (Year)

7. AGE: About 78 yrs. ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Montana

10. NAME OF FATHER: ✓

11. BIRTHPLACE OF FATHER (State or Country): ✓

12. MAIDEN NAME OF MOTHER: ✓

13. BIRTHPLACE OF MOTHER (State or Country): ✓

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) William Corbett
(Address) Kooskia

15. Filed March 30 1921 J M Weberkuses Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 6 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 1 1920, to Feb 1921, that I last saw h.m alive on Mar 2 1921, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Asteno Sclerosis
Cerebral Embolism
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Cancer
..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) J M Weberkuses M. D.
March 7 1921 (Address) Kooskia Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Corbett Cemetery, Kooskia — DATE OF BURIAL: 3/9 1921

20. UNDERTAKER: Geo Feeney — ADDRESS: Kooskia Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33859
Registered No. 105

1. PLACE OF DEATH.
County of Idaho
City of Shtes (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 106
Primary Registration District No. 2184

RECEIVED
APR 14 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME Warren Earl Howard

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH. Jan (Month) 24 (Day) 1919 (Year)

7. AGE: 1 Yrs. 1 Mos. 9 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession, or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Daniel Cyrus Howard

11. BIRTHPLACE OF FATHER (State or Country): Arkansas

12. MAIDEN NAME OF MOTHER: Hattie Bonnie Percifull

13. BIRTHPLACE OF MOTHER (State or Country): Washington

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. Hattie Howard
(Address) Shtes Idaho

15.
Filed March 30 1921
J. M. Seberhens
Local Registrar

SYMS - YORK CO., PTRS. & SORS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 5th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 23 1921, to Mar 4 1921, that I last saw him alive on Mar 4 1921, and that death occured on the date stated above, at 5 A. M.

The CAUSE OF DEATH* was as follows:
Whooping cough —

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) H W Whitworth M. D.
Mar 5 1921 (Address) Shtes Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Shtes Idaho — DATE OF BURIAL: May 7 1921

20. UNDERTAKER: Geo Freeman — ADDRESS: Rooster Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33860
Registered No. 1044

RECEIVED
APR 14 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH.
County of Idaho
City of Kooskia (No. ..... St.)
Primary Registration District No. 2184
Registered District No. 106
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Emma Matilda Engle

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Oct (Month) 19 (Day) 1886 (Year)

7. AGE: 34 Yrs. 4 Mos. 27 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Frank Overton

11. BIRTHPLACE OF FATHER (State or Country): Don't Know

12. MAIDEN NAME OF MOTHER: Fannie King

13. BIRTHPLACE OF MOTHER (State or Country): Not Ascertained

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Leon Engle
(Address) Kooskia - Idaho

15. Filed March 18 1921
J. M. Verbeck Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 16 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 7 1921, to March 16 1921, that I last saw h[er] alive on March 16 1921, and that death occured on the date stated above, at 9:45 P.M.

The CAUSE OF DEATH* was as follows:
Puerperal Peritonitis

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Verbeck M. D.
Mch 17 1921 (Address) Kooskia - Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Kooskia Cemetery
DATE OF BURIAL: Mch 18 1921

20. UNDERTAKER: Geo Feeney
ADDRESS: Kooskia

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED
APR 20 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 98
Primary Registration District No. 2176

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33861
Registered No.

1. PLACE OF DEATH
County of Jefferson
City of Roberts
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Nina Lyle Cable

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: married (Write the word.)

6. DATE OF BIRTH: Feb 23 (Month) (Day) 1869 (Year)

7. AGE: 52 Yrs. 11 Mos. 18 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Michigan

10. NAME OF FATHER: Jackson Maddix

11. BIRTHPLACE OF FATHER (State or Country): N.Y.

12. MAIDEN NAME OF MOTHER: Ellen Martin

13. BIRTHPLACE OF MOTHER (State or Country): N.Y.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wm Cable
(Address) Roberts Ida

15. Filed 4-10 1921 Ray H. Fisher Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 11 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 31 1921 to Feb 11 1921 that I last saw h.er alive on Feb 11 1921 and that death occurred on the date stated above, at 9 P.M.
The CAUSE OF DEATH* was as follows:
Acute Endo Carditis

..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
..... (Duration) ..... yrs. ..... mos. 12 ds.
(Signed) Dr O.B. Beller M. D.
2-15 1921 (Address) Roberts, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Roberts
DATE OF BURIAL: 2-16 1921

20. UNDERTAKER: Cliff C. Hayes
ADDRESS: Ida Falls

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
MAY 7 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33863
Registered No.

1. PLACE OF DEATH
County of Twin Falls — Registration District No. 36
City of Kimberly — Primary Registration District No.
(No.) (St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Raymond Dale Breazeale
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE:

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.):

6. DATE OF BIRTH: Jan (Month) 23 (Day) 1 9 21 (Year)

7. AGE: Yrs. Mos. 4 5 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work:
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: James Blain Breazeale

11. BIRTHPLACE OF FATHER (State or Country): Mo

12. MAIDEN NAME OF MOTHER: Grace May Ellis

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. B. Breazeale
(Address) Kimberly, Ida

15. Filed Mar 10 1921 — J. M. Davis, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51083

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar (Month) 9 (Day) 19 21 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3-2 19 21, to Mar 9 19 21, that I last saw h alive on Mar 2 19 21, and that death occurred on the date stated above, at 1 1/2 P. M.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Duration) Yrs. mos. 2 ds.

Contributory (Secondary) Whooping cough

(Duration) yrs. mos. 4 ds.

(Signed) J. M. Davis M. D.

3/10 1921 (Address) Kimberly, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls. — DATE OF BURIAL: 3-10 1921

20. UNDERTAKER: none — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

Kamper.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Kootenai RECEIVED Registration District No. 30

City of Atlas MAY 7 Primary Registration District No. 1051

(No. St.)

BUREAU OF VITAL STATISTICS

File No. 33864

Registered No. 916

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William A. McConaghy

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Feb (Month) 11 (Day) 1864 (Year)

7. AGE: 57 Yrs. 2 Mos. 19 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Rancher

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Canada

10. NAME OF FATHER: David McConaghy

11. BIRTHPLACE OF FATHER (State or Country): Scotland

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Wm A McConaghy

(Address) Coeur d Alene Ida

15. Filed May 4 1921 D D Brennan Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 30th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 13 1921, to April 30 1921 that I last saw h.im alive on April 29 1921, and that death occurred on the date stated above, at 5P. M.

The CAUSE OF DEATH* was as follows:

Pernicious Anemia

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J D Mayn M. D.

5th 1921 (Address) Coeur d Alene Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State 30 yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetery

DATE OF BURIAL: 5/4 1921

20. UNDERTAKER: C P B Mooney

ADDRESS: Coeur d'alene Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Kootenai — Registration District No. 30

City of Gibbs — Primary Registration District No. 1037 — File No. 33865

(If not in incorporated limits, write "Village," "Township," or "Precinct," and name.) — Registered No. 913

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ralph Harley Higgins

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	

6. DATE OF BIRTH: March (Month) 8 (Day) 1921 (Year)

7. AGE: Yrs. 1 Mos. 20 ds. — IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country) Gibbs Idaho.

10. NAME OF FATHER Harley Wesley Higgins

11. BIRTHPLACE OF FATHER (State or Country) New Brunswick Canada

12. MAIDEN NAME OF MOTHER Beatrice Viola Strickland

13. BIRTHPLACE OF MOTHER (State or Country) Nova Scotia Canada.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H W Higgins
(Address) Gibbs Idaho

15. Filed May 4 1921 D D Drenna — Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 28 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 18 1921, to April 28 1921, that I last saw h[illegible] alive on April 26 1921, and that death occurred on the date stated above, at 8a M.

The CAUSE OF DEATH* was as follows:
Cerebro Spinal Meningitis

(Duration) — Yrs. — mos. 12 ds.
Contributory (Secondary) Malnutrition
(Duration) — yrs. — mos. 30 ds.

(Signed) W H Haeden M. D.
4/28 1921 (Address) Coeur d'Alene.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetery — DATE OF BURIAL: 4/29 1921

20. UNDERTAKER: R P Mooney — ADDRESS: Coeur d'Alene

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Kootenai — Registration District No. 30

City of Coeur d'Alene (Mullan) St.) — Primary Registration District No. 1057

File No. 33866

Registered No. 914

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charles Anders

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

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MAY 7 1923
BUREAU OF VITAL STATISTICS

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: April (Month) 26 (Day) 1921 (Year)

7. AGE: — Yrs. — Mos. 1 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Paul Anders

11. BIRTHPLACE OF FATHER (State or Country): Wis

12. MAIDEN NAME OF MOTHER: Elizabeth Kilborn

13. BIRTHPLACE OF MOTHER (State or Country): Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Carl Anders

(Address) Coeur d'Alene

15. Filed May 4 1921 D D Drema
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 27 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 26 1921 to April 27 1921 that I last saw him alive on April 27 1921 and that death occurred on the date stated above, at 1200 M.

The CAUSE OF DEATH* was as follows:

Atelectasis (Probable) Congenital

(Duration) ..... Yrs. ..... mos. 1 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J O Dreyer M. D.

4/27 1921 (Address) Coeur d'Alene Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. 1 days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: St Thomas Cem — DATE OF BURIAL: 4/28 1921

20. UNDERTAKER: P P Downey — ADDRESS: Coeur d'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

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FORM V. S. No. 5-25 M. 1-19.

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BUREAU OF VITAL STATISTICS
STATE OF IDAHO

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 30
Primary Registration District No. 1251
File No. 33867
Registered No. 913

1. PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Frank X. Graf
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Feb (Month) 9 (Day) 1862 (Year)

7. AGE: 59 Yrs. 2 Mos. 18 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: John Graf

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Margaret Bierman

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Frank Graf
(Address) Coeur d'Alene Ida.

15. Filed May 7 1921 — D D Drenna, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 27th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 4 1921, to April 27 1921, that I last saw h.. alive on April 20 1921, and that death occurred on the date stated above, at 10.30 M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(Duration) 1 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J C Bryan M. D.
4/28 1921 (Address) Coeur d'Alene Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State 10 yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: St Thomas Cemetery — DATE OF BURIAL: 4/29 1921

20. UNDERTAKER: C P B Mooney — ADDRESS: Coeur d'Alene Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
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FORM V. S. No. 5-25 M. 1-19.

RECEIVED MAY 7 BUREAU OF VITAL STATISTICS STATE OF IDAHO

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 30
Primary Registration District No. 1057
File No. 33868
Registered No. 912

1. PLACE OF DEATH

County of Kootenai
City of Coeur d'Alene (No. 412 Garden Ave St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Henry K Klappenburg

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH: Dec (Month) 28 (Day) 1872 (Year)

7. AGE: 58 Yrs. 3 Mos. 25 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: City of Coeur d'Alene
(b) General nature of industry, business or establishment in which employed (or employer): Street Dept.

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: Henry K Klappenburg

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Ackermann

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs L. K. Klappenburg
(Address) Coeur d'Alene, Id.

15. Filed May 4 1921 D D Brennan, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 23 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19....., that I last saw h..... alive on ..... 19....., and that death occurred on the date stated above, at 10:30 A M.

The CAUSE OF DEATH* was as follows:
Probable Apoplexy
Found dead in his home
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Epilepsy
(Duration) several yrs. ..... mos. ..... ds.
(Signed) R B Mooney Coroner M. D.
19..... (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State 30 yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetery | DATE OF BURIAL: 4/25 1921

20. UNDERTAKER: R B Mooney | ADDRESS: Coeur d'Alene.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

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N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

RECEIVED MAY 7 BUREAU OF STATISTICS

Registration District No. 30

Primary Registration District No. 1057

File No. 33869

Registered No. 911

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Kootenai

City of Coeur d'Alene (If outside limits, give township) 318 8 11th St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Archibald A. Alkire

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): married

6. DATE OF BIRTH: May (Month) 13 (Day) 1876 (Year)

7. AGE: 44 Yrs. 11 Mos. 6 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Miner

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wis

10. NAME OF FATHER: W. A. Alkire

11. BIRTHPLACE OF FATHER (State or Country): Ill.

12. MAIDEN NAME OF MOTHER: Ella Davis

13. BIRTHPLACE OF MOTHER (State or Country): Iowa.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ella Alkire

(Address)

15. Filed May 7 1921 D. D. Brennan Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 19 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....

that I last saw h..... alive on ..... 19.....,

and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis complicated

Miners Consumption

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. J. Thurston M. D.

4/20 1921 (Address) D. D. Brennan

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetery — DATE OF BURIAL: April 21 1921

20. UNDERTAKER: C. Cassedy — ADDRESS: Coeur d'

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 30
Primary Registration District No. 1051
File No. 33870
Registered No. 910

1. PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene (No. 4th & Best St.)
If death occurs away from usual residence, give facts called for under special information.

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BUREAU OF VITAL STATISTICS
STATE OF IDAHO

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Anna Jacobsen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widow (Write the word.)
6. DATE OF BIRTH: 6 (Month) 25 (Day) 1857 (Year)
7. AGE: 63 Yrs. 9 Mos. 9 ds. IF LESS than 1 day how many ... hrs. or ... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry, business or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Austria Hungary
10. NAME OF FATHER: [illegible] Nowlike
11. BIRTHPLACE OF FATHER (State or Country): Austria Hungary
12. MAIDEN NAME OF MOTHER: ———
13. BIRTHPLACE OF MOTHER (State or Country): Austria Hungary
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Mat Jacobsen
(Address):
15. Filed May 4 1921 D D Drenna Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April 13 (Month) (Day) 21 (Year) 19
17. I HEREBY CERTIFY, That I attended deceased from April 10 19 21 to ... 19 ..., that I last saw h[illegible] alive on April 10 19 21, and that death occurred on the date stated above, at ... M.
The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ... Yrs. ... mos. 7 ds.
Contributory (Secondary)
(Duration) ... yrs. ... mos. ... ds.

(Signed) J C Dwyer M. D.
4/15 19 21 (Address) Coeur d'Alene Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: St Thomas Cem | DATE OF BURIAL: 4/15 19 21
20. UNDERTAKER: C Cassedy | ADDRESS: C of G

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MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Kootenai — Registration District No. 30

City of Coeur d'Alene — Primary Registration District No. 1037

(No. ... St.) Windy Bay

File No. 33871

Registered No. 989

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charles F Selberg

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH — ... (Month) ... (Day) 1 (Year)

7. AGE About 63 Yrs. ... Mos. ... ds.

IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Timberman

(b) General nature of industry, business or establishment in which employed (or employer) ...

9. BIRTHPLACE (State or Country) Minnesota

10. NAME OF FATHER ...

11. BIRTHPLACE OF FATHER (State or Country) ...

12. MAIDEN NAME OF MOTHER ...

13. BIRTHPLACE OF MOTHER (State or Country) ...

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C. D. Lamoreaux

(Address) Worley Idaho

15. Filed May 4 1921 D D Brennan Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH ... 19... (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ... 19... to ... 19..., that I last saw h... alive on ... 19..., and that death occurred on the date stated above, at ... M.

The CAUSE OF DEATH* was as follows: Body found April 15th 1921 in Little Coeur d'Alene, had been dead a number of days.

accidental Drowning

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary) ...

(Duration) ... yrs. ... mos. ... ds.

(Signed) P. B. Mooney Coroner M. D.

4/16 1921 (Address) Coeur d'Alene, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State 10 yrs. ... mos. ... days

Where was disease contracted if not at place of death? ...

Former or usual residence ...

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Forest Cemetery	4/16 1921

20. UNDERTAKER P B Mooney — ADDRESS Coeur d'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

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FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

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MAY 7 1921
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1. PLACE OF DEATH

Registration District No. 30
Primary Registration District No. 1051

County of Kootenai
City of Rathdrum (St.)

File No. 33872
Registered No. 9082

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John K Lee

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
male	white	married

6. DATE OF BIRTH

..... 1 .....
(Month) (Day) (Year)

7. AGE

52 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Wood s. foreman

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Germany.

10. NAME OF FATHER .....

11. BIRTHPLACE OF FATHER (State or Country) .....

12. MAIDEN NAME OF MOTHER .....

13. BIRTHPLACE OF MOTHER (State or Country) .....

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Dr. Frank Wm

(Address) Rathdrum, Ida.

15. Filed May 7 1921 D D Drennan
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 30. 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 24 1921 to March 30 1921 that I last saw h.. alive on March 30 1921 and that death occurred on the date stated above, at 8.15 P.M.

The CAUSE OF DEATH* was as follows:

Idiopathic Peritonitis

..... (Duration) ..... Yrs. ..... mos. 7 ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Frank Wm M. D.

4/7 1921. (Address) Rathdrum, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Rathdrum Ida	April 3 1921
20. UNDERTAKER	ADDRESS
C W Glaun	

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
MAY 7 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Kootenai — Registration District No. 30

City of Rathdrum — Primary Registration District No. 1037

(Ward) (St.)

File No. 33873

Registered No. 907

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Joseph E. Duncan

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	W	

6. DATE OF BIRTH: March 20 (Month) (Day) 1921 (Year)

7. AGE: 69 Yrs. 6 Mos. 20 ds. — IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Vet
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wisconsin

10. NAME OF FATHER: Elijah Duncan

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Foran

13. BIRTHPLACE OF MOTHER (State or Country): New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. [illegible]
(Address) Belmont Island

15. Filed May 7 1921 — D D Drenna, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 20th 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 18 1921 to March 20 1921 that I last saw him alive on March 18. 1921, and that death occurred on the date stated above, at 4:45 A. M.

The CAUSE OF DEATH* was as follows:
Chronic pyaemic Nephritis
a Cont
(Duration) 2 Yrs. mos. ds.
Contributory (Secondary) Chronic Cystitis
a Cont 2
(Duration) 2 yrs. mos. ds.

(Signed) Frank Weng M. D.
3/20 1921 (Address) Rathdrum, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Athol Idaho — DATE OF BURIAL: Mar 21 1921

20. UNDERTAKER: A W Stone — ADDRESS: Rathdrum Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

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FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33874

Registered No. 906

RECEIVED
MAY 7
BUREAU OF STATISTICS

1. PLACE OF DEATH

County of Kootenai Registration District No. 30

Primary Registration District No. 1051

City of Coeur d'Alene (If not in incorporated city or village give township) 1026 3rd St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Carrie Green

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): married

6. DATE OF BIRTH: May (Month) 6 (Day) 1871 (Year)

7. AGE: 49 Yrs. 11 Mos. 3 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Neb.

10. NAME OF FATHER: Fred J. D. Hamlin

11. BIRTHPLACE OF FATHER (State or Country): Mich

12. MAIDEN NAME OF MOTHER: Henrietta J. Northan

13. BIRTHPLACE OF MOTHER (State or Country): N. Y.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Fred D. D. Hamlin
(Address)

15. Filed ~~April~~ May 14 1921 D D Drenna Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 9 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 8 1921, to April 9 1921, that I last saw h[er] alive on April 8 1921, and that death occurred on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A. Dwyer M. D.

April 9 1921 (Address) Coeur d'Alene Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF ~~BURIAL~~ OR REMOVAL: Whitefish, Mont. DATE OF BURIAL 1921

20. UNDERTAKER: C. Cassedy ADDRESS: CdAlene.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

REC... MAY ... BUREAU ... STA...

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 30
Primary Registration District No. 1057

File No. 33875
Registered No. 966

1. PLACE OF DEATH.

County of Kootenai
City of Athol, (If outside limits of city or village, write the name of township. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Robert Louis Agnew

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. December (Month) 10 (Day) 1853 (Year)

7. AGE: 67 Yrs. 2 Mos. 25 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Shoemaker
(b) General nature of industry, business, or establishment in which employed (or employer): Leather shop work.

9. BIRTHPLACE (State or Country): Tennessee

10. NAME OF FATHER: Samuel Ervin Agnew

11. BIRTHPLACE OF FATHER (State or Country): Tennessee

12. MAIDEN NAME OF MOTHER: Elizabeth Sinkler

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Esther Agnew Robinson
(Address) Athol, Idaho.

15. Filed May 4 1921 D.D. Drew Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 7. (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Febry 17. 1921, to March 7. 1921, that I last saw h... alive on March 4 1921, and that death occured on the date stated above, at 8 A. M.

The CAUSE OF DEATH* was as follows:
Emphysema, due to Chronic Pleuritis with effusion.
(Duration) Yrs. 1 mos. ds.
Contributory (Secondary) Myocarditis
(Duration 0 yrs. 6 mos. ds.

(Signed) Frank [illegible] M. D.
3/7 1921 (Address) Rathdrum, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Athol Ida. DATE OF BURIAL: March 9 1921

20. UNDERTAKER: A W. Stone ADDRESS: Rathdrum Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33876
Registered No. 904

1. PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene (If outside limits, give township) (No. ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. ...
Primary Registration District No. ...
MAR 22 1921
BUREAU OF STATISTICS

2. FULL NAME John Wunderlick

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M.	W.	Married

6. DATE OF BIRTH: 9 (Month) — 2 (Day) 1841 (Year)

7. AGE: 79 Yrs. 8 Mos. 3 ds. IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: retired
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: M. Wunderlick

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): E R Wunderlich
(Address): Lompoc, Idaho.

15. Filed May 4 1921 D D Brennan, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 5 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 22 1921, to April 5 1921
that I last saw him alive on April 2 1921
and that death occurred on the date stated above, at 12 00 M.
The CAUSE OF DEATH* was as follows:

Carcinoma of bladder

(Duration) Not known yrs. mos. ds.

Contributory (Secondary)
(Duration) ... yrs. ... mos. ... ds.

4/6 1921 (Signed) A Davis M. D.
(Address) Coeur d'Alene Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Forest Cem.	4-7 1921

20. UNDERTAKER	ADDRESS
C. Cassedy	C D Alene.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Kootenai Registration District No. 30

City of Coeur d'Alene (No.) 9th (St.) Primary Registration District No. 1051

File No. 33877

Registered No. 903

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Baby Nelson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

RECEIVED MAY 7 1921 BUREAU OF VITAL STATISTICS

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: single (Write the word.)

6. DATE OF BIRTH: 4 (Month) 4 (Day) 1921 (Year)

7. AGE: ___ Yrs. ___ Mos. ___ ds.

IF LESS than 1 day how many ___ hrs. or ___ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work ___

(b) General nature of industry, business or establishment in which employed (or employer) ___

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER John C. Nelson

11. BIRTHPLACE OF FATHER (State or Country) Penn.

12. MAIDEN NAME OF MOTHER Glodys A. Dryden

13. BIRTHPLACE OF MOTHER (State or Country) Colo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John C. Nelson

(Address) ___

15. Filed May 4 1921 D D Drenna Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April 4 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ___ 19___, to ___ 19___, that I last saw h___ alive on ___ 19___, and that death occurred on the date stated above, at 10:40 P. M.

The CAUSE OF DEATH* was as follows:

Asphyxia during delivery

(Duration) ___ Yrs. ___ mos. ___ ds.

Contributory (Secondary) ___

(Duration) ___ yrs. ___ mos. ___ ds.

(Signed) J. A. Wagner M. D.

4/6 1921 (Address) Coeur d'Alene Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ___ yrs. ___ mos. ___ days. In the State ___ yrs. ___ mos. ___ days

Where was disease contracted if not at place of death? ___

Former or usual residence ___

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetery

DATE OF BURIAL: 4-6 1921

20. UNDERTAKER: C. Cassedy

ADDRESS: C'dalene

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED MAY 4 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Kootenai — Registration District No. 30

City of Coeur d'Alene (No. ..... St.) — Primary Registration District No. 1051

File No. 22878

Registered No. 202

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Andrew C. Thompson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: married (Write the word.)

6. DATE OF BIRTH: 8 (Month) 7 (Day) 1872 (Year)

7. AGE: 48 Yrs. 7 Mos. 26 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: steam shovel Eng

(b) General nature of industry, business or establishment in which employed (or employer): construction

9. BIRTHPLACE (State or Country): Denmark

10. NAME OF FATHER: Andrew Thompson

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: Elyabeth Wint

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant): Mrs A C Thompson

(Address): Coeur D Alene Idy

15. Filed May 4 1921 — D D Drenna, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 3 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 12 1920, to April 3 1921, that I last saw h[illegible] alive on April 1 1921, and that death occurred on the date stated above, at 3:10 P M.

The CAUSE OF DEATH* was as follows:

Pernicious Anemia

(Duration) 2 Yrs. ..... mos. ..... ds.

Contributory (Secondary) —

(Duration) — yrs. ..... mos. ..... ds.

(Signed) J. K. Hoedeen M. D.

4/4 1921 (Address) Coeur d Alene Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetery — DATE OF BURIAL: 4-5 1921

20. UNDERTAKER: C. Cassedy — ADDRESS: C'Dalene Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 30

Primary Registration District No. 1051

File No. 33879

Registered No. 917

County of Kootenai

City of Rathdrum (St.)

RECEIVED MAY 7 BUREAU OF VITAL STATISTICS

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME W. Kennon

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
male	white	

6. DATE OF BIRTH

..... 1 .....
(Month) (Day) (Year)

7. AGE

about 40 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE
(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER
(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15. Filed May 4 1921 D D Drennan
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 17 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....

that I last saw him alive on April 17. 1921

and that death occurred on the date stated above, at 6.00 P.M.

The CAUSE OF DEATH* was as follows:

Probably pulmonary tuberculosis

This man was found unconscious in a barn at the river near Mr. Glover's.

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) He was no marks of violence or evidences of foul play.

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Frank Perry M. D.

4/21 1921 (Address) Rathdrum, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. 1 days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? Unknown

Former or usual residence Unknown.

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Rathdrum Idaho	April 1921

20. UNDERTAKER	ADDRESS
A. W. Groom	Rathdrum Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

Form V. S. No. 5. 12½M-7-24-11

CERTIFICATE OF DEATH

RECEIVED MAY 7 1921 BUREAU OF VITAL STATISTICS

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33881
Registered No. 919

1. PLACE OF DEATH. Registration District No. 30
County of ..... Primary Registration District No. 1057
City of ..... (If outside limits, give township) ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Thorsfon ?

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: Wh
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: About 50 yrs old ..... (Month) ..... (Day) 1 (Year)

7. AGE: 50 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Dark Knew
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Serbia ?

10. NAME OF FATHER: John Thorsfon ?

11. BIRTHPLACE OF FATHER (State or Country): Genba ?

12. MAIDEN NAME OF MOTHER: ?

13. BIRTHPLACE OF MOTHER (State or Country): ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Thorsfon Jr
(Address) Afton Idaho

15. Filed May 4 1921 D D Brenna Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Apr - 6 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4-5- 1921, to 4-5- 1921 that I last saw h[illegible] alive on 4-5 1921 and that death occurred on the date stated above, at 6.30 P. M.

The CAUSE OF DEATH* was as follows:
Double Lober pneumonia
probably eight days - I saw him once a few hrs before death

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Earl O Reed M. D.
4-6 1921 (Address) Afton Wyo

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Fairmont Cemetary Spokane Wash
DATE OF BURIAL: April 8 1912

20. UNDERTAKER: R W. Stone Rathdrum Idaho
ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
MAY 10 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33883
Registered No. 9

1. PLACE OF DEATH
County of Latah Registration District No. 62
City of Genesee (If outside limits of city or village give township) St.) Registration District No. 2142

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Fred Follett

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: July (Month) 25 (Day) 1862 (Year)

7. AGE: 58 Yrs. 8 Mos. 9 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Merchant.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Minn, Dodge Co,

10. NAME OF FATHER: Geo W. Follett

11. BIRTHPLACE OF FATHER (State or Country): Vermont

12. MAIDEN NAME OF MOTHER: Ellen Williams

13. BIRTHPLACE OF MOTHER (State or Country): N. Y.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Lian Follett
(Address) Genesee Idaho

15. Filed 4-5- 1921 W. O'Connell Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 4- (Month) 4 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3-17- 1921, to 4-4- 1921 that I last saw h.. alive on 4-4- 1921 and that death occurred on the date stated above, at 9.50 (A.M.)

The CAUSE OF DEATH* was as follows:
Fatty degeneration of heart and Bron.

(Duration) 5 Yrs. 5 mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) W. H. Bonner M. D.
4-5- 1921 (Address) Genesee - Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Genesee - Ida, — DATE OF BURIAL: 4-5 1921

20. UNDERTAKER: J. C. Lambert — ADDRESS: Genesee

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Deliver This Certificate to Your Local Registrar. Not to the State Board of Health.

RECEIVED MAY 6 1921 BUREAU OF VITAL STATISTICS

PLACE OF DEATH ~~Washington~~ State Board of Health

33884 Record No.

County of [illegible]

BUREAU OF VITAL STATISTICS

City or Town of

CERTIFICATE OF DEATH

Primary Registered No. 2145

Registration Dist. No. 65 (No. , Registration D. No 65 St.; Ward)

[If death occurs away from USUAL RESIDENCE give facts called for under Item 18.]

FULL NAME Mable Browning

[If death occurred in a Hospital or Institution give its NAME instead of street and number.]

Personal and Statistical Particulars

3 Sex: Femal | 4 Color or Race: White | 5 Single, Married, Widowed, or Divorced (Write the word): Infant

6 Date of Birth: April (Month) 9 (Day) 1921 (Year)

7 Age: ..... yrs. ..... mos. 15 ds. If LESS than 1 day, ... hrs. or ..... min?

8 Occupation
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business or establishment in which employed (or employer):

9 Birthplace (State or country): Salish Co

PARENTS

10 Name of Father: James E Browning

11 Birthplace of Father (State or country): Mo

12 Maiden name of Mother: Hanna May Waite

13 Birthplace of Mother (State or country): Mo

14 The above is true to the best of my knowledge

(Informant) J. E. Browning

(Address) Potlatch R. F. D.

15 Filed April 24, 1921 D. J. Thompson Registrar.

I HEREBY CERTIFY, That I have been unable to secure answers to Questions ..... (Insert numbers of unanswered questions)

..... (Signature of Undertaker)

Medical Certificate of Death

16 Date of Death: Apl (Month) 24 (Day) 1921 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Apl 9, 1921, to Apl 22, 1921, that I last saw her alive on Apl 22, 1921, and that death occurred, on the date above, at 12 P m.

The CAUSE OF DEATH* was as follows:

Mal nutrition

..... (Duration) ..... yrs. ..... mos. 15 ds.

Contributory (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D B Harrison, M. D.

4/23/ 1921 (Address) Palouse Wn

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 Length of Residence (For Hospitals, Institutions, Transients, or Recent Residents)

At Place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 Place of Burial or Removal: Freeze Cemetery — Date of Burial: 4/24/, 1921

20 Undertaker: Parents — Address: Potlatch Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33885
Registered No. .....

1. PLACE OF DEATH.
County of Latah Registration District No. 65
City of Potlatch Primary Registration District No. 8141
(No. .... St.)
If death occurs away from usual residence, give facts called for under special information.

RECEIVED MAY 6 1921 BUREAU OF STATISTICS

2. FULL NAME Jamie Hemmelman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married
6. DATE OF BIRTH. Sept (Month) 6 (Day) 1868 (Year)
7. AGE: 52 Yrs. 7 Mos. 15 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): Wisconsin
10. NAME OF FATHER: Fred. Morchont
11. BIRTHPLACE OF FATHER (State or Country): England
12. MAIDEN NAME OF MOTHER: Caroline Sherman
13. BIRTHPLACE OF MOTHER (State or Country): New York
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) David Hemmelman
(Address) Potlatch Ida.
15. Filed April 23rd 1921 D. Jr. Thompson Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 21st (Day) 1921 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Feb. 10th 1921, to April 18th 1921, that I last saw her alive on April 18. 1921, and that death occured on the date stated above, at 11 A M.
The CAUSE OF DEATH* was as follows:
Chronic. Myocarditis
.....(Duration) 2 Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
.....(Duration ..... yrs. ..... mos. ..... ds.
(Signed) D. Jr. Thompson M. D.
4/23 1921 (Address) Potlatch.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Potlatch — DATE OF BURIAL: 4/23 1921
20. UNDERTAKER: E. M. Orwin — ADDRESS: Potlatch

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33886

Registered No. 17

RECEIVED
MAY 6 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 61

Primary Registration District No. 2141

County of Latah

City of Moscow (If outside limits, give township) St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Frederick A. Dunn

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	

6. DATE OF BIRTH: Feb [redacted] 23 1918
(Month) (Day) (Year)

7. AGE: [redacted] Yrs. 1 Mos. 25 Ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Idaho.

10. NAME OF FATHER George W. Dunn

11. BIRTHPLACE OF FATHER (State or Country) Canada

12. MAIDEN NAME OF MOTHER Mandy Johnston

13. BIRTHPLACE OF MOTHER (State or Country) Illinois

14. I HEREBY CERTIFY, THAT THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R.F.D. Geo W. Dunn
(Address) Moscow

15. Filed April 20 1921 W. M. Barthers
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April 20 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 20 1921 to April 20 1921 that I last saw him alive on April 20 1921 and that death occurred on the date stated above, at 11-30 A.M.

The CAUSE OF DEATH* was as follows:
Accidental Poisoning (arsenat of Lead)

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. N. Clark M. D.
4/20 1921 (Address) Moscow Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Moscow | DATE OF BURIAL: 4/21 1921

20. UNDERTAKER: Glenn Price | ADDRESS: Moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-

RECEIVED MAY 6 19[illegible] BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33887
Registered No. 15

1. PLACE OF DEATH. Registration District No. 61
County of Latah Primary Registration District No. 2141
City of ..... (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Annie Lowe

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: January (Month) 17 (Day) 1857 (Year)

7. AGE: 64 yrs. 2 mos. 23 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: Archibald Parker

11. BIRTHPLACE OF FATHER (State or Country): Penn

12. MAIDEN NAME OF MOTHER: Annie Combs

13. BIRTHPLACE OF MOTHER (State or Country): Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Sam Lowe
(Address) Farmington, Wash.

15.
Filed April 10 1921 W. H. Carithers Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Apr (Month) 9 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr - 4 1921, to Apr 9 1921, that I last saw h[illegible] alive on Apr 8 - 1921, and that death occurred on the date stated above, at 1 a M.

The CAUSE OF DEATH* was as follows:
Cancer of Stomach
(Duration) 30 yrs. X mos. X ds.
Contributory (Secondary) Cirrhosis
(Duration) X yrs. X mos. X ds.
(Signed) W. C. Brandon M. D.
4-9-1921 (Address) Garfield Wn

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Farmington — DATE OF BURIAL: Apr. 10 1921

20. UNDERTAKER: L. L. Bunning — ADDRESS: Colfax

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED MAY 6 19 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Latah Registration District No. 61

City of Moscow Primary Registration District No. 1011

(St.)

File No. 33888

Registered No. 20

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George Wright

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: May (Month) 17 (Day) 1859 (Year)

7. AGE: 61 Yrs. 11 Mos. 12 ds.

IF LESS than 1 day how many..... hrs. or.....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer.

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Ruben Wright

11. BIRTHPLACE OF FATHER (State or Country): New York.

12. MAIDEN NAME OF MOTHER: Mary Taylor,

13. BIRTHPLACE OF MOTHER (State or Country): New York.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs George Wright

(Address) Moscow

15. Filed 4/29 19 21 N. Hawthorne Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 29 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....

that I last saw h..... alive on ..... 19.....,

and that death occurred on the date stated above, at 8 A.M.

The CAUSE OF DEATH* was as follows:

Heart Failure

.....(Duration) .....Yrs.....mos.....ds.

Contributory (Secondary)

.....(Duration) .....yrs.....mos.....ds.

(Signed) Glen Price Coroner M. D.

4pm 19 21 (Address) Moscow

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Moscow | DATE OF BURIAL: April 2 19 21

20. UNDERTAKER: Glen Price | ADDRESS: Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33889
Registered No. 19

1. PLACE OF DEATH
County of Latah
City of Moscow (If outside limits, give township) St.)
If death occurs away from usual residence, give facts called for under special information.

RECEIVED MAY 6 1921 BUREAU OF VITAL STATISTICS

Registration District No. 61
Primary Registration District No. 1011

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Margaret L Reeder

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Jan 6 1854 (Month) (Day) (Year)

7. AGE: 67 Yrs. 3 Mos. 22 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home,
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: Thomas B. Reeder

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Elizabeth Vorhees

13. BIRTHPLACE OF MOTHER (State or Country): Penn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs H.L. Coates
(Address) Moscow

15. Filed 4/29 1921 M Marthers Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April 28 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 1920., to April 28th 1921
that I last saw her alive on April 28th 1921
and that death occurred on the date stated above, at 9 a.M.
The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W.T. Carithers M. D.
4/29/21 (Address) Moscow

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Moscow — DATE OF BURIAL: 4/30 1921

20. UNDERTAKER: Glen Fiel — ADDRESS: Moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33890
Registered No. 18

1. PLACE OF DEATH
County of Latah
City of Moscow
(No. ..... St.)
Registration District No. 61
Primary Registration District No. 1011
If death occurs away from usual residence, give facts called for under special information.

RECEIVED
MAY 6 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME Infant Johnson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	

6. DATE OF BIRTH April 28 1921
(Month) (Day) (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or 45 min.

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Hugo Johnson

11. BIRTHPLACE OF FATHER (State or Country) Michigan

12. MAIDEN NAME OF MOTHER Evangaline Fayette

13. BIRTHPLACE OF MOTHER (State or Country) Nebraska

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. Hugo Johnson
(Address) Moscow

15. Filed April 28 1921 W. H. Matthews Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 28 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 28 1921, to April 28 1921, that I last saw him alive on April 28 1921 and that death occurred on the date stated above, at 3:35 A. M.

The CAUSE OF DEATH* was as follows:

Premature - six months

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas. L. Fortune M. D.
4/29 1921 (Address) Moscow Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Moscow | DATE OF BURIAL 4/29 1921

20. UNDERTAKER Allen Price | ADDRESS Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 61

County of Latah

Primary Registration District No. 1011

File No. 33891

City of Moscow (No. ..... St.)

Registered No. 119

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
MAY 6 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME Agusta M Eldridge

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widowed

6. DATE OF BIRTH: May (Month) 1 (Day) 1849 (Year)

7. AGE: 71 Yrs. 11 Mos. 12 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business or establishment in which employed (or employer): with Children

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER: Andrew Van Wormer

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Mary Wallace

13. BIRTHPLACE OF MOTHER (State or Country): New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) L. J. Eldridge

(Address) Moscow

15. Filed April 13 1921 A. H. Smithers Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 13 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 5th 1921 to April 13th 1921

that I last saw h.e.r. alive on April 11 1921

and that death occurred on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:

Encephalitis

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. F. Gilmore M. D.

4/13 1921 (Address) Moscow Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Moscow — DATE OF BURIAL: 4/14 1921

20. UNDERTAKER: Glen Price — ADDRESS: Moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

33892

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
MAY 1 1921
BUREAU OF VITAL STATISTICS

Registration District No. 2147
Primary Registration District No. 67
File No. 3
Registered No. 34

1. PLACE OF DEATH
County of Latah
City of Avon
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Martin Rue
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: single (Write the word.)

6. DATE OF BIRTH: July (Month) 20 (Day) 1865 (Year)

7. AGE: 55 Yrs. 9 Mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business or establishment in which employed (or employer): cripple

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: O. Rue

11. BIRTHPLACE OF FATHER (State or Country): Norway

12. MAIDEN NAME OF MOTHER: Helga Ness

13. BIRTHPLACE OF MOTHER (State or Country): Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) O. Rue
(Address) Avon

15. Filed 4-25 19 21 P. C. Faust Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 24 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....
and that death occurred on the date stated above, at 9 P.M.
The CAUSE OF DEATH* was as follows:
Reported stomach trouble
(Duration) 0 Yrs. 0 mos. 8 ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) ..... M. D.
19..... (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Avon Cemetery
DATE OF BURIAL: 4-26 19 21

20. UNDERTAKER: none
ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33893
Registered No. .....

RECEIVED
APR 13 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH.
County of Latah Registration District No. 65
City of Potlatch Registration District No. 2145
(If outside limits of city or village, give township.) (Ward) (St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Jacquetta Hoy Barnes.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Feb (Month) 14 (Day) 1901 (Year)

7. AGE: 20 Yrs. 1 Mos. 29 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife.
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ida.

10. NAME OF FATHER: C F Wolhetar

11. BIRTHPLACE OF FATHER (State or Country): Kansas.

12. MAIDEN NAME OF MOTHER: Pearl Augar.

13. BIRTHPLACE OF MOTHER (State or Country): Iowa.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) C F Wolhetar
(Address) Palouse Wash

15. Filed April 4th 1921 D. J. W. Thompson Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24854

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 9 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mch 28 1921, to Apl 2 1921, that I last saw her alive on Apl 2 1921, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Organic Heart Disease.
(Duration) 3 Yrs. mos. ds.
Contributory (Secondary)
(Duration yrs. mos. ds.

(Signed) W. H. Harrison M. D.
4/2 1921 (Address) Palouse Wn

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Troyce — DATE OF BURIAL: April 4 1921

20. UNDERTAKER: E. H. Irwin — ADDRESS: Palouse

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33894
Registered No. .....

1. PLACE OF DEATH.

Registration District No. 65.
Primary Registration District No. 2145
County of Latah
City of Potlatch (No. ..... St.)

RECEIVED APR 13 1921 BUREAU OF VITAL STATISTICS

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Rassa Margarie Throop.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Baby.
6. DATE OF BIRTH. Jan (Month) 20 (Day) 1921 (Year)
7. AGE: Yrs. 2 Mos. 14 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work... Baby.
(b) General nature of industry, business, or establishment in which employed (or employer).....
9. BIRTHPLACE (State or Country): Idaho
10. NAME OF FATHER: Alva Troop.
11. BIRTHPLACE OF FATHER (State or Country): Wash.
12. MAIDEN NAME OF MOTHER: Linden
13. BIRTHPLACE OF MOTHER (State or Country): Neb
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Alva Throop
(Address) Potlatch, Idaho
15. Filed April 2nd 1921 Dr. J.W. Thompson Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 2 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 2 1921, to April 2 1921, that I last saw her alive on April 2 1921, and that death occured on the date stated above, at 6 P M.

The CAUSE OF DEATH* was as follows:

Marasmus.

(Duration) Yrs. 1 mos. - ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J.W. Thompson M. D.

4/3 1921 (Address) Potlatch Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Palouse Wash — DATE OF BURIAL: April 3 1921

20. UNDERTAKER: E.H. Irwin — ADDRESS: Palouse

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33895

Registered No. .....

1. PLACE OF DEATH.

Registration District No. 65

Primary Registration District No. 2145

County of Latah.

City of Potlatch (If outside limits of city or village, give township) St.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED APR 13 1921 BUREAU OF VITAL STATISTICS

2. FULL NAME James. Keith Smith.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: White

5. SINGLE, ~~MARRIED, WIDOWED OR DIVORCED.~~ (Write the word.): Single.

6. DATE OF BIRTH. March. 22 1921
(Month) (Day) (Year)

7. AGE: ..... Yrs. ..... Mos. 14 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None.
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country) Idaho.

10. NAME OF FATHER William. W. Smith.

11. BIRTHPLACE OF FATHER (State or Country) Idaho.

12. MAIDEN NAME OF MOTHER Mary. Milne.

13. BIRTHPLACE OF MOTHER (State or Country) Wash.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Tom Smith.
(Address) Potlatch.

15. Filed April. 4 1921 D. J. Thompson
Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
April. 4 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April. 3 1921, to April. 4 1921,
that I last saw him alive on April. 3 1921,
and that death occured on the date stated above, at 12. M.
The CAUSE OF DEATH* was as follows:

Marasmus.

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Premature. birth.

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Potlatch M. D.

4/4/1921 (Address) D. J. Thompson

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Potlatch Cemetery — DATE OF BURIAL: April. 5 1921

20. UNDERTAKER: Parents. — ADDRESS: Potlatch

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

Idaho

Deliver This Certificate to Your Local Registrar. Not to the State Board of Health.

33896

PLACE OF DEATH RECEIVED ~~Washington~~ State Board of Health

Record No. 65

County of Latah APR 13 1921 BUREAU OF VITAL STATISTICS

City or Town of BUREAU OF VITAL STATISTICS CERTIFICATE OF DEATH

Registered No. 2145

Registration Dist. No. (No. , St.; Ward)

[If death occurs away from USUAL RESIDENCE give facts called for under Item 18.]

FULL NAME Wm M H Bryant

[If death occurred in a Hospital or Institution give its NAME instead of street and number.]

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1.

Personal and Statistical Particulars

3 Sex: Fem.

4 Color or Race: White

5 Single, Married, Widowed, or Divorced (Write the word): Single

6 Date of Birth: April (Month) 4 (Day) 1921 (Year)

7 Age: ~~over~~ yrs. mos. ds. If LESS than 1 day, ~~8~~ hrs. or min?

8 Occupation
(a) Trade, profession or particular kind of work: ✓
(b) General nature of industry, business or establishment in which employed (or employer): ✓

9 Birthplace (State or country): Latah Co Idaho

PARENTS

10 Name of Father: Hans Bryant

11 Birthplace of Father (State or country): Germany

12 Maiden name of Mother: Addie Mae Fuller

13 Birthplace of Mother (State or country): Miss

14 The above is true to the best of my knowledge
(Informant) Hans Bryant
(Address) Garfield Wash

15 Filed April 6 1921 W. Jn. Thompson Registrar.

Medical Certificate of Death

16 Date of Death: April (Month) 4 (Day) 1921 (Year)

17 I HEREBY CERTIFY, That I attended deceased from , 191 , to , 191 , that I last saw her alive on Apr 4 , 1921 , and that death occurred, on the date above, at ~~about~~ 7 a.m. The CAUSE OF DEATH* was as follows:

Hemorrhage of the Cord

(Duration) yrs. mos. ds.

Contributory (Secondary) Malformation of the cord

(Duration) yrs. mos. ds.

(Signed) W. S. Dart, M. D.

4-5—, 1921 (Address) Pullman Wn

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 Length of Residence (For Hospitals, Institutions, Transients, or Recent Residents)
At Place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 Place of Burial or Removal: Freys Cemetery — Date of Burial: April 6, 1921

20 Undertaker: Parents — Address: Garfield. Wash

I HEREBY CERTIFY, That I have been unable to secure answers to Questions
(Insert numbers of unanswered questions)

(Signature of Undertaker)

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 47 — 33897
Primary Registration District No. 2116
File No. .....
Registered No. .....

1. PLACE OF DEATH
County of Lewis — RECEIVED APR 14 1921 BUREAU OF VITAL STATISTICS
City of Salmon
If death occurs away from usual residence, give facts called for under special information. (No. ....., ... St.)
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lee Jackson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Not known ..... (Month) ..... (Day) 1 ..... (Year)

7. AGE: about 63 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many .... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Day Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Not known

10. NAME OF FATHER: " "

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wm C Jacobs
(Address) Salmon Ida.

15.
Filed 4/10 ..... 1921 .. M. L. Greene ..... Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: February 23rd 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 10 ..... 1920 to Feb 23 1921
that I last saw h~~im~~ alive on Feb 23 1921
and that death occurred on the date stated above, at 8 A. M.

The CAUSE OF DEATH* was as follows:
Diabetes Mel.
.....
.....
About 4 years ..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
..... (Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) Chas F. Hannum M. D.
2/25 1921 (Address) Salmon

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Salmon Cemetery — DATE OF BURIAL: 2-24- 1921

20. UNDERTAKER: Wm C Jacobs — ADDRESS: Salmon Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
APR 14 1921
BUREAU OF VITAL STATISTICS

Registration District No. 41
Primary Registration District No. 2116
File No. 33898
Registered No.

1. PLACE OF DEATH
County of Lemhi
City of Salmon (If outside limits of city or village, write RURAL and give name of township. St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs. Lottie Esther Sharp

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): married
6. DATE OF BIRTH: 10 (Day) March (Month) 1892 (Year)
7. AGE: 28 Yrs. 10 Mos. 28 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: House keeping
(b) General nature of industry, business or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Montana
10. NAME OF FATHER: W. Orr Currency from Espanola
11. BIRTHPLACE OF FATHER (State or Country): Prince Edward
12. MAIDEN NAME OF MOTHER: Mary Roselle Hilton
13. BIRTHPLACE OF MOTHER (State or Country): Indiana
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Barney Sharp
(Address) Box 2 Salmon Ida
15. Filed 4-10 1921 M. D. Greene Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb 18th (Month) (Day) 1921 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Dec 1919 to Feb 1921
that I last saw her alive on Dec 29th 1920,
and that death occurred on the date stated above, at 7 P.M.
The CAUSE OF DEATH* was as follows:
Cholecystitis & gall Stones
(Duration) 3 mos. 20 ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) F. S. Wright M. D.
3/6 1921 (Address) Salmon Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Salmon Cemetery — DATE OF BURIAL: 3-20" 1921
20. UNDERTAKER: Wm C Hacker — ADDRESS: Salmon Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33899
Registered No. .....

RECEIVED
APR 14 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH.
County of Lemhi Registration District No. 41
City of Salmon Primary Registration District No. 2116
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Dorothea Carlson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: f.
4. COLOR OR RACE: w.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Nov. 20 1920 (Month) (Day) (Year)

7. AGE ..... Yrs. 4 Mos. 1 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country) Canada

10. NAME OF FATHER Hiram T. Carlson

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Sarah Smith

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Hiram T Carlson
(Address) Carmen Ida.

15. Filed 4-10 1921 M. D. Greene Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Mar 26 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 16 1921, to Mar 26 1921, that I last saw her alive on Mar 26 1921, and that death occured on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:
Cholera infantum
..... (Duration) ..... Yrs. ..... mos. 10 ds.
Contributory (Secondary) .....
..... (Duration ..... yrs. ..... mos. ..... ds.
(Signed) Chas F. Hammer M. D.
3/26 1921 (Address) Salmon

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Salmon Cemetery — DATE OF BURIAL 3-30 1921

20. UNDERTAKER W C Jacobs — ADDRESS Salmon Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

[redacted] of Idaho
[redacted]ARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Lemhi — Registration District No. 41

RECEIVED
APR 14 1921
BUREAU OF VITAL STATISTICS

Primary Registration District No. 2116

File No. 33900

City of Salmon (No. ____ St.)

Registered No. ____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elihu Womack

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
		married

6. DATE OF BIRTH: November 6 1858
(Month) (Day) (Year)

7. AGE: 62 Yrs. 4 Mos. 21 ds.
IF LESS than 1 day how many ____ hrs. or ____ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Blacksmithing
(b) General nature of industry, business or establishment in which employed (or employer): ____

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: Asa Womack

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Susannah Wells

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Nessa Barr
(Address) Salmon

15. Filed 4-10 1921 M. D. Greene
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 27 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 10 1919 to March 27 1921, that I last saw h[illegible] alive on March 27 1921, and that death occurred on the date stated above, at 7 [illegible] M.

The CAUSE OF DEATH* was as follows:

Bronchitis pneumonia

(Duration) about Yrs. 15 mos. ____ ds.

Contributory (Secondary) ____

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) Chas F. Hammer M. D.

3/28 1921 (Address) Salmon

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days

Where was disease contracted if not at place of death? ____

Former or usual residence ____

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Salmon Cemetery	3-24 1921
20. UNDERTAKER	ADDRESS
W C Doebbl	Salmon Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

LA... -41

...unty of ... RECEIVED ... Registration District No. 2116

APR ... 1921

City of ... BUREAU OF VITAL STATISTICS ... S...

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Lee 33901

Bureau of Vi...
File No. ...
Registered No. ...

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSI... should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact sta... of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Not known (Month) (Day) 1... (Year)

7. AGE: about 73 Yrs. ... Mos. ... ds.
IF LESS than 1 day how many .... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laundry Worker
(b) General nature of industry, business, or establishment in which employed (or employer) ...

9. BIRTHPLACE (State or Country): Not known

10. NAME OF FATHER: " "

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wm C Jacobs
(Address) Salesman

15. Filed 4-10 1921. M. D. Greene Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 17" 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 13 1917 to Nov 13 1921
that I last saw h... alive on Nov 13 1921
and that death occurred on the date stated above, at ... M.

The CAUSE OF DEATH* was as follows:
Chronic Parenchymatous Nephritis
(Duration) about 3 years Yrs. ... mos. ... ds.
Contributory (Secondary) ...
(Duration) ... Yrs. ... mos. ... ds.
(Signed) Chas F. Hammer M. D.
March 30 1921. (Address) Salem

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death? ...
Former or usual residence ...

19. PLACE OF BURIAL OR REMOVAL: Belleaunsville County — DATE OF BURIAL: 3-20" 1921.

20. UNDERTAKER: Wm C Jacobs — ADDRESS: Salem Ore.

FORM [illegible] No. 6-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33502
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

Registration District No. 41
Primary Registration District No. 4116

RECEIVED
APR 14 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Lemhi
City of Salmon
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME: Joseph Cuvare

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH: November (Month) ... (Day) 1857 (Year)
7. AGE: 63 Yrs. 5 Mos. ... ds. IF LESS than 1 day how many .... hrs. or .... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: General
(b) General nature of industry, business, or establishment in which employed (or employer): Day Laborer
9. BIRTHPLACE (State or Country): Conn.
10. NAME OF FATHER: Peter Cuvare
11. BIRTHPLACE OF FATHER (State or Country): Mass.
12. MAIDEN NAME OF MOTHER: Cealia Brookes
13. BIRTHPLACE OF MOTHER (State or Country): Mass.
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Frank Cuvare
(Address): Salmon Ida.
15. Filed 4/10 1921 M. D. Greene Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April 3rd (Month) (Day) 1921 (Year)
17. I HEREBY CERTIFY, That I attended deceased from April 3 1921 to April 3rd 1921
that I last saw h[illegible] alive on April 3rd 1921
and that death occurred on the date stated above, at 8 P. M.
The CAUSE OF DEATH* was as follows:

Uremic Coma

.....(Duration) ... Yrs. ... mos. ... ds.
Contributory (Secondary): Nephritis
.....(Duration) Dont know Yrs. ... mos. ... ds.
(Signed) 45 Wright M. D.
4/7 1921. (Address) Salmon Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the ,State....yrs....mos....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Salmon Cemetery — DATE OF BURIAL: 4-5" 1921.
20. UNDERTAKER: Fred C. Dabbs — ADDRESS: Salmon

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33903
Registered No. .....

1. PLACE OF DEATH.
County of Lewis
City of Kamiah (No. ..... St.)
Registration District No. 49
Primary Registration District No. 1428

RECEIVED
MAY 10 1921
BUREAU OF VITAL STATISTICS

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John P Taylor

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. June (Month) 15 (Day) 1836 (Year)

7. AGE: 84 Yrs. 10 Mos. 22 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired farmer
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Mass.

10. NAME OF FATHER: ?

11. BIRTHPLACE OF FATHER (State or Country): ?

12. MAIDEN NAME OF MOTHER: ?

13. BIRTHPLACE OF MOTHER (State or Country): ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) W R Hazenman
(Address) Kamiah Ida

15. Filed 5/6 1921
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 7 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 1921, to February 1921, that I last saw him alive on April 29 1921, and that death occured on the date stated above, at 11 a M.

The CAUSE OF DEATH* was as follows:
Nephritis
(Duration) 1 Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) C. V. Bryan M. D.
5/7 1921 (Address) Kamiah Idaho

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Kamiah Ida — DATE OF BURIAL: 5/8 1921

20. UNDERTAKER: C. J. Johnson — ADDRESS: Kamiah Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24658

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED
MAY 10 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 49
Primary Registration District No. 2428
File No. 33904
Registered No.

1. PLACE OF DEATH.
County of Idaho
City of Nai Kamick (St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Thompson A Hardenbrook

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed
6. DATE OF BIRTH. ? (Month) ? (Day) 1844 (Year)
7. AGE: 77 Yrs. ✓ Mos. ✓ ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Dont Know
10. NAME OF FATHER: Wm Hardenbrook
11. BIRTHPLACE OF FATHER (State or Country): Dont Know
12. MAIDEN NAME OF MOTHER: Dont Know
13. BIRTHPLACE OF MOTHER (State or Country): Dont Know
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) L. L. Hardenbrook
(Address) Namiah Idaho
15. Filed 5/14 1921 — J J Johnson — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 4 (Day) 1921 (Year)
17. I HEREBY CERTIFY, That I attended deceased from May 1891, to January 1921, that I last saw h[illegible] alive on January 4th 1921, and that death occured on the date stated above, at 10 A.M.
The CAUSE OF DEATH* was as follows:
Paralysis
(Duration) 2 Yrs. 4 mos. 4 ds.
Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) J J Johnson M. D.
5-14 1921 (Address) Namiah

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Namiah Ida — DATE OF BURIAL: 5/5 1921
20. UNDERTAKER: J J Johnson — ADDRESS: Namiah Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24853

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
MAY 10 1921
BUREAU OF VITAL STATISTICS

Registration District No. 49
Primary Registration District No. 2428
File No. 33905
Registered No.

1. PLACE OF DEATH.
County of
City of
(No. St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elizabeth Grolz

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: fmale
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. April (Month) 8 (Day) 1842 (Year)

7. AGE: 79 Yrs. 1 Mos. ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ill

10. NAME OF FATHER: Samuel Leichman

11. BIRTHPLACE OF FATHER (State or Country): Penn

12. MAIDEN NAME OF MOTHER: Maria ——

13. BIRTHPLACE OF MOTHER (State or Country): (?)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant)
(Address) Kamiah, Ida

15. Filed 5/4/21 191 — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 4 en (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 13th 1921, to ——— 191—, that I last saw h.s.a. alive on May 3rd 1921, and that death occured on the date stated above, at —— M.

The CAUSE OF DEATH* was as follows:
Interstitial Nephritis
(Duration) ? Yrs. mos. ds.
Contributory (Secondary)
(Duration yrs. mos. ds.
(Signed) C. A. Bryan M. D.
5/4 1921 (Address) Kamiah Idaho

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Kamiah Ida — DATE OF BURIAL: 5/5 1921

20. UNDERTAKER: C. J. Johnson — ADDRESS: Kamiah Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SORS. 24658

FORM V. S. No. 5-25 M. 1-16-18

RECEIVED MAY 6 1921

CERTIFICATE OF DEATH. 33906

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Idaho

Registration District No. .....

Primary Registration District No. .....

File No. .....

County of Nez Perce

City of Indian Res. (No. ....., ... St.)

Registered No. 6

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Matthew Dickson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
F	Indian	Single

6. DATE OF BIRTH.

1900 (Month) 1 (Day) (Year)

7. AGE

21 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Invalid

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country) Kamiah, Idaho.

10. NAME OF FATHER James Dickson,

11. BIRTHPLACE OF FATHER

(State or Country) Pendleton, Oregon

12. MAIDEN NAME OF MOTHER Jeanette Ezekiel

13. BIRTHPLACE OF MOTHER

(State or Country) Kamiah, Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. J. Guyer,

(Address) Kamiah, Idaho.

15. Filed 4/26/21 191 ..... State Registrar

Filed 3/6/23

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 26, 1921 191

(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191..., that I last saw h... alive on ..... 191..., and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

T.B.

No attendant

.....(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

.....(Duration ..... yrs. ..... mos. ..... ds.

(Signed) ..... Clerk ..... M. D.

.....19..... (Address) ..... Lapwai, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Indian Cemetery	4/28/21 191

20. UNDERTAKER	ADDRESS
C. J. Johnson	Kamiah, Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

BYNUM - YORK CO., PTRS. & BORS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33906

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

RECEIVED
MAY 10 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH. Registration District No. 49
County of Latah Primary Registration District No. 24-29
City of Kamiah (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Matthew Dixon

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: Ind
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH. Apr (Month) 22 (Day) 1897 (Year)
7. AGE: 24 Yrs. ..... Mos. 4 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): Idaho
10. NAME OF FATHER: James Dixon
11. BIRTHPLACE OF FATHER (State or Country): Oregon
12. MAIDEN NAME OF MOTHER: Jennett Ezekiel
13. BIRTHPLACE OF MOTHER (State or Country): Idaho
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mathias Ezekiel
(Address) Kamiah Ida
15. Filed 4/26 1921 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
April (Month) 26th (Day) 1921 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Feb 1921, to April 26 1921, that I last saw him alive on April 26th 1921, and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Pulmonary tuberculosis
(Duration) 2 Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) [illegible] M. D.
4/27 1921 (Address) Kamiah Ida

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Ind Cem No 1, Kamiah Ida — DATE OF BURIAL: 4/27 1921
20. UNDERTAKER: C J Johnson — ADDRESS: Kamiah Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24858

FORM V. S. No. 5-25 M. 1-16-13 RECEIVED MAY 10 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33907

Registration District No. 49
Primary Registration District No. 2428

1. PLACE OF DEATH.
County of Latah
City of Kamiah (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Ann Wohlerin

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX [redacted]
4. COLOR OR RACE white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married (Write the word.)

6. DATE OF BIRTH. March 18 1847 (Month) (Day) (Year)

7. AGE 74 Yrs. 1 Mos. 2 ds. IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Germany

10. NAME OF FATHER Anthony Engelhoff

11. BIRTHPLACE OF FATHER (State or Country) Germany

12. MAIDEN NAME OF MOTHER Agnes Kroeger

13. BIRTHPLACE OF MOTHER (State or Country) Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Carl Wohlerin
(Address) Kamiah Idaho

15. Filed 4/21 1921 C. J. Johnson Local Registrar

SYMS - YORK CO., PTRS. & SDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 20th 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 1st 1921, to April 1921, that I last saw her alive on April 1921, and that death occured on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:
Mitral Insufficiency
Bronchial Asthma

..... (Duration) 5 Yrs. mos. ds.
Contributory (Secondary) Arterio Sclerosis

..... (Duration) 3 yrs. mos. ds.

(Signed) C. A. Bruyer M. D.
4/21 1921 (Address) Kamiah Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Kamiah Ida — DATE OF BURIAL 4/23 1921

20. UNDERTAKER C. J. Johnson — ADDRESS Kamiah

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED
MAY 10 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH.

Registration District No. 49
Primary Registration District No. 2428

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33908
Registered No. .....

1. PLACE OF DEATH.
County of Idaho
City of Kendrick (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jasper Clay McClintic

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Divorced

6. DATE OF BIRTH. (Month) Aug (Day) 27 (Year) 1865

7. AGE: 55 Yrs. 7 Mos. 16 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... farmer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): California

10. NAME OF FATHER: Archibald McClintic

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Mary Elizabeth McClain

13. BIRTHPLACE OF MOTHER (State or Country): Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. W. Wood
(Address) Kamiah Idaho

15. Filed 4/16 1921 — J. J. Johnson, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 13 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 13th 1921, to April 1921, that I last saw h— alive on April 1921, and that death occured on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:
Accident,
..... 6 hours (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Mitral insufficiency
..... (Duration 1 yrs. ..... mos. ..... ds.

(Signed) D. H. Bryan M. D.
4/14 1921 (Address) Kamiah, Idaho

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Lot 4 Cem. Kamiah — DATE OF BURIAL: 4/17 1921

20. UNDERTAKER: J. J. Johnson — ADDRESS: Kamiah

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33909

Registered No. 5

1. PLACE OF DEATH.

County of Lewis Registration District No. 61

City of Craigmont (Primary Registration District No. 2129. St.)

RECEIVED
MAY 5 1921
BUREAU OF VITAL STATISTICS

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William T. Buttrey.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. May 30 (Month) 1838 (Day) (Year)

7. AGE: 82 Yrs. 10 Mos. 29 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Retired farmer.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Indiana

10. NAME OF FATHER Geo. Buttrey

11. BIRTHPLACE OF FATHER (State or Country) Indiana Kentucky.

12. MAIDEN NAME OF MOTHER Barbara Scott

13. BIRTHPLACE OF MOTHER (State or Country) Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) James Buttrey
(Address) Craigmont Idaho.

15.
Filed 4/30 1921 R. G. Dunlap Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Apl (Month) 29 (Day) 1921. (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apl 12 1921, to Apl 29 1921, that I last saw him alive on Apl 29 1921 and that death occured on the date stated above, at 12. P.M.

The CAUSE OF DEATH* was as follows:
Chronic meningo-encephalitis.

(Duration) 10 Yrs. mos. ds.

Contributory (Secondary) High Blood Pressure

(Duration Some yrs. mos. ds.

(Signed) R. G. Dunlap M. D.

4/30 1921 (Address) Craigmont Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: I.O.O.F. Cemetery — DATE OF BURIAL: 5/1 1921

20. UNDERTAKER: Stott Bldg & Supply Co. — ADDRESS: Craigmont.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STNRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

RECEIVED APR 16 1921 BUREAU OF VITAL STATISTICS

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33910

Registered No. .....

1. PLACE OF DEATH.

Registration District No. 49

Primary Registration District No. 2428

County of Lewis

City of Kamiah (Or Town) ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Simon Whitman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: Indian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): widower

6. DATE OF BIRTH. January ? 1867 (Month) (Day) (Year)

7. AGE: 54 Yrs. ? Mos. ? ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: ?

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Samantha Whitman

13. BIRTHPLACE OF MOTHER (State or Country): Idaho Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Silas P. Whitman
(Address) Kamiah

15. Filed 3/14 1921 C J Johnson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 14 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1 1920, to Mch 14 1921, that I last saw him alive on Feb 28 1921, and that death occured on the date stated above, at 2:30 A.M.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J M Weyerhaeuser M. D.
Mch 17 1921 (Address) Kamiah Idaho

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Ind Cem. I — DATE OF BURIAL: Mch 16 1921

20. UNDERTAKER: C J Johnson — ADDRESS: Kamiah Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33911
Registered No. .....

1. PLACE OF DEATH.
County of Lewis
City of Kamiah (If not in incorporated limits, give township.) St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 49
Primary Registration District No. 1427

RECEIVED
APR 16 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME Carl F Wegner

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH.
March (Month) 18 (Day) 1861 (Year)

7. AGE
59 Yrs. 11 Mos. 9 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Farmer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Germany

10. NAME OF FATHER Dan Wegner

11. BIRTHPLACE OF FATHER (State or Country) Germany

12. MAIDEN NAME OF MOTHER ?

13. BIRTHPLACE OF MOTHER (State or Country) Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Daniel C Wegner
(Address) Kamiah Ida

15. Filed 3/19 1921
C J Johnson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
March (Month) 9 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 25th 1921, to March 1921, that I last saw him alive on March 9th 1921, and that death occured on the date stated above, at 7 P M.

The CAUSE OF DEATH* was as follows:
Facial Erysipelas
(Duration) ..... Yrs. ..... mos. 15 ds.
Contributory (Secondary) Chronic Rheumatism
(Duration ..... yrs. ..... mos. 3 ds.
(Signed) C F Wegner M. D.
3/16 1921 (Address) Kamiah Idaho

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Lost Lem Kamiah — DATE OF BURIAL: 3/19 1921

20. UNDERTAKER: C J Johnson — ADDRESS: Kamiah Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33912
Registered No. .....

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APR 16 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH. Registration District No. 49
Primary Registration District No. 1428
County of Idaho
City of Kamiah (If outside limits, give township) No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Harmon Craig

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: Indian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Oct (Month) 31 (Day) 1920 (Year)

7. AGE: ..... Yrs. 4 Mos. 25 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho County

10. NAME OF FATHER: Joseph Craig

11. BIRTHPLACE OF FATHER (State or Country): Oregon

12. MAIDEN NAME OF MOTHER: Rena Johnson

13. BIRTHPLACE OF MOTHER (State or Country): Idaho Co

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Joseph Craig
(Address) Kamiah Ida

15. Filed 3/26 1921 C J Johnson Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
March (Month) 25 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 25 1921, to [illegible] 191..., that I last saw him alive on [illegible] 1921, and that death occured on the date stated above, at 8 A M.

The CAUSE OF DEATH* was as follows:
Acute Indigestion
.....
.....
.....(Duration) ..... Yrs. ..... mos. 2 ds.
Contributory (Secondary) .....
.....(Duration ..... yrs. ..... mos. ..... ds.

(Signed) O. T. Bryan M. D.
3/25 1921 (Address) Kamiah Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Kamiah Cem. Kamiah — DATE OF BURIAL: 3/27 1921

20. UNDERTAKER: C J Johnson — ADDRESS: Kamiah Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

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BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33913

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Lewis Registration District No. 49

City of Kamiah Idaho Primary Registration District No. 2428

(If not in incorporated territory, give township.)

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Thomas Lindsley

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: Indian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Nov ? (Month) (Day) 1853 (Year)

7. AGE 68 Yrs. 3 Mos. ? ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: ?

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: ?

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Amelia L Gabbert
(Address) Kamiah Id.

15. Filed 3/25 1921 C J Johnson Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 24 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 19 1921, to March 1921, that I last saw h.. alive on March 1921, and that death occured on the date stated above, at 11 p M.

The CAUSE OF DEATH* was as follows:

Lupus Erythematosus

(Duration) ..... Yrs. ..... mos. 5 ds.

Contributory (Secondary) Myocarditis and Senility

(Duration) ..... yrs. ..... mos. 2 ds.

(Signed) C H Bryan M. D.

3/25 1921 (Address) Kamiah Idaho

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Ind. Cem Kamiah Ida — DATE OF BURIAL: 3/27 1921

20. UNDERTAKER: C. J. Johnson — ADDRESS: Kamiah Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33914
Registered No. .....

1. PLACE OF DEATH.
Registration District No. 49
Primary Registration District No. 2 + 28
County of Lewis
City of Kamiah (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

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APR 16 1921
BUREAU OF VITAL STATISTICS

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary Elvira Brown

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married
6. DATE OF BIRTH. (Month) Feby (Day) 24 (Year) 1856
7. AGE: 65 Yrs. 1 Mos. 3 ds. IF LESS than 1 day how many ..... hrs. or ..... min.
8. OCCUPATION
(a) Trade, profession or particular kind of work... housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....
9. BIRTHPLACE (State or Country) Illinois
10. NAME OF FATHER Abraham Bechtel
11. BIRTHPLACE OF FATHER (State or Country) ?
12. MAIDEN NAME OF MOTHER Roseanna Bruce
13. BIRTHPLACE OF MOTHER (State or Country) Pennsylvania
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) G. H. Hals
(Address) Kamiah Idaho
15. Filed 3/24 1921
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March (Month) 22 (Day) 1921 (Year)
17. I HEREBY CERTIFY, That I attended deceased from 3-25- 1921, to 3-26 1921, that I last saw h[illegible] alive on 3-25- 1921, and that death occured on the date stated above, at 9 1/2 A.M.
The CAUSE OF DEATH* was as follows:
Carcinoma
(Duration) 2 Yrs. ..... mos. 6 ds.
Contributory (Secondary) .....
(Duration ..... yrs ..... mos. ..... ds.
(Signed) E Taylor M. D.
19..... (Address) Kamiah Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF ~~BURIAL OR~~ REMOVAL: Garfield wash
DATE OF BURIAL: 3/29 1921
20. UNDERTAKER: C. J. Johnson
ADDRESS: Kamiah Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

DYER - YORK CO., PTRS. & STNRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 16
Registration District No. 1016
File No. 33915
Registered No. 7

1. PLACE OF DEATH.
County of Lincoln
City of Shoshone (If not in city give township) St.)

If death occurs away from usual residence, give facts called for under special information.

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MAY 10 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME Francisco Mocha

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Not known (Month) (Day) 1 (Year)

7. AGE: 57 Yrs. 00 Mos. 00 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Sheep herder
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) unknown

10. NAME OF FATHER Not known

11. BIRTHPLACE OF FATHER " " (State or Country)

12. MAIDEN NAME OF MOTHER " "

13. BIRTHPLACE OF MOTHER " " (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. H. Bell
(Address) Shoshone Ida.

15. Filed May 6 " 1921 J. L. Allen Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 4 (Month) 4 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 20 1921, to May 4 1921, that I last saw h— alive on May 4 1921, and that death occured on the date stated above, at 3 P M.

The CAUSE OF DEATH* was as follows:
Gallet Fever.
..... (Duration) ..... Yrs. ..... mos. 20 ds.
Contributory (Secondary) Exposure
..... (Duration ..... yrs. ..... mos. ..... ds.
4/4 1921 (Signed) J. H. Bell M. D.
(Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Shoshone — DATE OF BURIAL 5-7 1921

20. UNDERTAKER D. F. Brennan — ADDRESS Shoshone

SYMS - YORK CO., PTGS. & ENGS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 16
Primary Registration District No. 2016
File No. 33916
Registered No. 6

1. PLACE OF DEATH.
County of Lincoln
City of Shoshone (St.)
If death occurs away from usual residence, give facts called for under special information.

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MAY 10 19
BUREAU OF VITAL STATISTICS

2. FULL NAME Dwight C Munro

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. July 17 1901
(Month) (Day) (Year)

7. AGE: 20 Yrs. 9 Mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Evagem Maxwell

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Ethel A Potter

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant): Eugene Maxwell
(Address):

15. Filed April 14 1921
J L Tuller
Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
April 13 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 13 1921, to April 13 1921, that I last saw her alive on April 13 1921 and that death occured on the date stated above, at 11:22 a. M.

The CAUSE OF DEATH* was as follows:
Botulism, due to eating canned corn
(Duration) Yrs. mos. 5 ds.
Contributory (Secondary) corn
(Duration Yrs. mos. 5 ds.
(Signed) M. D.
4/14 1921 (Address) Shoshone Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 6 mos. days State 5 yrs. mos. days
Where was disease contracted if not at place of death? Rupert Ida
Former or usual residence Rupert Ida.

19. PLACE OF BURIAL OR REMOVAL: Shoshone
DATE OF BURIAL: 4-16 1921

20. UNDERTAKER: O J Brennan
ADDRESS: Shoshone Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

Form V. S. No. 5 20M.1-16-12

RECEIVED MAY 8 BUREAU OF STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32917

Registered No. 34

1. PLACE OF DEATH. Registration District No. .....
County of Madison Primary Registration District No. Moody
City of ..... (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number. .....

2. FULL NAME Jesse Barney

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH: Apr. (Month) 9 (Day) 1921 (Year)

7. AGE: 0 yrs. 0 mos. 0 ds. IF LESS than 1 day how many ~~hrs.~~ or ..... mins.? 22 hrs.

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... None
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Moody Creek Idaho

10. NAME OF FATHER Moses Barney

11. BIRTHPLACE OF FATHER (State or Country) Spanish Fork Utah

12. MAIDEN NAME OF MOTHER Rachel Nertchison

13. BIRTHPLACE OF MOTHER (State or Country) Spanish Fork Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Moses Barney
(Address) Moody Creek Idaho

15. Filed 4/11 1921 G. L. Esplin Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: April (Month) 10 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 9 1921, to Apr 10 1921, that I last saw him alive on Apr. 9 1921, and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:
Premature Birth

(Duration) ..... yrs. ..... mos. 22 Hrs.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Farley Nelson M. D.
4-11 1921 (Address) Ellenwood Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Sugar City.	191...

20. UNDERTAKER	ADDRESS
Tatlow & Moses Barney	Moody Creek Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED MAY 4 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33918
Registered No. 35

1. PLACE OF DEATH.
County of Jefferson
City of Hamer (Registration District No.....; Primary Registration District No.....; St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Fred Gerber

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M-
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH. April (Month) 11 (Day) 1872 (Year)
7. AGE: 49 Yrs. 0 Mos. 18 ds. IF LESS than 1 day how many.....hrs. or .....min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work... Stockgrower and Farmer
(b) General nature of industry, business, or establishment in which employed (or employer).....
9. BIRTHPLACE (State or Country) Switzerland
10. NAME OF FATHER Samuel Gerber
11. BIRTHPLACE OF FATHER (State or Country) Switzerland
12. MAIDEN NAME OF MOTHER Mary Ludy
13. BIRTHPLACE OF MOTHER (State or Country) Switzerland
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Matilda Gerber
(Address) Hamer, Ida.
15. Filed 4/30 1921 G. G. Estes Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 29 (Day) 1921 (Year)
17. I HEREBY CERTIFY, That I attended deceased from .....1921....., to .....1921....., that I last saw h.....alive on .....1921....., and that death occured on the date stated above, at .....M.
The CAUSE OF DEATH* was as follows:
Gun shot wound — self inflicted on head.
.....(Duration) .....Yrs. .....mos. .....ds.
Contributory (Secondary)
.....(Duration .....yrs. Coroner ds.
(Signed) John Bohmer M.D.
.....19..... (Address) Roberts, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Clyburg	May 2 1921
20. UNDERTAKER David R. Young	ADDRESS Clyburg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SVMS - YORK CO., PTRS. & BORS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. RECEIVED MAY 1 1921 BUREAU OF VITAL STATISTICS

Registration District No. 100

Summary Registration District No. 2189

File No. 33919

Registered No. 36

County of Madison

City of Sugar (If not in incorporated city or village give township) St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Myrtle Ricks

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. March (Month) 31 (Day) 1921 (Year)

7. AGE — Yrs. — Mos. 11 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Ephraim Ricks

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Minnie A. Park

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Ephraim Ricks
(Address) Sugar City

15. Filed 4/11 1921 G G Espe Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 4 (Month) 10 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3/31 1921, to 4/10 1921, that I last saw her alive on 4/9 1921, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

atelectasis

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G G Espe M. D.

19..... (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Sugar City — DATE OF BURIAL: 4-11 1921

20. UNDERTAKER: David R. Young — ADDRESS: Rigby

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24654

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

Buck

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33920

Registered No. 37

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

RECEIVED MAY 7 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH.

Registration District No. .....

Primary Registration District No. .....

County of Madison

City of Rexburg (If not in city or village give township.) .....St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ray W Buck

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Bach

6. DATE OF BIRTH: April (Month) 11 (Day) 1921 (Year)

7. AGE: ..... yrs. ..... mos. 1 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Baker
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Rexburg

10. NAME OF FATHER: William Beck

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Rose Rotunder

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) William Beck
(Address) Rexburg

15. Filed 4/13 1921 G. H. Estes Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: April (Month) 12 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from april 11 1921, to april 12 1921 that I last saw him alive on april 12 1921 and that death occurred on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:

Premature birth

(Duration) ..... yrs. ..... mos. 1 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Louis A. Buck M. D.

4/12 1921 (Address) Rexburg Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rexburg — DATE OF BURIAL: 4/13 1921

20. UNDERTAKER: J. Bryson — ADDRESS: Rexburg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

RECEIVED
MAY
BUREAU OF
STATISTICS

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Madison
City of Rexburg (St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 100
Primary Registration District No. 2187
File No. 33921
Registered No. 38
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Susan E Watts

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): widowed

6. DATE OF BIRTH: August (Month) 17 (Day) 1838 (Year)

7. AGE: 84 yrs. 7 mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) Housewife

9. BIRTHPLACE (State or Country) America

10. NAME OF FATHER A Reynolder Austin

11. BIRTHPLACE OF FATHER (State or Country) America

12. MAIDEN NAME OF MOTHER Mahala Watts

13. BIRTHPLACE OF MOTHER (State or Country) America

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Austin Watts
(Address) Rexburg Ida

15. Filed 4/9 1921
G G Espe
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 4 (Month) 9 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4/6 1921, to 4/8 1921, that I last saw h~~e~~r alive on 4/8 1921, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Cause unknown

..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) old age
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) G G Espe M. D.
19.. (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Burton Cemetery-Madison Co. | DATE OF BURIAL: Apr 11 1921

20. UNDERTAKER: John Hollist | ADDRESS: Rexburg Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 107

County of Madison. Registration District No. 2178 File No. 33922

City of Sugar City. (If not in city give township) St.) Registered No. 39

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
MAY 7 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME Baby Perez.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: Mexican.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Apr. (Month) 15 (Day) 1921 (Year)

7. AGE ....Yrs. ....Mos. 3 ds. IF LESS than 1 day how many ....hrs. or ....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work....
(b) General nature of industry, business, or establishment in which employed (or employer)....

9. BIRTHPLACE (State or Country) Suga City Ida.

10. NAME OF FATHER Joe Perez.

11. BIRTHPLACE OF FATHER (State or Country) Mexico.

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER (State or Country) Mexico.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Joe Perez
(Address) Sugar.

15. Filed 4/19 1921 Lyle Espe Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 18 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 15 1921, to April 18 1921, that I last saw him alive on April 17 1921, and that death occured on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

Premature

....(Duration) ....Yrs. ....mos. ....ds.

Contributory (Secondary)

....(Duration ....Yrs. ....mos. ....ds.

(Signed) W. B. Crane M. D.

19.... (Address) Sugar City, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?....

Former or usual residence ....

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL ....191....

20. UNDERTAKER | ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24854

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33923
Registered No. 40

RECEIVED MAY 7 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH. Registration District No.....
County of Madison Primary Registration District No.....
City of Rexburg .....St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sarah Madsen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. September 20 1843 (Month) (Day) (Year)

7. AGE: 77 Yrs. 6 Mos. 27 ds.
IF LESS than 1 day how many.....hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) England

10. NAME OF FATHER William Bellamy

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER Ellen Redfern

13. BIRTHPLACE OF MOTHER (State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Harry P. Madsen
(Address) Rexburg Idaho

15. Filed 4/19 1921 G. L. Teaspe Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 17 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 6/1/20 1920, to 4/17 1921, that I last saw her alive on 4/11/21 191..., and that death occured on the date stated above, at 1-30 P. M.

The CAUSE OF DEATH* was as follows:
No particular cause
Heart lesion,
.....(Duration) ... Yrs. ... mos. ... ds.
Contributory (Secondary) High blood pressure
.....(Duration ... yrs. ... mos. ... ds.
(Signed) G. L. Teaspe M. D.
19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Burton Idaho. DATE OF BURIAL: 4-19 1921

20. UNDERTAKER: John M. Richards ADDRESS: Rexburg, Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BORS. 24654

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED MAY 7 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33924
Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
Registration District No. .....
County of Shoshone
Registration District No. .....
City of Gifford (.....St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ivy May Blewett

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. March 23 (Month) (Day) 1905 (Year)

7. AGE: 16 Yrs. ..... Mos. 27 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... School Scholer
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Kansas

10. NAME OF FATHER Daniel W. Blewett

11. BIRTHPLACE OF FATHER (State or Country) Wisconsin

12. MAIDEN NAME OF MOTHER Lillian A Umbrit

13. BIRTHPLACE OF MOTHER (State or Country) Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Daniel W Blewett
(Address) Gifford Idaho

15.
Filed 4-19 1921
E. E. Watts
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 19 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2-4 1918, to 4-18 1921, that I last saw her alive on 4-18 1921, and that death occured on the date stated above, at 3 a M.

The CAUSE OF DEATH* was as follows:
Valvular insufficency

(Duration) 3 Yrs. 3 mos. 15 ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) E. E. Watts M. D.
4-19 1921 (Address) Gifford Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Gifford — DATE OF BURIAL: April 20 1921

20. UNDERTAKER: [illegible] — ADDRESS: [illegible]

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24658

Braddock

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 33925
Registered No. 610

RECEIVED
APR 16 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Nez Perce
City of Lewiston (If not in incorporated limit, so state) St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George C. Bruce

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: S (Write the word)

6. DATE OF BIRTH: June (Month) 11 (Day) 1893 (Year)

7. AGE: 28 Yrs. 1 Mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Salesman - Confectionery
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mich

10. NAME OF FATHER: Chas. Bruce

11. BIRTHPLACE OF FATHER (State or Country): Mich

12. MAIDEN NAME OF MOTHER: Ella Topping

13. BIRTHPLACE OF MOTHER (State or Country): Mich.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Ella Bruce
(Address) Grangeville, Ida.

15. Filed Apr 12 1921 Susan E Bruce Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 1 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 22 1921, to March 1 1921
that I last saw h... alive on March 1 1921
and that death occurred on the date stated above, at 7 P. M.
The CAUSE OF DEATH* was as follows:
Tuberculosis Pulmonary
" Larynx
(Duration) Yrs. 6 mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) E G Braddock M. D.
Mar 2 1921 (Address) Lewiston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston Ida. — DATE OF BURIAL: 3/4 1921

20. UNDERTAKER: Bassar Under. Co. — ADDRESS: Lewiston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED APR 16 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 96

County of Nez Perce — Primary Registration District No. 1009

City of Lewiston (If not in city give township) (St.)

File No. 33926

Registered No. 611

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Girard Thomas

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH: Nov (Month) 23 (Day) 1844 (Year)

7. AGE: 76 Yrs. 3 Mos. 9 ds. — IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farming
(b) General nature of industry, business or establishment in which employed (or employer): Retired

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER: John Thomas

11. BIRTHPLACE OF FATHER (State or Country): New York.

12. MAIDEN NAME OF MOTHER: Ann Harris.

13. BIRTHPLACE OF MOTHER (State or Country): New York State

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. S. Thomas
(Address) Oregon City, Ore.

15. Filed Apr 12 1921 — Lorin E. Bruce, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar (Month) 2 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 15 1921, to Mch 2 1921, that I last saw him alive on Mch 2 1921, and that death occurred on the date stated above, at 3:20 P.M.

The CAUSE OF DEATH* was as follows:
Valvular Disease of heart and paralysis
(Duration) one Yrs. mos. — ds.
Contributory (Secondary) Paralysis + enlarged prostate
(Duration) yrs. ? mos. ds.

(Signed) J. B. Morris M. D.
19..... (Address) Lewiston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Oregon City Ore- — DATE OF BURIAL 19

20. UNDERTAKER: [illegible] UNDERTAKING CO. — ADDRESS Ernest Brower

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

F.B. Currock

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
APR 16 1924
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 96

Primary Registration District No. 1009

File No. 33927

Registered No. 692

County of Nez Perce

City of Lewiston (or Village, Township, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Fred Hughes Ball

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widower

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1 (Year)

7. AGE: 55 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Salesmanager

(b) General nature of industry, business or establishment in which employed (or employer): Wholesale Mer.

9. BIRTHPLACE (State or Country): Mich.

10. NAME OF FATHER: Orson A. Ball

11. BIRTHPLACE OF FATHER (State or Country): Mt. N. Y.

12. MAIDEN NAME OF MOTHER: Hughes.

13. BIRTHPLACE OF MOTHER (State or Country): N. Y.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Lucien B. Bruce

(Address) 4024 Interlake Ave Seattle Wn

15. Filed Apr 12 1924 Lucien E. Bruce Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 2nd (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 1920, to March 2nd 1921, that I last saw h[im] alive on Feb 28 1921, and that death occurred on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Structure of Sympathetic intestine

(Duration) Don't know Yrs. ..... mos. ..... ds.

Contributory (Secondary) Chronic Appendicitis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [signature] M. D.

19..... (Address) Lewiston Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Grand Rapids Mich.

DATE OF BURIAL: 3/6 1921

20. UNDERTAKER: Parsons Co

ADDRESS: Lewiston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33929

Registered No. 613

RECEIVED
APR 16 1921
BUREAU OF VITAL STATISTICS

Registration District No. 96

Primary Registration District No. 1009

1. **PLACE OF DEATH**

County of Nez Perce

City of Lewiston (or Village) Main St.)

If death occurs away from usual residence, give facts called for under special information.

2. **FULL NAME** Marcelin Dongar

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. **SEX**: male

4. **COLOR OR RACE**: White

5. **SINGLE, MARRIED, WIDOWED OR DIVORCED** (Write the word): Married

6. **DATE OF BIRTH**: Feb. (Month) 23rd (Day) 1844 (Year)

7. **AGE**: 77 Yrs. 0 Mos. 23 ds.

IF LESS than 1 day how many..... hrs. or.....min.?

8. **OCCUPATION**

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business or establishment in which employed (or employer):

9. **BIRTHPLACE** (State or Country): France

10. **NAME OF FATHER**: Dongar

11. **BIRTHPLACE OF FATHER** (State or Country): France

12. **MAIDEN NAME OF MOTHER**:

13. **BIRTHPLACE OF MOTHER** (State or Country): France

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**

(Informant) Elizabeth L. Sublimates

(Address)

15. Filed Apr 12 1921 Wm E Brune
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH**: March (Month) 6 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1 1921, to March 6 1921, that I last saw h.wife alive on March 5 1921, and that death occurred on the date stated above, at 3.30 A.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Pancreas

(Duration) Yrs. 6 mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Elmer G Braddock M. D.

March 19 21 (Address) Lewiston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. **PLACE OF BURIAL OR REMOVAL**: Lewiston

DATE OF BURIAL: Mch 8 1921

20. **UNDERTAKER**: Vassar Undt Co.

ADDRESS: Lewiston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 96

Primary Registration District No. 1009

File No. 33930

Registered No. 614

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
APR 16 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH.

County of Nez Perce

City of Lewiston (or St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME W. S. Frye

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. May (Month) 22nd (Day) 1859 (Year)

7. AGE: 61 Yrs. 9 Mos. 17 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Blacksmith
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): Ill

10. NAME OF FATHER: A. A. J. Frye

11. BIRTHPLACE OF FATHER (State or Country): Pa.

12. MAIDEN NAME OF MOTHER: Ruth Brooks

13. BIRTHPLACE OF MOTHER (State or Country): Ky.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. R. Frye
(Address) Lewiston Ida

15. Filed Apr 12 1921 Susan E. Bruce Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 9 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1920, to Mch 9 1921, that I last saw him alive on Mch 8 1921, and that death occured on the date stated above, at 6 a. M.

The CAUSE OF DEATH* was as follows:
Organic heart disease

(Duration) six months or more Yrs. mos. ds.

Contributory (Secondary) Bronchitis

(Duration yrs. mos. 7 ds.

(Signed) Paul W. Johnson M. D.

3/10 1921 (Address) Lewiston Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Lewiston Ida — DATE OF BURIAL: 3/11 1921

20. UNDERTAKER: [illegible] — ADDRESS: Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & SORS. 24658

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 96

Primary Registration District No. 1009

File No. 33931

Registered No. 615

County of Nez Perce

City of Lewiston, (St.)

RECEIVED APR 16 1921 BUREAU OF VITAL STATISTICS

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Marie Anna Vebres

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Marries (Write the word.)

6. DATE OF BIRTH: July (Month) 13th (Day) 1892 (Year)

7. AGE: 28 Yrs. 7 Mos. 28 ds.

IF LESS than 1 day how many..... hrs. or.....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Colton, Wash.

10. NAME OF FATHER: Henry Knobes

11. BIRTHPLACE OF FATHER (State or Country): Lokensburg, Germany

12. MAIDEN NAME OF MOTHER: Anna Marie Byer

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Henry Knobes

(Address) Asotin, Wash.

15. Filed Apr 12 1921 Susan E Bruce Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 11 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 8 1921, to Mar 11 1921 that I last saw h... alive on Mar 11 1921, and that death occurred on the date stated above, at 1 P M.

The CAUSE OF DEATH* was as follows:

Pleurla Pneumonia Post Operative Shock following Cesarian Section

.....(Duration) .....Yrs.....mos.....ds.

Contributory (Secondary)

.....(Duration) .....yrs.....mos.....ds.

(Signed) E. L. White M. D.

Mar 12 1921 (Address) Juniata Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Anatone, Wash. DATE OF BURIAL: 3/13/21

20. UNDERTAKER: H.R. Merchant ADDRESS: Clarkston, Wn.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
APR 16 1921
BUREAU OF VITAL STATISTICS

Registration District No. 96
Primary Registration District No. 1009
File No. 33932
Registered No. 616

1. **PLACE OF DEATH**
County of Nez Perce
City of Lewiston (Or Town) (St.)
If death occurs away from usual residence, give facts called for under special information.

2. **FULL NAME** Ruth Sadie Vest
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. **SEX**: Female
4. **COLOR OR RACE**: White
5. **SINGLE, MARRIED, WIDOWED OR DIVORCED**: Married (Write the word.)

6. **DATE OF BIRTH**: March (Month) 14 th (Day) 1893 (Year)

7. **AGE**: 27 Yrs. 11 Mos. 27 ds.
IF LESS than 1 day how many..... hrs. or.....min.?

8. **OCCUPATION**
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business or establishment in which employed (or employer):

9. **BIRTHPLACE** (State or Country): Vermillion, S.Dak.

10. **NAME OF FATHER**: J.B. Montgomery

11. **BIRTHPLACE OF FATHER** (State or Country): Lind County, Ore.

12. **MAIDEN NAME OF MOTHER**: Sadie Schooley

13. **BIRTHPLACE OF MOTHER** (State or Country): New Nebraska

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**
(Informant) Mrs D Patterson
(Address) Asotin, Wash.

15. Filed Apr 12 1921 Wm E Bruce
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH**: Mar (Month) 11 (Day) 1921 (Year)

17. **I HEREBY CERTIFY, That I attended deceased from** Feb 13 1921 to Mar 11 1921 **that I last saw h.. alive on** Mar 11 1921 **and that death occurred on the date stated above, at** 1 P. M.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis

.....(Duration) .....Yrs.....mos.....ds.
Contributory (Secondary)
.....(Duration) .....yrs.....mos.....ds.

(Signed) E. L. Wolfe M. D.
Mar 11 1921 (Address) Lewiston Idaho

*State the **Disease Causing Death**; or in deaths from **Violent Causes**, state (1) **Means of Injury**; and (2) whether **Accidental, Suicidal or Homicidal.**

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. **PLACE OF BURIAL OR REMOVAL**: Asotin, Wash — **DATE OF BURIAL**: 3/14/21

20. **UNDERTAKER**: H.R.Merchant, — **ADDRESS**: Clarkston Wash.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

Nampa

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 3393

Registered No. 617

RECEIVED
APR 16 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 96

Primary Registration District No. 1009

County of Nez Perce

City of Lewiston (No. 620 "C" Street St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Samuel Holmes

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH: Mar (Month) 17 (Day) 1863 (Year)

7. AGE: 57 Yrs. 11 Mos. 26 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Carpenter
(b) General nature of industry, business or establishment in which employed (or employer): Retired

9. BIRTHPLACE (State or Country): Ida

10. NAME OF FATHER: Andrew Holmes

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Mary Irwin

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Myrtle Lemmon
(Address) 614 C Street City Lewis

15. Filed Apr 12 1921 Susan E. Bruce Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar (Month) 13 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1" 1920 to March 13 1921 that I last saw h[illegible] alive on March 13 1921, and that death occurred on the date stated above, at 2 30 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis

(Duration) 5 Yrs. ..... mos. ..... ds.

Contributory (Secondary) Influenza (Duration) 5 yrs. 11 mos. 26 ds.

(Signed) J. R. Motley M. D.

19 ..... (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Lewiston Ida	3/14 1921
20. UNDERTAKER	ADDRESS
[illegible] UNDERTAKING CO.	Lewiston Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 33934
Registered No. 618

1. PLACE OF DEATH
County of Nez Perce
City of Lewiston St.)
If death occurs away from usual residence, give facts called for under special information.

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BUREAU OF VITAL STATISTICS

2. FULL NAME Ella Gustafson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: April (Month) 1 (Day) 1885 (Year)

7. AGE: 35 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Mathias Oberd

11. BIRTHPLACE OF FATHER (State or Country): Norway

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country): Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Emil Gustafson
(Address)

15. Filed Apr 12 1921 Brian E Brun
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 14 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 11 1921 to March 14 1921 that I last saw her alive on Mar 14 1921 and that death occurred on the date stated above, at 5:35 P.M.

The CAUSE OF DEATH* was as follows:
Shock following Operation
for Strangulation of small intestine
due to post operative adhesions
(Duration) Yrs. mos. 6 hours ds.
Contributory (Secondary) adhesions
(Duration) 4 yrs. mos. 2 ds.

(Signed) Edgar L. White M. D.
Mar 14 1921 (Address) Lewiston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Semmes
DATE OF BURIAL: 3 — 1921

20. UNDERTAKER: Vassar Fun Co
ADDRESS: Lewiston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33935
Registered No. 619

RECEIVED
APR 16 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 96
Primary Registration District No. 1009

County of Nez Perce
City of Lewiston (No.) St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs. Edith Bash

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F	White	Widow

6. DATE OF BIRTH: July (Month) 8 (Day) 1853 (Year)

7. AGE: 67 Yrs. 8 Mos. 7 ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: Engelbrecht

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Rose Wortmann
(Address) Nez Perce Idaho

15. Filed Apr 12 1921 Susan E. Bruce Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar (Month) 15 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 12 1921, to March 15 1921, that I last saw h[illegible] alive on March 15 1921, and that death occurred on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:
Carcinoma of liver.

(Duration) 1 Yrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) P. A. Waters M. D.
3/16 1921 (Address) Lewiston Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. 3 days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence Nez Perce Ida

19. PLACE OF BURIAL OR REMOVAL: Nez Perce Idaho — DATE OF BURIAL 19

20. UNDERTAKER [illegible] — ADDRESS Lewiston, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 961
Primary Registration District No. 1009
File No. 3806
Registered No. 620

1. PLACE OF DEATH

County of Nez Perce
City of Lewiston (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
APR 16 1921
BUREAU OF VITAL STATISTICS

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

FULL NAME Joe Rasas August

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	white	Single

6. DATE OF BIRTH: Feb (Month) 14 (Day) 1921 (Year)

7. AGE: — Yrs. 1 Mos. 4 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Joe August

11. BIRTHPLACE OF FATHER (State or Country): Italy

12. MAIDEN NAME OF MOTHER: Rose Bjena

13. BIRTHPLACE OF MOTHER (State or Country): Italy

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) P.O. C.D. Bell
(Address) Lewiston Idaho

15. Filed Apr 12 1921 Susan E Byrne Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 18th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 16 1921, to March 18 1921, that I last saw him alive on March 17 1921, and that death occurred on the date stated above, at 3 A.M.
The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) ..... Yrs. ..... mos. 1 ds.
Contributory (Secondary) Whooping Cough
(Duration) ..... yrs. ..... mos. 10 ds.

(Signed) R.J. Rasmus M. D.
2/18/1921 (Address) Lewiston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Normal Hill Cemetary	Mar 19 1921

20. UNDERTAKER	ADDRESS
Vassar Undertaking Co	Lewiston, Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 33937
Registered No. 621

1. PLACE OF DEATH
County of Nez Perce
City of Lewiston
(No. RECEIVED APR 16 1921 St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Joseph Kambitsch
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: June (Month) ... (Day) ... 1834 (Year)

7. AGE: 86 Yrs. ... Mos. ... ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Austria

10. NAME OF FATHER: John Kambitsch

11. BIRTHPLACE OF FATHER (State or Country): Austria

12. MAIDEN NAME OF MOTHER: Maria Schaller

13. BIRTHPLACE OF MOTHER (State or Country): Austria

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) T. P. Lampos
(Address) Clarkston Wash.

15. Filed Apr 12 1921 Adam E. Bruce Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar (Month) 19 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1st 1919, to May 19 1921, that I last saw h[illegible] alive on May 18th 1921, and that death occurred on the date stated above, at 6:30 P.M.
The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
(Duration) ... Yrs. ... mos. — ds.
Contributory (Secondary) Controlled Kidney
(Duration) † yrs. ... mos. ... ds.
(Signed) O. C. Canaday M. D.
19... (Address) Lewiston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Pleasant View Cem. Lewiston Wash.
DATE OF BURIAL ... 19...

20. UNDERTAKER: PASSAR UNDERTAKING CO
ADDRESS Lewiston Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 33938
Registered No. 622

1. PLACE OF DEATH
County of Nez Perce
City of Lewiston (St.)
If death occurs away from usual residence, give facts called for under special information.

APR 16 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME Ellen L. Montague

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widowed

6. DATE OF BIRTH: Nov (Month) 5 (Day) 1857 (Year)

7. AGE: 63 Yrs. 4 Mos. 14 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Minn.

10. NAME OF FATHER: Robert Montague

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Ellen McLaughlin

13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jayne Montague
(Address) Genesee, Idaho.

15. Filed Mar 3 1921 Susan E Bruce Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 19th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from — 19..., to — 19...
that I last saw h... — alive on — 19...
and that death occurred on the date stated above, at 5 P M.
The CAUSE OF DEATH* was as follows:

Hypostatic Congestion of Lungs
(Duration) ... Yrs. ... mos. + ... ds.
Contributory (Secondary) Cardiac Dropsy
(Duration) ... yrs. + ... mos. ... ds.
(Signed) O. L. Pearson M. D.
19... (Address) Lewiston Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Genesee, Idaho. DATE OF BURIAL ... 19...

20. UNDERTAKER: MASSAR UNDERTAKING CO. ADDRESS Lewiston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 33939
Registered No. 623

RECEIVED
APR 16 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Nez Perce
City of Lewiston
(No. ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Slickpoo

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: Indian
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: ... (Month) ... (Day) 1 (Year)

7. AGE: 54 Yrs. ... Mos. ... ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer): ...

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Joe Thomas

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Jane ———

13. BIRTHPLACE OF MOTHER (State or Country): Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Jane Slickpoo
(Address): ...

15. Filed Apr 12 1921 Susan E Bruce
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51068

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar 23rd 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 8 1921 to Mar 23rd 1921
that I last saw h... alive on ... 19...
and that death occurred on the date stated above, at 7 15 P.M.
The CAUSE OF DEATH* was as follows:

Acute Hemorrhage about March 22nd
2nd Mar
Cerebral Hemorrhage

(Duration) ... Yrs. ... mos. 21 ds.
Contributory (Secondary): Interstitial Nephritis
(Duration) ... yrs. 4 mos. ... ds.
(Signed) D C Canavan M. D.
19... (Address) Lewiston Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death? ...
Former or usual residence ...

19. PLACE OF BURIAL OR REMOVAL: Lewiston Ida
DATE OF BURIAL: Mar 24 1921

20. UNDERTAKER: Vassar Fr Co
ADDRESS: Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 33940
Registered No. 624

1. PLACE OF DEATH

County of Nez Perce
City of Lewiston, Ida. (St.)

If death occurs away from usual residence, give facts called for under special information.

BUREAU OF STATISTICS APR 10

2. FULL NAME Stella L. Nelson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F	White	Single

6. DATE OF BIRTH: Oct. (Month) 31st (Day) 1899 (Year)

7. AGE: 21 Yrs. 4 Mos. 24 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Teaching
(b) General nature of industry, business or establishment in which employed (or employer): Deary, Idaho

9. BIRTHPLACE (State or Country): Troy, Idaho

10. NAME OF FATHER: James S Nelson

11. BIRTHPLACE OF FATHER (State or Country): Virokue, Wis

12. MAIDEN NAME OF MOTHER: Selma Anderson

13. BIRTHPLACE OF MOTHER (State or Country): Glenwood, Minn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) James S Neelson
(Address) Clarkston

15. Filed Apr 12 1921 Swan E Bruce Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 3 (Month) 25 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3-21 1921, to 3 25 1921
that I last saw h.. alive on 3 25 1921,
and that death occurred on the date stated above, at 7.30 P.M.
The CAUSE OF DEATH* was as follows:
Lethargic Encephalitis

(Duration) Yrs. mos. 10 ds.
Contributory (Secondary) none
(Duration) yrs. mos. ds.
(Signed) John M. Allen M. D.
3-26 1921 (Address) Lewiston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
T Clarkston Wash	Mar. 1921
20. UNDERTAKER	**ADDRESS**
A. R. Merchant	Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

BYRS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33941
Registered No. 625

1. PLACE OF DEATH

County of Nez Perce

City of Lewiston

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 96

Primary Registration District No. 1009

(No. ..... St.)

RECEIVED APR 16 19.. BUREAU OF VITAL STATISTICS

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Henry Lamont

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: July (Month) 6 (Day) 1878 (Year)

7. AGE: 42 Yrs. 8 Mos. 20 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Barber

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Maine.

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) H. D. Lamont

(Address) City

15. Filed Apr 12 1921 Wm E Bruce Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar (Month) 26 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3-26 1921, to 3-26 1921 that I last saw him alive on 3-19 1921 and that death occurred on the date stated above, at 9.50 A.M.

The CAUSE OF DEATH* was as follows:

Gun Shot wound Right Temple (Suicidal)

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John H Alley M. D.

19.. (Address) Lewiston Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston Ida

DATE OF BURIAL: 3/29 1921

20. UNDERTAKER: Vassar Undertaking Co

ADDRESS: Lewiston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Nez Perce

City of Lewiston

(No. ..... St.)

Registration District No. 96

Primary Registration District No. 1009

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BUREAU OF VITAL STATISTICS

File No. 33942

Registered No. 626

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ruby May Hendrickson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: April (Month) 13 (Day) 1891 (Year)

7. AGE: 29 Yrs. 11 Mos. 16 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Asotin County Washington

10. NAME OF FATHER: William Appleford

11. BIRTHPLACE OF FATHER (State or Country): England.

12. MAIDEN NAME OF MOTHER: Mattie Stone

13. BIRTHPLACE OF MOTHER (State or Country): Iowa.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs H Appleford

(Address) Asotin Wash.

15. Filed Apr 12 1921 Susan E Bruce Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 28 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 15 1920, to March 28 1921 that I last saw h[illegible] alive on March 28 1921, and that death occurred on the date stated above, at 7:30 A.M.

The CAUSE OF DEATH* was as follows:

General Tuberculosis

(Duration) ..... Yrs. 2 mos. ..... ds.

Contributory (Secondary): Flu

(Duration) ..... yrs. 6 mos. ..... ds.

(Signed) Edgar L. White M. D.

3-28 1921 (Address) Lewiston Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Asotin Iowa — DATE OF BURIAL: 3/30 1921

20. UNDERTAKER: A. R. Merchant — ADDRESS: Clarkston Wash

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 33944
Registered No. 625

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APR 16 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Nez Perce
City of Lewiston (or Village or Township) St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George W. Simpson
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): ~~married~~ widowed

6. DATE OF BIRTH: April (Month) 11 (Day) 1848 (Year)

7. AGE: 72 Yrs. 11 Mos. — ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Carpenter - retired 15 yrs
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER: Thomas Simpson

11. BIRTHPLACE OF FATHER (State or Country): Scotland

12. MAIDEN NAME OF MOTHER: Aurelia Lawrence

13. BIRTHPLACE OF MOTHER (State or Country): New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) L. Rae Simpson
(Address) Clarkston Wash.

15. Filed Ap 12 1921 Susan E Bruce Local Registrar

SUNSET-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 11 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1 1921, to Mch 11 1921, that I last saw ~~him~~ alive on Mch 8 1921, and that death occurred on the date stated above, at 4 A.M.

The CAUSE OF DEATH* was as follows:
Paralysis Agitans
10 years or more (Duration) Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) Paul W Johnson M. D.
3/17 1921 (Address) Clarkston Wash

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Clarkston Wash — DATE OF BURIAL: 3/13 1921

20. UNDERTAKER: H. C. Merchant — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33945
Registered No. 2

1. PLACE OF DEATH.
County of Nezperce
City of Spalding
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 9
Primary Registration District No. 2 1
(No. 1321, St.)

APR 6 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME Silas Lawyer

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	Indian	Widower

6. DATE OF BIRTH
(Month) (Day) (Year)
1

7. AGE
86 yrs. mos. ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Farmer & Stock
(b) General nature of industry business, or dstablishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Lewiston Ida

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER
(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Sam Lickfoot
(Address)

15.
Filed Mar 26 1921 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Mar 25 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Angina Pectoris

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs ..... mos. ..... ds.

(Signed) [illegible] M. D.
Mar 26 1921 (Address) Lapwai Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Kamiah Ida	Mar 26 1921

20. UNDERTAKER	ADDRESS
L. B. Wann	Lewiston Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
APR 14 192
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH. Registration District No. 97
County of Nez Perce Primary Registration District No. 2174
City of Lapwai (No. ; St.)
File No. 33946
Registered No. 1
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary Jane Mattoon

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
F	N	

6. DATE OF BIRTH: Feb (Month) 8 (Day) 1865 (Year)

7. AGE: 56 yrs. 1 mos. 12 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer): Illinois

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: J. K. Howard

11. BIRTHPLACE OF FATHER (State or Country): Not Known

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) D. W. Mattoon
(Address) Nez Perce Idaho.

15. Filed Mar. 22 1921 L.L. Riggs Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March (Month) 21st (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar. 18 1921, to Mar 20th 1921 that I last saw h[illegible] alive on Mar 20th 1921 and that death occurred on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

Asthma Bronchial

(Duration) Final yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) L.L. Riggs M. D.

3/22 1921 (Address) Lapwai Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death?

Former or usual residence Lewiston Ida

19. PLACE OF BURIAL OR REMOVAL: Lewiston Ida — DATE OF BURIAL: 3/23 1921

20. UNDERTAKER: [illegible] — ADDRESS: Lewiston Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

GYMS - YORK CO., PTRS. & SONS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33947

Registered No. .....

RECEIVED
APR 29 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH.

County of Salah ... Primary Registration District No. 68

City of Julietta ... (No. ..... St.)

If death occurs away from usual residence give facts called for under special information.

2. FULL NAME William G. Lewis

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Dec. 4 (Month) 1837 (Day) Eighty years (Year)

7. AGE: Eighty Years 3 Mos. 13 Ds. 9

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Winchester Scot Co Ill.

10. NAME OF FATHER: George Lewis

11. BIRTHPLACE OF FATHER (State or Country): Kentucky

12. MAIDEN NAME OF MOTHER: Lurena Woodson

13. BIRTHPLACE OF MOTHER (State or Country): Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) C J Lewis
(Address) Kendrick Ida

15. Filed 3/15/21 191 ..... R F Pepple Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 3 (Month) 13 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 5 1921 to Mar 13 1921, that I last saw h~~im~~ alive on Mar. 12 1921, and that death occured on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:
Direct Cause was Brain trouble

(Duration) 1 Yrs. 5 mos. 7 ds.
Contributory (Secondary) ~~Old age~~

(Duration ..... yrs. ..... mos. ..... ds.
(Signed) J D Kelly M. D.
3-15 1921 (Address) Juliette Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Juliette Idaho — DATE OF BURIAL: 3-15 1921

20. UNDERTAKER: J. Grosclose — ADDRESS: Juliette

J. Grosclose

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

A F F I D A V I T.

STATE OF CALIFORNIA,) ss.
COUNTY OF RIVERSIDE.)

CHARLES E. LEWIS, being first duly sworn, deposes and says:-

That he is a resident of the County of Riverside, State of California, and that he resides in the City of Riverside, in said County and State; that he is 54 years of age, a married man and has a family of three children.

That he is the fourth son of William George Lewis, sometimes known as W.G. Lewis, and that his mother's name was Nancy Jane Lewis; that his father, William G. Lewis was born in Winchester, Scot, County, Illinois; that his father and mother are both now deceased.

That the said William G. Lewis, sometimes known as W.G. Lewis, died in Juliaette, Latah County, Idaho, on the 13th day of March, 1921; that he was 84 years of age at the time of his death, and that at the date of his decease he was a resident of said City, County and State.

Affiant further states that at the time of his father's death, he and his family resided at Kendrick, Idaho, about four miles from Juliaette, Idaho; that prior to his father's last illness he saw his father, the said William G. Lewis, most every few days; that he was in the house of his father's and Mother's at the time of his father's illness; that he attended his father during his last sickness by sitting up during the nights and assisting in his care; that at the time of his death, he was present at the funeral services held in the house of decedent; that he also attended the services held at the cemetary, and that he viewed the body of the deceased after the death, and that he knew it to be the body of his father, William G. Lewis, sometimes known as W.G. Lewis and sometimes as William George Lewis.

DATED this 21 day of January, 1932.

Charles E Lewis Jr
AFFIANT.

STATE OF CALIFORNIA,) ss.
COUNTY OF RIVERSIDE.)

BEFORE ME, C. W. Benshoof, a Notary Public, personally appeared Charles E. Lewis, and acknowledged to me that he executed the foregoing affidavit.

C. W. Benshoof.
Notary Public in and for the County of Riverside, State of California.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33948

Registered No. 12

RECEIVED
MAY 6
BUREAU OF VITAL STATISTICS

Registration District No. 26

Primary Registration District No. 2069

1. PLACE OF DEATH

County of Oneida

City of Malad (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

FULL NAME Grant Owens

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED: (Write the word.)
male	white	single

6. DATE OF BIRTH: March 2 1921 (Month) (Day) (Year)

7. AGE: ..... Yrs. ..... Mos. 13 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Malad Idaho

10. NAME OF FATHER Edward Owens

11. BIRTHPLACE OF FATHER (State or Country) Malad Idaho

12. MAIDEN NAME OF MOTHER Lizzie Jones

13. BIRTHPLACE OF MOTHER (State or Country) Malad Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Owens

(Address) Malad Idaho

15. Filed May 4 1921 R T Maney M.D. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 15 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 8 1921, to March 15 1921, that I last saw him alive on Mar 15 1921, and that death occurred on the date stated above, at 7 P M.

The CAUSE OF DEATH* was as follows:

Pneumonia

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) 2 yrs. ..... mos. ..... ds.

(Signed) R T Maney M. D.

3-17 1921 (Address) Malad Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Malad Idaho — DATE OF BURIAL: 3/17 1921

20. UNDERTAKER: 129 D E Johnson — ADDRESS: Malad Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

RECEIVED Registration District No. 26

MAY 6 Registration District No. 2069

BUREAU OF STATISTICS

File No. 33949

County of

City of (No. St.)

Registered No. 13

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ellen Colton

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F	W	Widowed

6. DATE OF BIRTH: Aug 14 (Month) (Day) 1832 (Year)

7. AGE: 88 Yrs. 7 Mos. 12 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: Robert White

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Anna Hewett

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Merritt Colton
(Address):

15. Filed May 4 1921 R M Mauer M.D. Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr 3 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 1 1921, to Apr 3 1921 that I last saw h[illegible] alive on Apr 3 1921 and that death occurred on the date stated above, at 1.00 M.
The CAUSE OF DEATH* was as follows:

Paralysis

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) C. F. Colton M. D.

4-7 1921. (Address) Malad Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
St Johns Ida	4-4 1921
20. UNDERTAKER	ADDRESS
[illegible]	Malad

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33950
Registered No. 3

1. PLACE OF DEATH

County of Elmore
City of Mtn Home (If outside limits, give township) Ida. (St.)

Registration District No. 34
Local Registration District No. 2020

RECEIVED
MAY 10 1921
BUREAU OF VITAL STATISTICS

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Parley Shawver

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH: May (Month) 9 (Day) 1852 (Year)

7. AGE: 68 Yrs. 11 Mos. 2 ds. IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: John Shawver

11. BIRTHPLACE OF FATHER (State or Country): Penn.

12. MAIDEN NAME OF MOTHER: Sarah Foot

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Grant Wilson
(Address)

15. Filed April 13 1921 — I. E. Evans, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 11 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 1, 1921, to April 11 1921, that I last saw him alive on April 11, 1921, and that death occurred on the date stated above, at 2:30 P. M.
The CAUSE OF DEATH* was as follows:

Rocky Mountain Spotted Fever

(Duration) ... Yrs. ... mos. 14 ds.

Contributory (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) I. E. Evans M. D.
4-13-1921 (Address) Mtn Home Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Dillon Mont	4-15 1921

20. UNDERTAKER	ADDRESS
A. V. Conover	Mtn Home Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33951
Registered No. 4

1. PLACE OF DEATH

Registration District No. 34

County of Elmore

Primary Registration District No. 2020

City of Mtn Home (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
MAY 10 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME Infant of Eugenio Mingo

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH: April (Month) 2 (Day) 1921 (Year)

7. AGE: ..... Yrs. ..... Mos. ..... ds. IF LESS than 1 day how many 20 hrs. hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Mtn Home Ida

10. NAME OF FATHER Eugenio Mingo

11. BIRTHPLACE OF FATHER (State or Country) Vizcaya Marquina Espraina

12. MAIDEN NAME OF MOTHER Dominga Solaaga

13. BIRTHPLACE OF MOTHER (State or Country) Vizcaya Marquina Espraina

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Eugenio Mingo
(Address) Mtn Home Ida

15. Filed 5-1-1921 J E Evans Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 3 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4-2-1921, to 4-3-1921 that I last saw h.. alive on 4-2-1921 and that death occurred on the date stated above, at 2:00 A.M.

The CAUSE OF DEATH* was as follows:

Heart Difficulty

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. E. Evans M. D.

5-1-1921 (Address) Mtn Home Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mtn Home Cem — DATE OF BURIAL: 4-3-1921

20. UNDERTAKER: A M Connor — ADDRESS: Mtn Home Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

Form V. S. No. 5 20M.1-16-12

RECEIVED MAY 5 1921 BUREAU

CERTIFICATE OF DEATH

43

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. .....

County of Owyhee Primary Registration District No. 2120

File No. 33952

City of Silver (No. ....., ... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Josephine Lavender

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)
Female	White	Divorced

6. DATE OF BIRTH January 17 1877
(Month) (Day) (Year)

7. AGE 44 yrs. 2 mos. 26 ds.

IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work House Work.
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Unknown

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (State or Country) Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) L. A. Dean
(Address) Silver City Idaho.

15. Filed April 15th 1921 Asheuel Pickett (Local Registrar)

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH April 13th 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from No Doctor 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

.....

.....

.....

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

..... 19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
I.O.O.F. Cemetery	April 14th 1921
20. UNDERTAKER John Route.	ADDRESS Silver City Idaho.

GYMS - YORK CO., PTRS. & BDRS. 19760

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

~~OREGON~~ Idaho STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

RECEIVED MAY 4 1921 BUREAU OF VITAL STATISTICS

State Registered No. 33953

Local Registered No. 11

1 PLACE OF DEATH

County Payette State Ida

Township ..... or Village ..... or

City Payette No. ....., North 6th St St., ... Ward

(If death occurred in a hospital or institution, give its name instead of street and number)

2 FULL NAME John Boyd

(a) Residence. No. ..... North 6th St St., ...

(Usual place of abode) (If nonresident, give city or town and state)

Length of residence in city or town where death occurred 12 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Marred

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nancy Boyd

6 DATE OF BIRTH (month, day, and year) 1845

7 AGE	Years	Months	Days	If less than 1 day, ... hrs. or ..... min.
	76	2	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10 NAME OF FATHER Boyd

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant A. O. Green (Address) Payette

15 Filed Apr 13, 1921 J. C. Woodward Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 20 1921

17 I HEREBY CERTIFY, That I attended deceased from March 19, 1921, to March 20, 1921, that I last saw him alive on March 20, 1921, and that death occurred on the date stated above, at 9:30 a. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

..... (duration) ..... yrs., ... mos., 2 days.

CONTRIBUTORY (Secondary) Senility

..... (duration) ..... yrs., ... mos., ... days.

18 Where was disease contracted if not at place of death? ~

Did an operation precede death? No Date of ~

Was there an autopsy? No

What test confirmed diagnosis? ~

(Signed) E. McConnell, M. D.

March 20, 1921 (Address) Payette Ida

* State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
J. H. Adair Payette	Mar 21 1921
20 UNDERTAKER	**ADDRESS**
J. H. Adair Payette	Ida

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

Idaho ~~OREGON~~ STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

RECEIVED MAY 4 1921 BUREAU OF VITAL STATISTICS

State Registered No. 33954

1 PLACE OF DEATH County Payette State Ida Local Registered No. 121

Township ..... or Village ..... or

City Payette No. 504 North 9th St., ... Ward

(If death occurred in a hospital or institution, give its name instead of street and number)

2 FULL NAME Asa C. Douglass

(a) Residence. No. 504 North 9th St., ...

(Usual place of abode) (If nonresident, give city or town and state)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Myrta A Douglass

6 DATE OF BIRTH (month, day, and year) Oct 18 1847

7 AGE	Years	Months	Days	If less than 1 day, ... hrs. or ... min.
	73	5	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (~~city~~ or town) Baraboo, (State or country) Sauk Co., Wisconson.

PARENTS

10 NAME OF FATHER Elisha Douglass

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Penn

12 MAIDEN NAME OF MOTHER Mary Kerr

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Penn

14 Informant Howard T. Douglass (Address) Payette, Ida.

15 Filed Apr 13, 1921 J. C. Woodward Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 12, 1921

17 I HEREBY CERTIFY, That I attended deceased from April 4, 1921, to April 12, 1921, that I last saw him alive on April 12, 1921, and that death occurred on the date stated above, at 1:15 a m.

The CAUSE OF DEATH * was as follows .....

Uremia

.....

.....

.....(duration) ..... yrs., ... mos., 8 days.

CONTRIBUTORY (Secondary) .....

.....(duration) ..... yrs., ... mos., ... days.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) O. H. Avery, M. D.

4/13/, 1921 (Address) Payette, Idaho

* State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, ~~CREMATION OR~~ REMOVAL	DATE OF BURIAL
Payette Ida	Sept 14 1921
20 UNDERTAKER	ADDRESS
D N Edair	Payette Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED MAY 4 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH.

Registration District No. 4

Primary Registration District No. 1008

File No. 33955

County of

City of Gruntland -

(No. , St.)

Registered No. 13

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Enborg -

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH: April 9 (Month) (Day) 1921 (Year)

7. AGE: — yrs. — mos. ½ day

IF LESS than 1 day how many .....*hrs. or* .....*mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work: ✓
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Gruntland Idaho

10. NAME OF FATHER: Carl E Enborg.

11. BIRTHPLACE OF FATHER (State or Country): Idaho. Utah

12. MAIDEN NAME OF MOTHER: Sarah Hooker.

13. BIRTHPLACE OF MOTHER (State or Country): Iowa.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): H. H. Whitney
(Address): Ontario - Ore

15. Filed April 15 1921 J. C. Woodward Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: April 9 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 9 1921, to Apr 9 1921, that I last saw her alive on Apr. 9 1921, and that death occurred on the date stated above, at 1.00 P.M.

The CAUSE OF DEATH* was as follows:
Premature Birth -

(Duration) — yrs. — mos. — ½ ds.

Contributory (Secondary) ✓ (Duration) ✓ yrs. mos. ds.

(Signed) H. H. Whitney M. D.

19.... (Address) Ontario, Ore

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Gruntland - Idaho

DATE OF BURIAL: Apr. 10 1921

20. UNDERTAKER: Carl E Enborg.

ADDRESS: Gruntland Idaho

SYMS - YORK CO. PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-19.

RECEIVED MAY 1 1921 BUREAU OF STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 4
Primary Registration District No. 1008
File No. 33956
Registered No. 14

1. PLACE OF DEATH
County of Malheur Oregon
City of Ontario Oreg. (No. ____ St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Frank William Wheeler
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: June (Month) 9 (Day) 1892 (Year)

7. AGE: 28 Yrs. 10 Mos. 5 ds.
IF LESS than 1 day how many ____ hrs. or ____ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Neb

10. NAME OF FATHER: Fred Wheeler

11. BIRTHPLACE OF FATHER (State or Country): Wis

12. MAIDEN NAME OF MOTHER: Dalla L. Sides

13. BIRTHPLACE OF MOTHER (State or Country): Ill

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Frank Wheeler
(Address) Payette Idaho

15. Filed Apl 15 1921. J C Woodward Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 14 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 14, 1921, to April 14, 1921, that I last saw h alive on April 14 1921, and that death occurred on the date stated above, at 11.30 A.M.

The CAUSE OF DEATH* was as follows: Perforated Duodenal Ulcer

(Duration) ____ Yrs. ____ mos. ____ ds.

Contributory (Secondary)

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) J C Woodward M. D.
4/15/21 (Address) Payette Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ~ yrs. ~ mos. 1 days. In the State ~ yrs. ~ mos. 1 days
Where was disease contracted if not at place of death? Payette Ida
Former or usual residence Payette Ida.

19. PLACE OF BURIAL OR REMOVAL: Payette Idaho — DATE OF BURIAL: April 17 1921

20. UNDERTAKER: Glenn & Landon — ADDRESS: Payette Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SUMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33957

Registered No. 15

RECEIVED
MAY 4 1921
BUREAU OF VITAL STATISTICS

Registration District No. 4

Primary Registration District No. 1008

1. PLACE OF DEATH

County of Payette

City of Payette

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Hildrette Clanton

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Single

6. DATE OF BIRTH: May (Month) 27 (Day) 1919 (Year)

7. AGE: 1 Yrs. 10 Mos. 22 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: John Clanton

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Florence Cartwright

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) ..... Payette
(Address) .....

15. Filed Apr. 20 1921 J. C. Woodward Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr (Month) 19 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 15 1921, to Apr 19 1921, that I last saw h.. alive on Apr 19 1921, and that death occurred on the date stated above, at 10 A.M.
The CAUSE OF DEATH* was as follows:

Bronchio - pneumonia

(Duration) ..... Yrs. 1 mos. 4 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. R. Woodward M. D.

5/3 1921 (Address) Payette Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Payette	Apr 20 1921

20. UNDERTAKER	ADDRESS
J. N. Ellis	Payette Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED MAY 1 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33958
Registered No. 16

1. PLACE OF DEATH
County of Canyon
City of Caldwell (Registration District No. 4 / Primary Registration District No. 1008 / St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ezekial Smith
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Feb (Month) 15 (Day) 549 (Year)

7. AGE: 72 Yrs. 2 Mos. 7 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer Retired
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Nathan Smith

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Rozia Wheeler

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W R Williams
(Address) Payette Ida

15. Filed Apr 27 1921 J C Woodward Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 24 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 15 1921, to April 24 1921, that I last saw him alive on April 24 1921, and that death occurred on the date stated above, at 109 M.
The CAUSE OF DEATH* was as follows:

Aortic Insufficiency

(Duration) ? Yrs. ? mos. ? ds.
Contributory (Secondary) Chronic Myocarditis
(Duration) ? yrs. ? mos. ! ds.

(Signed) J L McGinnis M. D.
4/28 1921 (Address) Payette Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Payette Ida | DATE OF BURIAL: Apr 27 1921

20. UNDERTAKER: J N Cedarleaf | ADDRESS: Payette Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-12 M. 6-15-17.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

33959

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3
Registered No. 118
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

RECEIVED
APR 30 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Power
City of Am. Falls. (If death occurs away from usual residence, give facts called for under special information.)
Registration District No. 25
Primary Registration District No. 2072
St.)

2. FULL NAME Charles H. Torrance.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	white	Married

6. DATE OF BIRTH. June 30. 1867
(Month) (Day) (Year)

7. AGE 53 Yrs. 8 Mos. 20 ds. IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Deft. Sheriff
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Ore.

10. NAME OF FATHER W. S. Torrance.

11. BIRTHPLACE OF FATHER (State or Country) Mass.

12. MAIDEN NAME OF MOTHER Mary Jane Whitcomb

13. BIRTHPLACE OF MOTHER (State or Country) Mich

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. H. Torrance
(Address) American Falls Ida

15. Filed Mch 25 1921 R. F. Hoath M. D. Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mch 20 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mch 17 1921 to Mch 20 1921
that I last saw him alive on Mch 20 1921
and that death occurred on the date stated above, at 12.30 P. M.

The CAUSE OF DEATH* was as follows:

Gunshot wounds -

(Duration) .... Yrs.... mos.... ds.

Contributory (Secondary)

(Duration) .... Yrs.... mos.... ds.

(Signed) C. F. Schilt M. D.
3-21-1921 (Address) Amer. Falls, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the State....yrs....mos. 3 days
Where was disease contracted if not at place of death? Pauline, Idaho
Former or usual residence Amer. Falls, Ida.

19. PLACE OF BURIAL OR REMOVAL Colfox Wash. DATE OF BURIAL .... 191...

20. UNDERTAKER Am Davis ADDRESS Am Falls Ida

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

33961 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 9
Registered No. 120
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Power
City of American Falls,
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 25
Primary Registration District No. 2072
(No. ..... St.)

RECEIVED
APR 26 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME George W. Emigh

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH. May (Month) 1 (Day) 1848 (Year)

7. AGE: 72 Yrs. 10 Mos. 23 ds.
IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Lumberman
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Penn

10. NAME OF FATHER: Christian Emigh

11. BIRTHPLACE OF FATHER (State or Country): Not Known

12. MAIDEN NAME OF MOTHER: Christiana Daughbaugh

13. BIRTHPLACE OF MOTHER (State or Country): Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. F. Emigh
(Address) Burley, Idaho

15. Filed 4-25 1921 R. F. Nott Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 24 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mch 24 1921 to Mch 24 1921 that I last saw h[illegible] alive on Mch 24 1921 and that death occurred on the date stated above, at 7:25 P. M.

The CAUSE OF DEATH* was as follows:
Edema of the lungs.
(Duration) ... Yrs. ... mos. ... ds.
Contributory (Secondary) Mitral Regurgitation
(Duration) ... Yrs. ... mos. ... ds.
(Signed) C. F. Schultz M. D.
3/25 1921. (Address) Camas Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos...1 days. In the State....yrs....mos....days
Where was disease contracted if not at place of death? Burley, Idaho
Former or usual residence Burley Idaho

19. PLACE OF BURIAL OR REMOVAL: American Falls, Idaho
DATE OF BURIAL: 3/26/21 191...

20. UNDERTAKER
ADDRESS

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
MAY 10 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 77
Primary Registration District No. 2176
File No. 33963
Registered No. 13

County of Teton
City of Victor (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Chas. Maurice Blanchard

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: April (Month) 11 (Day) 1921 (Year)

7. AGE: ..... Yrs. ..... Mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Drayman
(b) General nature of industry, business or establishment in which employed (or employer): Drayman

9. BIRTHPLACE (State or Country): Victor, Idaho

10. NAME OF FATHER: W. F. Blanchard

11. BIRTHPLACE OF FATHER (State or Country): Canada

12. MAIDEN NAME OF MOTHER: Gladys Cattread

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. F. Blanchard
(Address) Victor, Idaho.

15. Filed May 6 — 1921 Martha Marker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 24 (Day) 1924 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April - 21 - 1924, to April - 24 1924, that I last saw him alive on April - 23 - 1924, and that death occurred on the date stated above, at 8 P.M.

The CAUSE OF DEATH* was as follows:

Gastro enteritis

(Duration) ..... Yrs. ..... mos. 4 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. H. Culbertson M. D.

April 24 1924 (Address) Dayton Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Victor, Idaho. DATE OF BURIAL: Apr. 25 1924

20. UNDERTAKER: C. O. Wing ADDRESS: Dayton, Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33964

Registered No. 12

If death occurred in a hospital, institution or camp, give its NAME instead of

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BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Latah Registration District No. 77

Primary Registration District No. 2176

City of Victor (If outside limits of city or village, give township) No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Hans James Hansen.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	white	married

6. DATE OF BIRTH June 24 1839
(Month) (Day) (Year)

7. AGE 81 Yrs. 10 Mos. 2 ds.
IF LESS than 1 day, how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry, business or establishment in which employed (or employer) Farming

9. BIRTHPLACE (State or Country) Denmark

10. NAME OF FATHER Do not know

11. BIRTHPLACE OF FATHER (State or Country) Do not know

12. MAIDEN NAME OF MOTHER Do not Know

13. BIRTHPLACE OF MOTHER (State or Country) Do not know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jas. Hans
(Address) Victor Idaho

15. Filed May 8— 1921 Martha Mack
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 22 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 15 1921 to April 22 1921
that I last saw him alive on April 5 1921
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Endocarditis & Myocarditis
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Alcoholism
(Duration) 2 yrs. ..... mos. ..... ds.
(Signed) H. H. Culbertson M. D.
April 24 1921 (Address) Driggs Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Victor Cemetery — DATE OF BURIAL 4-24 1921

20. UNDERTAKER L O Kinney — ADDRESS Driggs, Ida.

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

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CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
Registration District No. 77
County of Latah
Primary Registration District No. 2176
City of Kendrick (No. ..... St.)
File No. 33965
Registered No. 11
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James Hamilton Sr.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: August 9 1846 (Month) (Day) (Year)

7. AGE: 74 Yrs. 8 Mos. 1 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer): Farming

9. BIRTHPLACE (State or Country): Scotland

10. NAME OF FATHER: James Hamilton

11. BIRTHPLACE OF FATHER (State or Country): Scotland

12. MAIDEN NAME OF MOTHER: Edith E Fowler

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) James F Hamilton
(Address) Viola, Idaho.

15. Filed May 8 – 1921 Martha Marks Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 10 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 16 1921, to April 10 1921, that I last saw h.im alive on Feb. 3 1921, and that death occurred on the date stated above, at 1 p. m.
The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) 1 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) L. H. Culbertson M. D.

4-12-1921 (Address) Troy Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Kendrick | DATE OF BURIAL: April 13 1921

20. UNDERTAKER: E O Shuey | ADDRESS: Kendrick

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

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FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33966
Registered No. 16

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1. PLACE OF DEATH
County of Teton
City of Driggs (No. ..... St.)
Registration District No. 77
Primary Registration District No. 2176
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Infant Cooper

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: April (Month) 21 (Day) 1921 (Year)

7. AGE: ..... Yrs. ..... Mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business or establishment in which employed (or employer): Infant

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: Willard Cooper

11. BIRTHPLACE OF FATHER (State or Country): Louisiana Miss.

12. MAIDEN NAME OF MOTHER: Nellie Stevens

13. BIRTHPLACE OF MOTHER (State or Country): Driggs Ida.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Willard Cooper
(Address) Driggs Ida

15.
Filed May 8th 1921 Martha [illegible] Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 22 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April - 21 - 1921, to April - 22 - 1921 that I last saw h[illegible] alive on April - 21 - 1921, and that death occurred on the date stated above, at 11 P M.

The CAUSE OF DEATH* was as follows:
Congenital trauma of Thyroid & thymus glands & resulting strangulation due to pressure on trachea.
(Duration) ..... Yrs. ..... mos. / ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. L. Culbertson M. D.
April 22 1921 (Address) Driggs Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Victor Cemetery — DATE OF BURIAL: 4-24 1921

20. UNDERTAKER: [illegible] — ADDRESS: Driggs Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1085
File No. 33967
Registered No.

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BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Twin Falls
City of " " St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Cyrus A. Bennett
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Dec 31 1851
(Month) (Day) (Year)

7. AGE: 69 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer): Retired

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Cyrus Bennett

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER: Caroline Johnson

13. BIRTHPLACE OF MOTHER (State or Country): South America

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A. D. Sherlock
(Address) Twin Falls

15.
Filed 19
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April 30 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4/29 1921, to 4/30 1921
that I last saw h.im alive on 4/30 1921,
and that death occurred on the date stated above, at 1030 P.M.
The CAUSE OF DEATH* was as follows:
Apoplexy
(Duration) Yrs. mos. 2 ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) C. D. Weaver M. D.
19 (Address) Twin Falls, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls
DATE OF BURIAL 19

20. UNDERTAKER: J. J. Freeman
ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

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FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33968

Registered No.

1. PLACE OF DEATH

Registration District No. 37

Primary Registration District No. 1 0 8 3

County of Twin Falls

City of " " (No. St.)

If death occurs away from usual residence, give facts called for under special information.

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STATE OF IDAHO

2. FULL NAME Elsie Funkhouser

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Feb (Month) 18 (Day) 1921 (Year)

7. AGE: Yrs. 2 Mos. 12 Ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work:
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Twin Falls Ida

10. NAME OF FATHER: A. F. Funkhouser

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Lily Wilson

13. BIRTHPLACE OF MOTHER (State or Country): Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A. F. Funkhouser
(Address) Twin Falls Ida

15. Filed May 8 1921 John V. Coughlan Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 1 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sav once 5/1 1921, to ~~1921~~
that I last saw h[illegible] alive on 5/1 1921.
and that death occurred on the date stated above, at M.
The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.

(Duration) 2 Yrs. [illegible] Mos. [illegible] Ds.

Contributory (Secondary) Arteriosclerosis

(Duration) all life Yrs. [illegible] Mos. [illegible] Ds.

(Signed) C. H. Keyes M. D.

5/1 1921 (Address) Twin Falls Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs ... mos ... days. In the State ... yrs ... mos ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Ida — DATE OF BURIAL: May 2 1921

20. UNDERTAKER: P. J. Grossman — ADDRESS: Twin Falls Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

Weaver

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33969

Registered No. .....

1. PLACE OF DEATH

County of Twin Falls Registration District No. 37

Primary Registration District No. 1885

City of ..... (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

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BUREAU OF VITAL STATISTICS

2. FULL NAME Wm M Schuger

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Sept (Month) 29 (Day) 96 (Year)

7. AGE: 4 Yrs. 7 Mos. 8 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Twin Falls Idg

10. NAME OF FATHER: H.C. Schuger

11. BIRTHPLACE OF FATHER (State or Country): Ger.

12. MAIDEN NAME OF MOTHER: Josephine Metthys

13. BIRTHPLACE OF MOTHER (State or Country): Holland.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm M Schuger

(Address) Twin Falls Ida

15. Filed May 8 1921 John T. Gough Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 7 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 7 1921, to ..... 19.....

that I last saw him alive on May 7 1921

and that death occurred on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows: Intestinal Toxemia

(Duration) ..... Yrs. ..... mos. 4 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. D. Weaver M. D.

19..... (Address) Twin Falls, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Ida

DATE OF BURIAL: 5/9 1921

20. UNDERTAKER: P.J. Grossnicle

ADDRESS: Twin Falls

FORM V. S. No. 5-25 M. 1-19.

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CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1185
File No. 33970
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of (Or Town) St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Walter James

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Negro
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single
6. DATE OF BIRTH: Dont Know (Month) (Day) 1 (Year)
7. AGE: 40 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business or establishment in which employed (or employer): Warren Const. Co.,
9. BIRTHPLACE (State or Country): Dont Know
10. NAME OF FATHER: " " "
11. BIRTHPLACE OF FATHER (State or Country): " " "
12. MAIDEN NAME OF MOTHER: " " "
13. BIRTHPLACE OF MOTHER (State or Country): " " "
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) O. J. Foreman
(Address) Twin Falls
15.
Filed May 8 1921
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 5 (Month) (Day) 1921 (Year)
17. I HEREBY CERTIFY, That I attended deceased from 19..., to 19...
that I last saw h... alive on 19...
and that death occurred on the date stated above, at 9:15 P.M.
The CAUSE OF DEATH* was as follows:
Revolver wound (Homicidal)
(Duration) Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) O. J. Foreman Coroner
May 7 1921 (Address) Twin Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Ida
DATE OF BURIAL: May 8 1921
20. UNDERTAKER: O. J. Foreman
ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

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FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

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Registration District No. 37
Primary Registration District No. 1085
File No.
Registered No. 33971

1. PLACE OF DEATH
County of Twin Falls
City of ..... (If outside limits of city or village, give township.) No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James Miller
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Feb 22 (Month) (Day) 1848 (Year)

7. AGE: 73 Yrs. 2 Mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): N Car

10. NAME OF FATHER: Geo. Miller

11. BIRTHPLACE OF FATHER (State or Country): N Car

12. MAIDEN NAME OF MOTHER: Betty Koontz

13. BIRTHPLACE OF MOTHER (State or Country): West Tennessee or N Carolina

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. M. Miller
(Address) Twin Falls

15. Filed May 5 - 1921
John S. Coughlin
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 5 - (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 27 1921, to May 5 1921
that I last saw him alive on May 4 1921
and that death occurred on the date stated above, at 2 P.M.
The CAUSE OF DEATH* was as follows:
Spotted fever (Tick fever)

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Bronchial pneumonia and blood poison
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) H. W. Coughlin M. D.
19..... (Address) Twin Falls, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Orion Near | DATE OF BURIAL 19.....

20. UNDERTAKER: J. E. Newell | ADDRESS Twin Falls

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33972
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of (No.) St.)
If death occurs away from usual residence, give facts called for under special information.

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(Registration) District No. 37
Primary Registration District No. 1185

2. FULL NAME Baker D Scott

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word.)
Male	White	Married

6. DATE OF BIRTH: Nov (Month) 18 (Day) 1838 (Year)

7. AGE: 83 Yrs. 5 Mos. 14 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Don't Know

10. NAME OF FATHER " "

11. BIRTHPLACE OF FATHER (State or Country) " "

12. MAIDEN NAME OF MOTHER " "

13. BIRTHPLACE OF MOTHER (State or Country) " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Anna Nuley
Address Box 927, Buhl, Idaho

15. Filed May 4 1921 John H. Coughlin
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr (Month) 30 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 26 1921 to April 26 1921 that I last saw him alive on April 26 1921 and that death occurred on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemmorhage

(Duration) ..... Yrs. ..... mos. 1 ds.

Contributory (Secondary) Chronic Cystitis

(Duration) 10 yrs. ..... mos. ..... ds.

(Signed) A. W. McGinnis M. D.

19..... (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Twin Falls	May 2 1921
20. UNDERTAKER	ADDRESS
J. P. Gorman	Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 22973

Registered No.

1. PLACE OF DEATH

County of Twin Falls — Registration District No. 37

City of " " — Primary Registration District No. 1085

If death occurs away from usual residence, give facts called for under special information.

BUREAU No. County Hospital St.)

STATE

2. FULL NAME Thomas Olsen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Widowed

6. DATE OF BIRTH: Dont know (Month) (Day) 1 (Year)

7. AGE: 78 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Labor
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Michigan

10. NAME OF FATHER: Dont know

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) County Hospital record
(Address) Twin Falls Ida

15. Filed May 2- 1921 John F. Loughlin Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 28 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 18 1921 to April 28 1921 that I last saw him alive on April 28 1921 and that death occurred on the date stated above, at 9A M.

The CAUSE OF DEATH* was as follows:
Uremic poisoning

(Duration) Yrs. mos 10 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) W. C. McGinnis M. D.

19 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 4 yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls — DATE OF BURIAL: 4/29 1921

20. UNDERTAKER: J. J. Freeman — ADDRESS: Twin Falls

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
MAY 10 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 37
Primary Registration District No. 1085
File No. 33974
Registered No.

County of Twin Falls
City of (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Reggy Jane Campbell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Infant

6. DATE OF BIRTH: May 2 1921 (Month) (Day) (Year)

7. AGE: 0 Yrs. 0 Mos. 0 ds.
IF LESS than 1 day how many 3 hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: J A Campbell

11. BIRTHPLACE OF FATHER (State or Country): Mo

12. MAIDEN NAME OF MOTHER: Ethel Coates

13. BIRTHPLACE OF MOTHER (State or Country): Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J A Campbell
(Address) Twin Falls Idaho.

15. Filed May 11 1921 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 2 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 2 1921, to May 2 1921
that I last saw her alive on May 2 1921.
and that death occurred on the date stated above, at 2 P.M.
The CAUSE OF DEATH* was as follows:
Unknown

(Duration) Yrs. mos. ds.
Contributory (Secondary) Hard Labor
(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.
2-3 1921 (Address) Twin Falls, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Idaho | DATE OF BURIAL: May 3 1921

20. UNDERTAKER: [illegible] | ADDRESS: Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
MAY 10 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Twin Falls — Registration District No. 37

City of ..... (If outside limits of city or village, write the word "Rural") — Primary Registration District No. 1085 — St.)

File No. 33975

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jerry

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: April 20 (Month) (Day) 1921 (Year)

7. AGE: ..... Yrs. ..... Mos. 9 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Elick E Jerry

11. BIRTHPLACE OF FATHER (State or Country): Neb

12. MAIDEN NAME OF MOTHER: .....

13. BIRTHPLACE OF MOTHER (State or Country): .....

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs J. H. Henry
(Address) Edan Idaho

15. Filed April 30 1921 — John F Loughlin, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April 29 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 29, 1921, to Apr 29 1921 that I last saw him alive on Apr 29 1921 and that death occurred on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:

Marasmus

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. W. Sanchez M. D.

Apr 29 1921 (Address) Twin Falls, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls — DATE OF BURIAL: April 30 1921

20. UNDERTAKER: Ed Elwell — ADDRESS: .....

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED
MAY 10 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Alex

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37

Registration District No. 1085

File No. 33976

Registered No.

1. PLACE OF DEATH

County of Twin Falls

City of a.

(No. 613 4th ave E. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Leslie M Woodard.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Aug (Month) 26 (Day) 1883 (Year)

7. AGE: 37 Yrs. 7 Mos. 21 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Mach—

(b) General nature of industry, business or establishment in which employed (or employer): Auto.

9. BIRTHPLACE (State or Country): Kansas

10. NAME OF FATHER: J.W. Woodard.

11. BIRTHPLACE OF FATHER (State or Country): Ind

12. MAIDEN NAME OF MOTHER: Alvira A Bush

13. BIRTHPLACE OF MOTHER (State or Country): Ind.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J.W. Woodard

(Address) Twin Falls Ida

15. 403 4th E.

Filed Apr. 22 1921 John T. Gray Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr (Month) 17 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 11 1921, to April 17 1921, that I last saw h.m. alive on April 16 1921, and that death occurred on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:

Cancer Liver

(Duration) ..... Yrs. 1 mos. ..... ds.

Contributory (Secondary) x

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Duncan L Alexander M. D.

4/20 1921 (Address) Twin Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Ida — DATE OF BURIAL: Apr 18 1921

20. UNDERTAKER: J.J. Grossman — ADDRESS: Twin Falls Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED MAY 10 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1085
File No. 32077
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of Twin Falls (No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John W. Manning Jr.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	White	Married

6. DATE OF BIRTH: July (Month) 10 (Day) 1894 (Year)

7. AGE: 47 Yrs. 9 Mos. 8 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ore.

10. NAME OF FATHER: John W. Manning

11. BIRTHPLACE OF FATHER (State or Country): Ohio.

12. MAIDEN NAME OF MOTHER: Dora Burns

13. BIRTHPLACE OF MOTHER (State or Country): " " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Dolly Manning
(Address) Twin Falls

15. Filed Apr. 22 1921 John T. Coughlin Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 18 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 7/20 1920, to 4/18 1921, that I last saw him alive on 4/18 1921, and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Arterial sclerosis et dilatation of heart.

(Duration) Four yrs. Four mos. ds.

Contributory (Secondary) Arterial sclerosis

(Duration) Four mos. ds.

(Signed) C. A. Evans M. D.

4/20 1921 (Address) Twin Falls Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls — DATE OF BURIAL: 4-20-1921

20. UNDERTAKER: [illegible] — ADDRESS: Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

RECEIVED MAY BUREAU OF VITAL STATISTICS

Registration District No. 37.
Primary Registration District No. 1885
File No. 33978
Registered No.

County of Twin Falls
City of (No. County Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William Marcus Clark

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Jan 18 1 (Month) (Day) (Year)

7. AGE: 6 Yrs. 3 Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Local Boy
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: W B Clark

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Mary Sheller

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. B. Clark
(Address) Twin Creek Idaho

15. Filed April 19. 1921. John T. Fitzgerald Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April 18 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 6th 1921, to April 18th 1921 that I last saw him alive on April 18 1921, and that death occurred on the date stated above, at 9:10 A.M.

The CAUSE OF DEATH* was as follows:

Sepsis (General)

(Duration) Yrs. mos. 12 ds.

Contributory (Secondary) Sepsis from Tonsilo.

(Duration) yrs. mos. ds.

(Signed) C W Eaves M. D.

4-19 1921 (Address) Twin Falls Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. 7 days In the State yrs. mos. days

Where was disease contracted if not at place of death? Twin Creek Ida.

Former or usual residence Twin Creek Ida.

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Ida — DATE OF BURIAL: Apl 18 1921

20. UNDERTAKER: J. E. Wiswell — ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33979
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of (If outside limits, give township.) St.)
If death occurs away from usual residence, give facts called for under special information.

RECEIVED
MAY 10 1921
BUREAU OF VITAL STATISTICS

Registration District No. 87
Primary Registration District No. 1085

2. FULL NAME Letitia Scott

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widow

6. DATE OF BIRTH: Nov 22 (Month) (Day) 1869 (Year)

7. AGE: 52 Yrs. 4 Mos. 25 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House maid
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ill

10. NAME OF FATHER: John Stilleary

11. BIRTHPLACE OF FATHER (State or Country): Not Known

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. L. Greene
(Address) 555 - 3rd Ave. East.

15. Filed April 18 1921
John F. Coughlan
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April 18 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 1920, to April 1921 that I last saw her alive on April 17, 1921, and that death occurred on the date stated above, at 9:40 A.M.

The CAUSE OF DEATH* was as follows:
Arteriosclerosis

(Duration) 20 Yrs. mos. ds.
Contributory (Secondary) Angina Pectoris
(Duration) yrs. 2 mos. ds.

(Signed) Hal Bieler M. D.
Apr. 18 1921 (Address) Twin Falls, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Ditlay Mortuary DATE OF BURIAL 19

20. UNDERTAKER: L E Elliott ADDRESS Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33980

Registered No.

1. PLACE OF DEATH

County of Twin Falls

Registration District No. 37

Primary Registration District No. 1885

City of " " (No. La Merces Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME James L. Dilworth

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
M	White	Single (Write the word)

6. DATE OF BIRTH: April (Month) 2 (Day) 1854 (Year)

7. AGE: 67 Yrs. Mos. 10 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer (Retired)
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Dr Joseph Dillworth

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Bair

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. L. Staines
(Address) Twin Falls

15. Filed April 15 1921 John W. Greathouse Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 12 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 10 1921, to April 9, 1921, that I last saw h.im alive on April 9, 1921, and that death occurred on the date stated above, at 9:15 A.M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(Duration) 20 Yrs. mos. ds.

Contributory (Secondary) None.

(Duration) yrs. mos. ds.

(Signed) Hal Biles M. D.

Apr. 12, 1921. (Address) Twin Falls, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Glenwood Ohio | DATE OF BURIAL 19

20. UNDERTAKER: J. J. Rossman | ADDRESS Twin Falls Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-12 M. 6-15-17.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33981
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Twin Falls
City of Filer
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 35
Primary Registration District No. 2256

RECEIVED
MAY 7 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME Mary E. Sams

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Divorced
6. DATE OF BIRTH. Dec (Month) 3 (Day) 1875 (Year)
7. AGE 46 Yrs. 4 Mos. 5 ds. IF LESS than 1 day how many .... hrs. or .... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
9. BIRTHPLACE (State or Country) Iowa
10. NAME OF FATHER C E Harron
11. BIRTHPLACE OF FATHER (State or Country) Iowa
12. MAIDEN NAME OF MOTHER Not Known
13. BIRTHPLACE OF MOTHER (State or Country) Not Known
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. E. Sams
(Address) Filer
15.
Filed Apr. 12 1921
Dr. A. A. Wenderoth
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Apr. (Month) 8 (Day) 1921 (Year)
17. I HEREBY CERTIFY, That I attended deceased from on Apr. 7 1921 to ..... 191..
that I last saw her alive on Apr. 7 1921
and that death occurred on the date stated above, at .... M.
The CAUSE OF DEATH* was as follows:
Pneumonia,
(Duration) .... Yrs. .... mos. 4 ds.
Contributory (Secondary) Mitral regurgitation
(Duration) 2 Yrs. .... mos. .... ds.
(Signed) C. C. Dr. Weaver M. D.
Apr. 7 1921 (Address) Twin Falls Ida.
*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the ,State....yrs....mos....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Sco't Cemetery — DATE OF BURIAL: Apr. 10 1921
20. UNDERTAKER: J E Drake — ADDRESS: Filer

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED APR 14 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 37

County of Twin Falls Primary Registration District No. 2885

File No. 3398

City of " " St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs Minnie Eggersglues

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widowed

6. DATE OF BIRTH: Nov (Month) 29 (Day) 1863 (Year)

7. AGE: 57 Yrs. 3 Mos. 11 ds.

IF LESS than 1 day how many..... hrs. or.....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer): -

9. BIRTHPLACE (State or Country): Germany.

10. NAME OF FATHER: Fred Pfundorph

11. BIRTHPLACE OF FATHER (State or Country): Germany.

12. MAIDEN NAME OF MOTHER: Don't Know.

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs J.W. Green
(Address) Twin Falls Ida.

15. Filed March 23 1921. J. F. Langdon Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar (Month) 20 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....
and that death occurred on the date stated above, at 4:30 P.M.
The CAUSE OF DEATH* was as follows:
Valvular Heart Disease

.....(Duration) .....Yrs.....mos.....ds.

Contributory (Secondary)

.....(Duration) .....yrs.....mos.....ds.

(Signed) J. Fossenier M.D.
3/22 1921. (Address) Twin Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls | DATE OF BURIAL: 3/22 1921

20. UNDERTAKER: J. Fossenier | ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED
APR 14 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 37

Primary Registration District No. 2185

File No. 33983

County of Twin Falls

City of Rogerson (Ward, Precinct, or Village) St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Baby Silence

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F	White	Single

6. DATE OF BIRTH 4 / 1 / 1921 (Month) (Day) (Year)

7. AGE ....Yrs....Mos....ds. IF LESS than 1 day how many 4 hrs. or ....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business or establishment in which employed (or employer) —

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER James Silence

11. BIRTHPLACE OF FATHER (State or Country) Kansas

12. MAIDEN NAME OF MOTHER Susan Kelley

13. BIRTHPLACE OF MOTHER (State or Country) Oklahoma

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) James Silence
(Address) Rogerson Ida

15. Filed April 12. 1921 John W. Heneghan Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 4 — 11 — 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4/10 1921 to 4—11 1921 that I last saw her alive on 4/10 1921 and that death occurred on the date stated above, at 12:05 P.M.

The CAUSE OF DEATH* was as follows:

Premature

4 hrs. (Duration) ....Yrs....mos....ds.

Contributory (Secondary)

....(Duration) ....yrs....mos....ds.

(Signed) H A Leete M. D.

4/11 1921 (Address) Twin Falls Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs....mos....days. In the State ....yrs....mos....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Rogerson Ida	April 11 1921

20. UNDERTAKER	ADDRESS
B. J. Grossman	Twin Falls Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED
APR 14 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 37

County of Twin Falls — Primary Registration District No. 1085

City of [illegible] (No. ..... St.)

File No. 33985

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Louisa C. Smith

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Female	white	Widowed

6. DATE OF BIRTH: March (Month) 30 (Day) 1837 (Year)

7. AGE: 84 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife retired
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ind.

10. NAME OF FATHER: John Hamilton

11. BIRTHPLACE OF FATHER (State or Country): Ind.

12. MAIDEN NAME OF MOTHER: Priscilla Schrader

13. BIRTHPLACE OF MOTHER (State or Country): Ind.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Virginia W Seelenright
(Address) Twin Falls

15. Filed Mch. 30 1921 — John F. Coughlin, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 28 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3-27- 1921, to 3-28- 1921, that I last saw h[illegible] alive on Mch 28 1921, and that death occurred on the date stated above, at 5-P M.

The CAUSE OF DEATH* was as follows:
Senility — Angina Pectoris

(Duration) ..... Yrs. ..... mos. 2 — ds.

Contributory (Secondary) ?

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John F. Coughlin M. D.
3/30 1921 (Address) Twin Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Twin Falls	3/29 1921
20. UNDERTAKER	ADDRESS
J. F. Grossman	Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED
APR 14 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Twin Falls Registration District No. 37
City of " " Primary Registration District No. 1083 (Twin Falls County Hosp. St.)
If death occurs away from usual residence, give facts called for under special information.

File No. 33986
Registered No.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Celia Vasquez

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: Spanish
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Widowed, Divorced)

6. DATE OF BIRTH: Feb (Month) 7 (Day) 1894 (Year)

7. AGE: 27 Yrs. 1 Mos. 29 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Mexico

10. NAME OF FATHER: Jesus Beltran

11. BIRTHPLACE OF FATHER (State or Country): Spain.

12. MAIDEN NAME OF MOTHER: Guadalupe Zazueta

13. BIRTHPLACE OF MOTHER (State or Country): Mexico.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) P. V. Vasquez
(Address) Box 153. Kimberly Ida

15. Filed Mch 10 1921 John D. Crowther Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 1 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 31 1921, to April 1 1921, that I last saw h[er] alive on April 1 1921, and that death occurred on the date stated above, at 8:30 A.M.
The CAUSE OF DEATH* was as follows:
Tuberculosis Peritonitis
Probably
(Duration) Yrs. 6 mos. ds.
Contributory (Secondary) Appendectomy
(Duration) yrs. mos. ds.
(Signed) W. G. Fox M. D.
4/1/1921 (Address) Twin Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Ida. DATE OF BURIAL: 4-2 1921

20. UNDERTAKER: [illegible] ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED
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BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1085
File No. 33987
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of " " County Hospital St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Alvin Battin

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: W-Lite
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Dont Know (Month) (Day) 1 (Year)

7. AGE: 37 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farm Laborer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Canton Pa.

10. NAME OF FATHER: Dont Know

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Co Hospital record
(Address) Twin Falls Idaho

15. Filed Mch 23 1921 J. J. Goodman Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar (Month) 21 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar-18 1921, to Mar 21 1921 that I last saw h[illegible] alive on Mar 21 1921, and that death occurred on the date stated above, at 11 A.M.
The CAUSE OF DEATH* was as follows:

Pernicious Gastric Ulcer

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. M. Davis M. D.
9/21 1921 (Address) Kimberly Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls — DATE OF BURIAL: 3/26 1921
20. UNDERTAKER: P. J. Goodman — ADDRESS: Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33989
Registered No.

Registration District No. 37
Primary Registration District No. 1085

1. PLACE OF DEATH
County of Twin Falls
City of [illegible] (No. County Hospital St.)
If death occurs away from usual residence, give facts called for under special information.

RECEIVED APR 14 1921 BUREAU OF VITAL STATISTICS

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME George S Ackerman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (write the word)
6. DATE OF BIRTH: Feb. 10 1
(Month) (Day) (Year)
7. AGE: 40 Yrs. 1 Mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Traveling Salesman
(b) General nature of industry, business or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): New York.
10. NAME OF FATHER: G. S. Ackerman
11. BIRTHPLACE OF FATHER (State or Country): New York.
12. MAIDEN NAME OF MOTHER: Jane A. Saulsbery
13. BIRTHPLACE OF MOTHER (State or Country): New York
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A S Ackerman
(Address) 1124 E 12 ave Denver Colo.
15. Filed Mch. 15. 1921 J. F. Loughrin Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51067

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 14th 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 13 1921, to March 14 1921, that I last saw h.im alive on March 14 1921, and that death occurred on the date stated above, at 9a M.

The CAUSE OF DEATH* was as follows:

Shot through Left Eye into brain. Homicide

(Duration) ..... Yrs. ..... mos. 1 ds.

Contributory (Secondary) ✓

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Duncan D Alexander M. D.

3/15 1921 (Address) Twin Falls Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. 1 ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence: Portland Oregon.

19. PLACE OF BURIAL OR REMOVAL: Denver Colo. | DATE OF BURIAL: ..... 19.....

20. UNDERTAKER: J. J. Grossman | ADDRESS: Twin Falls

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

RECEIVED
APR 14 1921
BUREAU OF VITAL STATISTICS

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 37

Primary Registration District No. 1085

File No. 33990

County of Twin Falls

City of " (If outside limits of village or town, give township.)

No. (St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs Alta L Jones

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Sept (Month) 12 (Day) 1878 (Year)

7. AGE: 42 Yrs. 6 Mos. 5 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: John Morrison

11. BIRTHPLACE OF FATHER (State or Country): Ind.

12. MAIDEN NAME OF MOTHER: Milinda Lucas

13. BIRTHPLACE OF MOTHER (State or Country): Ind.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. W. Jones

(Address) Carlin Nevada

15. Filed March 18 1921 J. F. Coughlin Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar (Month) 17 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....19...., to ....19....,

that I last saw h.... alive on ....19....,

and that death occurred on the date stated above, at ....M.

The CAUSE OF DEATH* was as follows:

Valvular heart Disease

Nephritis

(Duration) ....Yrs....mos....ds.

Contributory (Secondary)

(Duration) ....yrs....mos....ds.

(Signed) T. J. Grossman Coroner

3/17 1921 (Address) Twin Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death....yrs....mos....days. In the State....yrs....mos....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Carlin Nev. DATE OF BURIAL: ....19....

20. UNDERTAKER: T. J. Grossman ADDRESS: Twin Falls

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33991

Registered No.

1. PLACE OF DEATH

RECEIVED
APR 14 1921
BUREAU OF VITAL STATISTICS

Registration District No. 37

Primary Registration District No. 1085

County of Twin Falls

City of (If outside limits of village or town, give its name and state "Not in.") St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lilly Priest

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: fe

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Feb 12 (Month) (Day) 1886 (Year)

7. AGE: 35 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Geo Mays

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Sarah Stoffel

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) George Mays
(Address) Bryan R D 1

15. Filed March 22 1921 John A. Coughlan Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mch 19 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3-17 1921, to 3-19 1921, that I last saw h[illegible] alive on 3-19 1921, and that death occurred on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:
acute nephritis

(Duration) Yrs. mos. ds.
Contributory (Secondary) Mitral regurgitation
(Duration) yrs. mos. ds.

(Signed) T. S. Mears M. D.
3-21 1921 (Address) Twin Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Id — DATE OF BURIAL: Mar 22 1921

20. UNDERTAKER: [illegible] Elwell — ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33992

1. PLACE OF DEATH

County of Twin Falls — Registration District No. 37

City of Hazelton (Twin Falls St.) — Primary Registration District No. 1085

Registered No.

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
APR 14 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME Ruth Ernestine Rieman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: (write the word.)

6. DATE OF BIRTH: Dec 21 (Month) (Day) 1919 (Year)

7. AGE: 1 Yrs. 9 Mos. 4 ds. — IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Daughter
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Ben F. Rieman

11. BIRTHPLACE OF FATHER (State or Country): Ills

12. MAIDEN NAME OF MOTHER: Alice Dunbrack

13. BIRTHPLACE OF MOTHER (State or Country): Ills

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) B. Frank Rieman
(Address) Hazelton

15. Filed March 25 1921 — John D. Clough Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 25 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 21 1921 to Mar 25 1921 that I last saw her alive on Mar 25 1921 and that death occurred on the date stated above, at 11:45 A M.

The CAUSE OF DEATH* was as follows:

Bacterial peritonitis due to perforation of intestine by foreign body.

(Duration) ..... Yrs. ..... mos. 1 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E. L. Berry M. D.

3-25 1921 (Address) Hazelton Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? Hazelton Ida
Former or usual residence Hazelton, Ida

19. PLACE OF BURIAL OR REMOVAL: Hazelton Ida — DATE OF BURIAL ..... 19.....

20. UNDERTAKER: J. E. Ward — ADDRESS Twin Falls

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED
APR 14 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37.
Primary Registration District No. 1085
File No. 3393
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of " " (If outside limits of city or village, write the word "Out") St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ada Schofield Paulin
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6. DATE OF BIRTH: March (Month) 6 (Day) 1921 (Year)

7. AGE: 57 Yrs. Mos. 5 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Clerk.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Morpeth, England

10. NAME OF FATHER: George Paulin

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Elizabeth Patterson

13. BIRTHPLACE OF MOTHER (State or Country): Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Ada Paulin
(Address) Twin Falls

15. Filed April 12, 1921 John F. Coughlin Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 11 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 1921, to April 11 1921
that I last saw h. alive on April 11, 1921
and that death occurred on the date stated above, at 2 P.M.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage

(Duration) Yrs. mos. ds.
Contributory (Secondary): Arterio Sclerosis
(Duration) yrs. mos. ds.

(Signed) J. Boyd M. D.
4/14 1921 (Address) Twin Falls, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls | DATE OF BURIAL: April 12 1921

20. UNDERTAKER: J. J. Isaman | ADDRESS: Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-25 M. 1-19.

RECEIVED MAY 6 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33994

Registered No.

1. PLACE OF DEATH

County of Valley — Registration District No. 15

Primary Registration District No.

City of (Ward) (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Newell Patterson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: wht.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: 1 (Month) 21 (Day) 1897 (Year)

7. AGE: 23 Yrs. 2 Mos. 27 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ida

10. NAME OF FATHER: G A Patterson

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Mary Callender

13. BIRTHPLACE OF MOTHER (State or Country): Ind

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) G E Hoggle Coroner
(Address) Caldwell Ida

15. Filed April 5th 1921 Stella Cain Dep. Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 17 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Not 19..., to 19...,
that I last saw h..... alive on 19...,
and that death occurred on the date stated above, at ....M.
The CAUSE OF DEATH* was as follows:

Suicide

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary): Despondency

(Duration) ... yrs. ... mos. ... ds.

(Signed) G E Hoggle M. D.

19... (Address) Caldwell

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
alpha	3-20 1921
20. UNDERTAKER	ADDRESS

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33999
Registered No.

RECEIVED
MAY 4 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Adams
City of Goodrich (No. St.)
Registration District No.
Primary Registration District No.
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs. Helen Agnes Thomas

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widowed

6. DATE OF BIRTH: October (Month) 30th (Day) 1838 (Year)

7. AGE: 82 Yrs. 3 Mos. 18 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Dixon, Illinois.

10. NAME OF FATHER: Truxton Swena

11. BIRTHPLACE OF FATHER (State or Country): In one of the New England States. U.S.A.

12. MAIDEN NAME OF MOTHER: — Blakesley

13. BIRTHPLACE OF MOTHER (State or Country): In one of the New England States U.S.A.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Mrs W. C. Dodge
(Address): Goodrich, Ida.

15. Filed 4/3/21 19.....
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: February (Month) 19th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 12 1921, to Feb. 19 1921, that I last saw h[illegible] alive on Feb. 12 1921, and that death occurred on the date stated above, at [illegible] M. The CAUSE OF DEATH* was as follows:
Bronch-Pneumonia.
(Duration) [illegible] mos. 7 ds.
Contributory (Secondary) Senility.
(Duration) yrs. mos. ds.
(Signed) W. M. Mahoney M. D.
3/4 1921 (Address) Cambridge Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Goodrich, Ida. DATE OF BURIAL: 2/21 1921

20. UNDERTAKER: Jos. Schuldeman ADDRESS: Cambridge Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

Idaho
BOA[redacted] HEALTH
Bureau of Vital Statistics

34000

1. PLACE OF DEATH

Registration District No. 86

Primary Registration District No. 2112

File No.

County of Washington

City of Weiser (No. [illegible] St.)

Registered No. 10

If death occurs away from usual residence, give facts called for under special formation.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Elsie Ettie Morrison

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Jan 5 1860 (Month) (Day) (Year)

7. AGE: 61 Yrs. 0 Mos. 13 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Michigan

10. NAME OF FATHER: Alock

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Joseph R. Jaggers

(Address) Weiser Idaho.

15. Filed Feb 1st 1921

W. R. Hamilton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan 31 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....

that I last saw h..... alive on ..... 19.....

and that death occurred on the date stated above, at 1 a M.

The CAUSE OF DEATH* was as follows:

found dead in Bed No indication of foul play

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

2-1-1921 (Address) Jas. J. McCauley Coroner

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Weiser Cemetery	2/2 1921
20. UNDERTAKER	ADDRESS
Mortham & McCann	Weiser Ida

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1-19.

EATH RECEIVED CERTIF

APR 21 19

BUREAU OF STATIS

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

County of U[illegible]nglas Registration District No. [illegible]6

City of Weiser Primary Registration District No. 2112 File No. 34001

(No. St.) Registered No. 11

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME W G McGinnis

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Divorced

6. DATE OF BIRTH: Dec (Month) 25 (Day) 1853 (Year)

7. AGE: 67 Yrs. 1 Mos. 8 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mo.

10. NAME OF FATHER: Erasmus McGinnis

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: Fannie Boatwright

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Elzer W. Ginnis
(Address) Weiser Ida.

15. Filed Feb 3rd 1921 W R Hamilton Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 3 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 23 1921, to Feb. 3 1921, that I last saw him alive on Jan. 29 1921; and that death occurred on the date stated above, at 5 A.M.

The CAUSE OF DEATH* was as follows:

Endocarditis

(Duration) Yrs. 3 mos. ds.

Contributory (Secondary) Hypostatic Pneumonia.

(Duration) yrs. mos. 7 ds.

(Signed) Ernest O. Tracey M. D.

2/3 1921 (Address) Weiser Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Cambridge Ida — DATE OF BURIAL 19

20. UNDERTAKER: Northcutt McCann — ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of card.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
APR 21 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 56

Primary Registration District No. 2112.

File No. 34002

County of Washington

City of Weiser (or) St.)

Registered No. 12

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Wm I Thompson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: May 28 1[illegible] (Month) (Day) (Year)

7. AGE: 74 Yrs. 9 Mos. 3 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): —

10. NAME OF FATHER: —

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Annie M. Roberts

(Address) Weiser Idaho

15. Filed Feb 6th 1921 W R Knuckles
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 6th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feby 6 1921, to ..... 19....., that I last saw him alive on Feby 6 1921, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Senility.

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. B. Shuler M. D.

2/6 1921 (Address) Weiser Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Hill Crest Cemetery — DATE OF BURIAL: 2/7 1921

20. UNDERTAKER: Northam & McCann — ADDRESS: Weiser Ida

FORM V. S. No. 5-25 M. 1-19.

Walenham

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 86
Primary Registration District No. 1010
File No. 34003
Registered No. 13

RECEIVED
APR 21 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Washington
City of Weiser (If outside limits of city or village, write the name of township.) St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Fern Louise McGinnis

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Jan (Month) 23 (Day) 1921 (Year)

7. AGE: — Yrs. — Mos. 17 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER E R McGinnis

11. BIRTHPLACE OF FATHER (State or Country) Cal

12. MAIDEN NAME OF MOTHER Sadie Belle Mustard

13. BIRTHPLACE OF MOTHER (State or Country) Wash.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E R McGinnis
(Address) Weiser Ida

15. Filed Feb 10th 1921 — W R Hamilton — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 9 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 23 1921 to Feb 9 1921 that I last saw h.w alive on Feb 9 1921, and that death occurred on the date stated above, at 5:30 P.M.

The CAUSE OF DEATH* was as follows:

Whooping Cough

(Duration) Yrs. mos. 17 ds.

Contributory (Secondary) Morbus Cerulenus

(Duration) yrs. mos. ds.

(Signed) G M Walenham M. D.

2/10 1921 (Address) Weiser Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Hillcrest Cemetery — DATE OF BURIAL: 2/10 1921

20. UNDERTAKER: Northam & McCann — ADDRESS: Weiser Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 86
Primary Registration District No. 2112
File No. 34004
Registered No. 14

1. PLACE OF DEATH
County of Washington
City of Weiser (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

APR 2 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME Henry W. Hawkins
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Wht
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widower (Write the word.)

6. DATE OF BIRTH: Feb (Month) 16 (Day) 1852 (Year)

7. AGE: 69 Yrs. 0 Mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ind.

10. NAME OF FATHER: Orin W Hawkins

11. BIRTHPLACE OF FATHER (State or Country): Conn.

12. MAIDEN NAME OF MOTHER: Jane Hawkins

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Etta C Hawkins
(Address) Weiser, Ida.

15. Filed 2/24/21 19.....
W. R. Hamilton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 22 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 4 1921, to Feb 22 1921, that I last saw him alive on Feb 4 1921, and that death occurred on the date stated above, at 10 45 A.M.

The CAUSE OF DEATH* was as follows:
Paralysis

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G M McCleskey M. D.
2/24 1921 (Address) Weiser Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Chagrin Falls Ohio
DATE OF BURIAL ..... 19.....

20. UNDERTAKER: Thomas McCann
ADDRESS: Weiser Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED APR 21 BUREAU OF STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Washington Registration District No. 86

City of Weiser (No. ..... St.) Primary Registration District No. 2112.

File No. 34005

Registered No. 15

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Leroy Delmer Paulson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	Wht	Single

6. DATE OF BIRTH: Nov. (Month) 19th (Day) 1921 (Year)

7. AGE: — Yrs. — Mos. 7 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Lynn N Paulson

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Dora Beamon

13. BIRTHPLACE OF MOTHER (State or Country) Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Lynn N. Paulson
(Address) Weiser Idaho

15.
Filed ..... 19 .....
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 26 (Day) 19 21 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ~~Nov~~ ..... 19..... to ~~March~~ ..... 19.....
that I last saw him alive on ~~March~~ ..... 19.....,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Died before Medical assistance could be called,
no indication of foul play,
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Jas. T. McCann ~~Coroner~~ ~~M. D.~~
3/27 19 21 (Address) Weiser Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Hillcrest Cemetry — DATE OF BURIAL: 3/27 19 21

20. UNDERTAKER: Northam & McCann — ADDRESS: Weiser Ida,

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34006

1. PLACE OF DEATH
County of Washington — Registration District No. 76
City of Weiser — Primary Registration District No. 1016
If death occurs away from usual residence, give facts called for under special information.

APR 21 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME Alfred Mikkelsen

Registered No. 16
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Male	White	Married

6. DATE OF BIRTH: Oct (Month) 10 (Day) 1894 (Year)

7. AGE: 26 Yrs. 5 Mos. 19 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: A Mikkelsen

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Charlotte Beeton

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): A M Mikkelsen
(Address): Weiser Ida

15.
Filed ..... 19 .....
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 26 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 26 1921 to Mar 26 1921
that I last saw h.was alive on Mar 26 1921,
and that death occurred on the date stated above, at 11 A.M.
The CAUSE OF DEATH* was as follows:
Ruptured heart following
Infusible clamy
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Tonsilitis
(Duration) ..... yrs. 7 mos. ..... ds.
(Signed) C C Conant M. D.
4/1 1921 (Address) Weiser Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Hillcrest Cemetery	4-2 1921

20. UNDERTAKER: Northam & McCan — ADDRESS: Weiser Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

Registration District No. 86

Primary Registration District No. 1010

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34007

Registered No. 17

1. PLACE OF DEATH

County of Washington

City of Weiser (Ward) St.)

If death occurs away from usual residence, give facts called for under special information.

APR 22 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME Margie V. True

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Female	White	single (Write the word.)

6. DATE OF BIRTH: Dec (Month) 10 (Day) 1897 (Year)

7. AGE: 23 Yrs. 3 Mos. 19 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ill.

10. NAME OF FATHER: Joseph True

11. BIRTHPLACE OF FATHER (State or Country): Ind

12. MAIDEN NAME OF MOTHER: Eliza Eppegate

13. BIRTHPLACE OF MOTHER (State or Country): Ill

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Sam True
(Address) Weiser Idaho

15. Filed 3/31/21 19 W. R. Hamilton Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 29 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from August 1917 to March 29 1921 that I last saw her alive on March 28 1921, and that death occurred on the date stated above, at 2 P M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis.

(Duration) 6 Yrs. ..... mos. ..... ds.

Contributory (Secondary) Exhaustion

(Duration) ..... yrs. ..... mos. 4 ds.

(Signed) Ernest O. Finney M. D.

3/31 1921 (Address) Weiser Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Weiser Cemetery — DATE OF BURIAL: 3/31 1921

20. UNDERTAKER: Northam & Bauer — ADDRESS: Weiser Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 8

Primary Registration District No. 2004

File No. 34008

Registered No. 42

1. PLACE OF DEATH

County of Ada

City of Boise

(No. Boise Barracks St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME David W. Dobbs.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word).
M.	White.	Married.

6. DATE OF BIRTH: Oct (Month) 16 (Day) 1861 (Year)

7. AGE: 59 Yrs. 7 Mos. 15 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Texas

10. NAME OF FATHER: Murphy Dobbs.

11. BIRTHPLACE OF FATHER (State or Country): Tennessee

12. MAIDEN NAME OF MOTHER: Hanna C. Dawson

13. BIRTHPLACE OF MOTHER (State or Country): Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Madison T. Dobbs.

(Address) Kuna, Idaho

15. Filed June 3 1921

R. H. Pratt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 1 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 26 1921 to June 1 1921, that I last saw h~~im~~ alive on June 1 1921, and that death occurred on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Nephritis (Uremia)

(Duration) — Yrs. — mos. — ds.

Contributory (Secondary) Cystitis

(Duration) ... yrs. ... mos. ... ds.

(Signed) W. F. Allen M. D.

19 ..... (Address) U. S. P. H. S. Hosp # 52

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Kuna Idaho. DATE OF BURIAL: June 2 1921

20. UNDERTAKER: Summers & Gibbs. ADDRESS: Boise Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SIMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34009
Registered No. 37

RECEIVED JUN 3 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 8
Primary Registration District No. 2047

County of Ada

City of ..... (No.) 8 Miles West of Boise

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Allan McClurg

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1841 (Year)

7. AGE: 80 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Clyde E. Summers

(Address) Boise Idaho

15. Filed May 10 1921 R. H. Pratt
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 9 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1 1921, to May 9 1921, that I last saw h.. alive on May 9 1921, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Inguinal Glands.

(Duration) 2 Yrs. ..... mos. ..... ds.

Contributory (Secondary) Anaemia.

(Duration) ..... yrs. 6 mos. ..... ds.

(Signed) T. N. Bratton M. D.

May 10 1921 (Address) Boise.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: County Cemetery — DATE OF BURIAL: May 11 1921

20. UNDERTAKER: Summers & Tebbs — ADDRESS: Boise Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Tallman

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JUN 22 1921 BUREAU OF VITAL STATISTICS STATE OF IDAHO

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34010
Registered No. 163

1. PLACE OF DEATH
County of Ada
City of Boise (If outside limits of city or village, give township) No. 818 State (St.)
Registration District No. 12
Primary Registration District No. 1004
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ethel C. Wicklund
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (the wife)

6. DATE OF BIRTH: Sept 3 (Month) (Day) 1887 (Year)

7. AGE: 33 Yrs. 9 Mos. 1 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Kansas.

10. NAME OF FATHER: Bud Davis.

11. BIRTHPLACE OF FATHER (State or Country): Iowa.

12. MAIDEN NAME OF MOTHER: Mary Leightman

13. BIRTHPLACE OF MOTHER (State or Country): Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. C. Wicklund
(Address) .....

15. Filed June 6 1921 R. W. Pratt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Feb. 19-20
June 4 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 6 1919, to June 4 1921, that I last saw h.. alive on June 1 1921, and that death occurred on the date stated above, at 9:35 P. M.

The CAUSE OF DEATH* was as follows:
Cancer of Breast.
1 4
(Duration) 3 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. N. Tallman M. D.
6/6 1921 (Address) Boise

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cem. DATE OF BURIAL: June 7 1921

20. UNDERTAKER: Summers & Keb. ADDRESS: Boise Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JUN 3 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 3401

Registered No. 38

1. PLACE OF DEATH

County of Ada — Registration District No. 8 — Boise

City of — Primary Registration District No. 2004

If death occurs away from usual residence, give facts called for under special information. — No. 6 miles N.W. of Boise

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Gladys Ernestine Elliott

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Feb. (Month) 4 (Day) 1919 (Year)

7. AGE: 2 Yrs. 3 Mos. 9 ds. — IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Boise Idaho

10. NAME OF FATHER: W. M. Elliott

11. BIRTHPLACE OF FATHER (State or Country): Kansas

12. MAIDEN NAME OF MOTHER: Florence McClung

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. M. Elliott
(Address) R1 Boise Idaho

15. Filed May 16 1921 — P. H. Bate, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 14th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 10 1921 to May 14th 1921 that I last saw h.er alive on May 10th 1921 and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Abnormality of central nervous system from birth — ending in Mechanicitis

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) None

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Mrs. Mae Beck M. D.

5-16 1921 (Address) Boise Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: May 15 1921

20. UNDERTAKER: Summers & Krebs — ADDRESS: Boise, Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34012
Registered No. 39

RECEIVED
JUN 3 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
Registration District No. 8
Primary Registration District No. 2007
County of Ada
City of Boise (No.) Barber Mile St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Paul Heinrich Jenkins
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Feb (Month) 6th (Day) 1920 (Year)

7. AGE: — Yrs. 3 Mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Barber Idaho

10. NAME OF FATHER: J. C. Jenkins

11. BIRTHPLACE OF FATHER (State or Country): Ohio.

12. MAIDEN NAME OF MOTHER: Minna Bramfeld

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. C. Jenkins
(Address) Barber, Idaho.

15. Filed May 17 1921 P. E. Pate Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 17th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 13, 1921, to May 18, 1921, that I last saw him alive on May 16 1921, and that death occurred on the date stated above, at 12.30 A. M.
The CAUSE OF DEATH* was as follows:
Sarcoma
(Duration) ..... Yrs. ..... mos. 11 ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Ernest E. Lanham M. D.
5-17 1921 (Address) Boise, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 5/17 1921

20. UNDERTAKER: Schreiber & Siddefaden — ADDRESS: Boise Ida

Dr. Lanham

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-A—25 M. 1-19

RECEIVED JUN 7 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

8

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34013

Registered No. 47

1. PLACE OF DEATH

Registration District No.

Primary Registration District No. 2024

County of Ada

City of Boise (No. U.S.P.H.S. Hospital, St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lowell E. Blanchard

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH

(Month) (Day) 1885 (Year)

7. AGE

36 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Carpenter contractor

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Oregon

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W.H.Allen, Surgeon in Charge

(Address) Boise Barracks, Boise, Idaho.

15. Filed May 23 1921 R.H.Ball Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May (Month) 23 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 24, 1921, to May 23, 1921, that I last saw him alive on May 23 1921, 6:35 A.M. and that death occurred on the date stated above, at A.M.

The CAUSE OF DEATH* was as follows:

Tuberculosis, Chr. Pulmonary

Unknown (Duration) Yrs. mos. ds.

Contributory (Secondary) xx

xx (Duration) yrs. mos. ds.

C.E. (Signed) W.H.Allen Surgeon in Charge (R) M. D.

U.S.P.H.S.Hospital #52, Boise, Idaho.

May 23 1921 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. 30 days. In the State yrs. mos. 30 days

U.S.P.H.S.Hospital #52, Boise, Idaho

Where was disease contracted if not at place of death? Military service

Former or usual residence Portland, Ore.

19. PLACE OF BURIAL OR REMOVAL: Portland Ore. DATE OF BURIAL 19

20. UNDERTAKER: W.M.C. Bratney ADDRESS Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34014
Registered No. 741

RECEIVED JUN 3 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 2
Primary Registration District No. 1004

County of Ada
City of Boise (If outside limits, give township) No. 6th & Bannock, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Stanley Luke McMann

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	White	Single

6. DATE OF BIRTH Unknown 1891
(Month) (Day) (Year)

7. AGE 30 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Lineman
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Canada

10. NAME OF FATHER Albert McMann

11. BIRTHPLACE OF FATHER (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (State or Country) Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant)
(Address) #707 N. 19th St

15. Filed May 15 1921 P. H. Pratt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 13 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I ~~attended~~ deceased ~~from~~ May 13 1921, to 19, that I ~~last saw him~~ alive on 19, and ~~that death occurred on the date stated above, at~~ 12:10 M.

The CAUSE OF DEATH* was as follows:

Coming in Contact with high Voltage electric Wire

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Clyde E. Summers Coroner of Ada County M.D.
5/14 1921 (Address) Boise Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Bluumarket, Ont. | DATE OF BURIAL May 16 1921

20. UNDERTAKER Summers & Trebs | ADDRESS Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO. PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34015

Registered No. 124

1. PLACE OF DEATH

County of Ada

Registration District No. 2

Primary Registration District No. 1234

City of Boise No. St. Luke's Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED JUN 3 1921 BUREAU OF VITAL STATISTICS

FULL NAME Infant Clemons

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: April 29 (Month) (Day) 1921 (Year)

7. AGE: ....Yrs. ....Mos. 2 ds.

IF LESS than 1 day how many ....hrs. or ....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Clemons

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Clyde E. Summers

(Address) Boise Idg

15. Filed June 3 1921 P. H. Coates Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 1 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 29 1921, to May 2 1921, that I last saw him alive on May 2 1921, and that death occurred on the date stated above, at 11 P M.

The CAUSE OF DEATH* was as follows:

Marasmus

(Duration) ....Yrs. ....mos. ....ds.

Contributory (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Fred Allen M. D.

5/2 1921 (Address) Boise Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs. ....mos. ....days. In the State ....yrs. ....mos. ....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: May 2 1921

20. UNDERTAKER: Summers & Kuhn — ADDRESS: Boise Idg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

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FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34017
Registered No. 126

1. PLACE OF DEATH

County of Ada — Registration District No. 2

City of Boise — Primary Registration District No. 1004

(St. 410 State St.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED JUN 3 1921 BUREAU OF VITAL STATISTICS

2. FULL NAME Adelaide M. Canning

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the Word.): Single

6. DATE OF BIRTH: Mar (Month) 19 (Day) 1921 (Year)

7. AGE: ___ Yrs. 1 Mos. 13 ds. IF LESS than 1 day how many ___ hrs. or ___ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Barber Idaho

10. NAME OF FATHER: R. W. Canning

11. BIRTHPLACE OF FATHER (State or Country): Wis

12. MAIDEN NAME OF MOTHER: Agnes Whytock

13. BIRTHPLACE OF MOTHER (State or Country): Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Phil. W. Canning
(Address) Barber, Idaho

15. Filed May 3 1921 — Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 2 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 17, 1921, to May 2, 1921, that I last saw h[er] alive on May 2, 1921, and that death occurred on the date stated above, at ___ M.

The CAUSE OF DEATH* was as follows:

Pyloric Stenosis.

(Duration) ___ Yrs. ___ mos. 23 ds.

Contributory (Secondary)

(Duration) ___ yrs. ___ mos. ___ ds.

(Signed) Ernest E Lamb M. D.

5/2/1921 (Address) Boise, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ___ yrs. ___ mos. 15 days. In the State ___ yrs. 1 mos. 13 days

Where was disease contracted, if not at place of death? Barber, Idaho.

Former or usual residence Barber, Idaho

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 5/3 1921

20. UNDERTAKER: Schreiber & Heidenfelder — ADDRESS: Boise Ida

Lamb

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

Born ?

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34020
Registered No. 12

1. PLACE OF DEATH

County of Ada — RECEIVED JUN 3 1921 BUREAU OF VITAL STATISTICS — Registration District No. 2
Primary Registration District No. 1004
City of Boise (No. 1310 Idaho St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mina Amos

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6. DATE OF BIRTH: Nov. (Month) 11 (Day) 1857 (Year)

7. AGE: 63 Yrs. 5 Mos. 25 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Penn.

10. NAME OF FATHER: John Carrol

11. BIRTHPLACE OF FATHER (State or Country): Penn

12. MAIDEN NAME OF MOTHER: Sarah Laughlyn

13. BIRTHPLACE OF MOTHER (State or Country): Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) George E Amos
(Address)

15. Filed May 19 24 — Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 6 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 3d 1921 to May 6th 1921 that I last saw h[illegible] alive on May 6th 1921, and that death occurred on the date stated above, at 3 P. M.
The CAUSE OF DEATH* was as follows:
Bronchia Pneumonia
+ Oedema. —

(Duration) ..... Yrs. ..... mos. 4 ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [signature] M. D.
5-7 1921 (Address) Boise Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: May 8 1921

20. UNDERTAKER: Summers & Trefs — ADDRESS: Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34021

Registered No. 15

RECEIVED JUN 3 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 2

Primary Registration District No. 1004

County of Ada

City of Boise (No. 410 State St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Samuel C. J. Myers

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Oct (Month) 27th (Day) 1857 (Year)

7. AGE: 63 Yrs. 6 Mos. 11 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer and Stock Raiser

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wis

10. NAME OF FATHER: Valentine Myers

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Dont Know

13. BIRTHPLACE OF MOTHER (State or Country): Germany.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. S J Myers.

(Address)

15. Filed May 10 1921

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 8th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1921 to May 8 1921 that I last saw h.. alive on May 7 1921 and that death occurred on the date stated above, at 9 P M.

The CAUSE OF DEATH* was as follows: Chronic Nephritis + Cystitis

Dropsy

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Hardening of Arteries

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

19..... (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence Bellevue, Idaho

19. PLACE OF BURIAL OR REMOVAL: Harris Hill Cemetery — DATE OF BURIAL: 5/10 1921

20. UNDERTAKER: Schreiber & Siedenfaden — ADDRESS: Boise, Idaho

Dr. Titus

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

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FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34025

1. PLACE OF DEATH
County of Ada RECEIVED JUN 3 1921 Registration District No. 3
City of Boise BUREAU OF VITAL STATISTICS Primary Registration District No. 1004
821½ Grove St.)
Registered No. 13

If death occurs away from usual residence, give former residence called for under special information.

2. FULL NAME Franklin D. Smith

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: Black.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Unknown

6. DATE OF BIRTH: Unknown (Month) (Day) 1844 (Year)

7. AGE: 77 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Veteran Civil War
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Hamburg Miss

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Clyde E. Summers
(Address) Boise Idaho.

15.
Filed May 11 19 21 R. W. Pratt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 8 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I ~~attended~~ saw deceased ~~from~~
May 8 1921 to 19
~~that I last saw h alive on~~ 19
and that death occurred on the date stated above, at 10 A. M.

The CAUSE OF DEATH* was as follows:
Valvular Heart disease.

(Duration) 1 Yrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) Clyde E. Summers, Coroner M. D.
5/9 1921 (Address) Boise Ada County

State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery DATE OF BURIAL: May 10 1921

20. UNDERTAKER: Summers & Krebs ADDRESS: Boise Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

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FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34023
Registered No.

RECEIVED
JUN 3 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Ada
City of Boise
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No.
No. St. Lukes Hospital St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mildred Miersdorf

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Aug. 26 1909 (Month) (Day) (Year)

7. AGE: 11 Yrs. 8 Mos. 14 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: In School
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Boise Idaho -

10. NAME OF FATHER: Herbert Miersdorf

11. BIRTHPLACE OF FATHER (State or Country): Mich.

12. MAIDEN NAME OF MOTHER: Sadie Johnson

13. BIRTHPLACE OF MOTHER (State or Country): Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. S. Mailer
(Address) Meridian . Idaho

15. Filed May 1921 R. H. Pratt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 5 — 10 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5-3- 1921, to 5- 10 1921, that I last saw her alive on 5- 8 1921, and that death occurred on the date stated above, at 9:30 P.M.

The CAUSE OF DEATH* was as follows: Concussion Brain thrown from horse

(Duration) ..... Yrs. ..... mos. 10 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. F. Neal M. D.
5-10 1921 (Address) Meridian Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Meridian Idaho — DATE OF BURIAL: 5/11 1921

20. UNDERTAKER: W. S. Mailer Meridian — ADDRESS

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34024
Registered No. 133

1. PLACE OF DEATH

RECEIVED JUN 3 1921 BUREAU OF VITAL STATISTICS

Registration District No. 2
Primary Registration District No. 1004

County of Ada
City of Boise (No. 410 State St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Leeta Knowlton

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: May (Month) 29th (Day) 1911 (Year)

7. AGE: 9 Yrs. 11 Mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Sweet, Idaho.

10. NAME OF FATHER: Jas. E. Knowlton

11. BIRTHPLACE OF FATHER (State or Country): Oregon

12. MAIDEN NAME OF MOTHER: Elizth Dill

13. BIRTHPLACE OF MOTHER (State or Country): Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jas. E. Knowlton
(Address) Sweet, Idaho

15. Filed May 11 1921 — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 10th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5/9 1921, to 5/10 1921 that I last saw h. alive on 5/10 1921 and that death occurred on the date stated above, at 7:30 M.

The CAUSE OF DEATH* was as follows: Amputation of thigh (Shock)

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Peritonitis of leg (stump sutures)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F. A. Pettinger M. D.
5/11 1921 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence Sweet, Idaho

19. PLACE OF BURIAL OR REMOVAL: Sweet Idaho — DATE OF BURIAL: 5/11 1921

20. UNDERTAKER: Schreiber & Sidenfaden — ADDRESS: Boise, Ida

Dr. Pettinger

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34025
Registered No. 1135

RECEIVED
JUN 3 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
Registration District No. 2
County of Ada
Primary Registration District No. [illegible]
City of Boise (If outside limits of city or village, give township) 10 State St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Fowler Boden Conetsee

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6. DATE OF BIRTH: Oct (Month) 15 (Day) 1902 (Year)

7. AGE: 18 Yrs. 6 Mos. 21 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Oklahoma

10. NAME OF FATHER: Solomon E. Conetsee

11. BIRTHPLACE OF FATHER (State or Country): Tenn.

12. MAIDEN NAME OF MOTHER: Nancy Harriet Sells

13. BIRTHPLACE OF MOTHER (State or Country): Tenn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) S. E. Conetsee
(Address) New Plymouth Idaho R.F.D.

15. Filed May 11 1921
R. H. Pratt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 11 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 19 1921, to May 11 1921, that I last saw h.... alive on May 11 1921, and that death occurred on the date stated above, at 11.30 A.M.

The CAUSE OF DEATH* was as follows:
Thrombo phlebitis
result of suppuration of middle ear
(Duration) 6 Yrs. — mos. — ds.
Contributory (Secondary) Lung abscess
(Duration) ... yrs. ... mos. 15 ds.

(Signed) Ed. E. Mayer M. D.
5/11 1921 (Address) Boise, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence Fruitland Idaho

19. PLACE OF BURIAL OR REMOVAL: Fruitland Idaho
DATE OF BURIAL: 5/12 1921

20. UNDERTAKER: Schreiber & Sidenfaden
ADDRESS: Boise Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51068

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34026
Registered No. 36

RECEIVED
JUN 3 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Ada Registration District No. 2
City of Boise Primary Registration District No. 1002
(No. 410 Main St., State St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Samuel Marion Giltner
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: July (Month) 7 (Day) 1 (Year)

7. AGE: 68 Yrs. 10 Mos. 5 ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ind.

10. NAME OF FATHER: Andrew Giltner

11. BIRTHPLACE OF FATHER (State or Country): Ind.

12. MAIDEN NAME OF MOTHER: Mary J. Baird

13. BIRTHPLACE OF MOTHER (State or Country): Ky.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. J. Giltner
(Address)

15. Filed May 12 1921 R. H. Pratt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 12 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 4 1921 to May 12 1921, that I last saw h... alive on ... 19..., and that death occurred on the date stated above, at ... M.

The CAUSE OF DEATH* was as follows:
Pulmonary cancer of the face

(Duration) 1 Yrs. ~~1~~ mos. ... ds.
Contributory (Secondary) Cancer cachexia
(Duration) ... yrs. ... mos. ... ds.

(Signed) Jonah L Stewart M. D.
5/12 1921 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery | DATE OF BURIAL ... 19...

20. UNDERTAKER: Schreiber & Hidenfeden | ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

Taylor

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34027

Registered No. 137

1. PLACE OF DEATH

County of Ada

City of Boise (No. 406 No 19. St.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED JUN 3 1921 BUREAU OF VITAL STATISTICS

Registration District No.

Primary Registration District No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Margaret A. Cummins

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Aug (Month) 1 (Day) 1848 (Year)

7. AGE: 72 Yrs. 9 Mos. 10 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: At Home.

(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: George C. Smith.

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Margaret Rochester.

13. BIRTHPLACE OF MOTHER (State or Country): Tennessee

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C. Cummins

(Address) Boise Idaho

15. Filed May 13 1921 L. H. Gate Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 11 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 11th 1921, to — 19—, that I last saw h[illegible] alive on 19—, and that death occurred on the date stated above, at 6 A M.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(Duration) Yrs. mos. ds.

Contributory (Secondary) Arterio Sclerosis

(Duration) 6 & 10 yrs. — mos. ds.

(Signed) L. M. Taylor M. D.

5/12 1921 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery

DATE OF BURIAL: May 13 1921

20. UNDERTAKER: Cummings & Cobb.

ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34029
Registered No. 139

RECEIVED
JUN 3 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Ada
City of Boise. (If death occurs away from usual residence, give facts called for under special information.)
Registration District No. 2
Primary Registration District No. 1004
No. 508 Hays. St.)

2. FULL NAME Elvira B. Snyder.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.
4. COLOR OR RACE: White.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widow

6. DATE OF BIRTH: Aug 14 (Month) (Day) 1848 (Year)

7. AGE: 72 Yrs. 8 Mos. 28 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: at Home.
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): New York.

10. NAME OF FATHER: Wilson Bradley.

11. BIRTHPLACE OF FATHER (State or Country): New York.

12. MAIDEN NAME OF MOTHER: Angelina Stone

13. BIRTHPLACE OF MOTHER (State or Country): Unknown.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Harry Krebs.
(Address) Boise Idaho.

15. Filed May 14 1921 R. N. Pratt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 5 (Month) 12 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 1 1921, to May 12 1921, that I last saw her alive on May 12 1921, and that death occurred on the date stated above, at 2 P M.

The CAUSE OF DEATH* was as follows:
Paresis. of the Pneumonia

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F. A. Patterson M. D.
5/13 1921 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cem. DATE OF BURIAL: May 14 1921

20. UNDERTAKER: Summers & Krebs. ADDRESS: Boise Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

Bowers.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED JUN 3 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 2

County of Ada

Primary Registration District No. 1004

City of Boise (No. 1008 Jus 9. St.)

File No. 34030

Registered No. 140

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ellen Atkinson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widow (Write the word.)

6. DATE OF BIRTH: May 8 (Month) (Day) 1837 (Year)

7. AGE: 84 Yrs. — Mos. 4 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: At Home.

(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Ohio,

10. NAME OF FATHER: Allen Blackwood.

11. BIRTHPLACE OF FATHER (State or Country): Penn.

12. MAIDEN NAME OF MOTHER: Sewell.

13. BIRTHPLACE OF MOTHER (State or Country): Penn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Mary Wiles.

(Address) .....

15. Filed May 14 1921 R. H. Pratt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 12 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....

that I last saw h..... alive on ..... 19.....

and that death occurred on the date stated above, at 9:30 P. M.

The CAUSE OF DEATH* was as follows:

Senility

(Duration) 8 4 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) L. Bowers M. D.

1921 (Address) Boise

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cem — DATE OF BURIAL: May 14 1921

20. UNDERTAKER: Summers & Kirby — ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34031

Registered No.

RECEIVED JUN 3 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No.

Primary Registration District No. 04

County of Ada

City of Boise (No. 309, North 8th St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Oakley L. Wyckoff

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widower (Write the word.)

6. DATE OF BIRTH: March (Month) 22 (Day) 1865 (Year)

7. AGE: 56 Yrs. 1 Mos. 21 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Washington

10. NAME OF FATHER: Andrew H. Wyckoff

11. BIRTHPLACE OF FATHER (State or Country): America

12. MAIDEN NAME OF MOTHER: Elizabeth Perkins

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) O. M. Wyckoff

(Address) Lenore, Idaho.

15. Filed May 14 1921 D. H. Peale Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 13 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 4, 1921, to May 13, 1921, that I last saw h.... alive on May 11, 1921, and that death occurred on the date stated above, at 11 P. M.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(Duration) Yrs. 2 mos. ds.

Contributory (Secondary) Cystitis and Prostatitis (Duration) yrs. mos. ds.

(Signed) Ernest E. Lauber M. D.

5-14-1921 (Address) Boise, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ...yrs...mos...days. In the State ...yrs...mos...days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Star Cemetery — DATE OF BURIAL: 5/15/1921

20. UNDERTAKER: Schreiber & Liebenstein — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

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FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
IDN 3 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Ada — Registration District No. ____
City of Meridian (No. ____ St.) — Primary Registration District No. 10
File No. 34032
Registered No. 143
If death occurs away from usual residence, give facts called for under special information.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary M Berry

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (or Widowed)
6. DATE OF BIRTH: April (Month) 30 (Day) 1856 (Year)
7. AGE: 65 Yrs. ____ Mos. 14 ds. IF LESS than 1 day how many ____ hrs. or ____ min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Housekeeper
(b) General nature of industry, business or establishment in which employed (or employer): ____
9. BIRTHPLACE (State or Country): Indiana
10. NAME OF FATHER: Wm Journey
11. BIRTHPLACE OF FATHER (State or Country): Unknown
12. MAIDEN NAME OF MOTHER: P Hamm
13. BIRTHPLACE OF MOTHER (State or Country): Penn —
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Berry
(Address) Meridian Idaho
15. Filed May 16 1921 — R H Pratt, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 14 (Day) 1921 (Year)
17. I HEREBY CERTIFY, That I attended deceased from May 12 1921, to May 14 1921, that I last saw h.. alive on May 14 1921, and that death occurred on the date stated above, at 6 P M.
The CAUSE OF DEATH* was as follows:
Asthenia gastrica
(Duration) ____ Yrs. ____ mos. ____ ds.
Contributory (Secondary) ____
(Duration) ____ yrs. ____ mos. ____ ds.
(Signed) M. W. Falconer M. D.
5/15 1921 (Address) Boise Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days
Where was disease contracted if not at place of death? ____
Former or usual residence ____

19. PLACE OF BURIAL OR REMOVAL: Masonic Cemetery — DATE OF BURIAL: 5/16 1921
20. UNDERTAKER: W. B. Walker — ADDRESS: Meridian Id

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JUN 3 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Ada — Registration District No. 7
City of Boise — Primary Registration District No. 1004
(If not in city give township) (6th & Bannock St.)
If death occurs away from usual residence, give facts called for under special information.

File No. 34033
Registered No. 744
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Earl Lee McNutt

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	White	Married

6. DATE OF BIRTH: Jan. 3 (Month) 1888 (Day) (Year)

7. AGE: 33 Yrs. 4 Mos. 10 ds. — IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Lineman foreman
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Kansas

10. NAME OF FATHER: R B McNutt

11. BIRTHPLACE OF FATHER (State or Country): West Virginia

12. MAIDEN NAME OF MOTHER: Mary J. Goul.

13. BIRTHPLACE OF MOTHER (State or Country): Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mary J McNutt
(Address) Route 1 Box 218 Boise Ida

15. Filed May 14 1921 — P H Cole, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 13 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I saw deceased from May 13 1921 to ..... 19..., that I last saw h alive on ..... 19..., and that death occurred on the date stated above, at 12 10 P.M.

The CAUSE OF DEATH* was as follows:
Coming in Contact with high voltage Electric Wires
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Clyde E. Summers Coroner (M.D.)
5/14 1921 (Address) Boise Ida Ada County

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Morris Hill Cemetery	May 17 1921

20. UNDERTAKER	ADDRESS
Summers & Eaton	Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34034
Registered No. 148

RECEIVED JUN 3 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
Registration District No. 2
Primary Registration District No. 1004
County of Ada
City of Boise (If outside limits, give township) No. 2009 N 10 St. (St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Maude Evelyn Walker
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Sept 18 (Month) (Day) 1879 (Year)

7. AGE: 41 Yrs. 7 Mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Minnesota

10. NAME OF FATHER: James A. Walker

11. BIRTHPLACE OF FATHER (State or Country): Canada.

12. MAIDEN NAME OF MOTHER: Mary White.

13. BIRTHPLACE OF MOTHER (State or Country): Minnesota

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Edward W Walker
(Address) 2009 N 10th St

15. Filed May 16 1921 — P. H. Craig, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 14 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 8th 1921, to May 14 1921, that I last saw her alive on May 14 1921, and that death occurred on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:
Exophthalmic Goitre
toxic variety
(Duration) 2 Yrs. — mos. — ds.
Contributory (Secondary) Pancreatitis
(Duration) — yrs. 2 mos. — ds.

(Signed) W L Frazier M. D.
5/16 1921 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: May 17 1921
20. UNDERTAKER: Summers & Krebs — ADDRESS: Boise Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO. PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

RECEIVED JUN 3 1921 BUREAU OF VITAL STATISTICS

County of Ada — Registration District No. 2
City of Boise (If outside limits, give township) — Primary Registration District No. 1004
410 State St.)
File No. 34035
Registered No. 196

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ella Alpersteett

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F.	White	Divorced

6. DATE OF BIRTH ~~1873~~ March 15, ~~19~~ 1883 (Month) (Day) (Year)

7. AGE 38 Yrs. 1 Mos. 29 ds. — IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Kansas

10. NAME OF FATHER Henry Jones

11. BIRTHPLACE OF FATHER (State or Country) Indiana

12. MAIDEN NAME OF MOTHER Melissa Caroline Gentry

13. BIRTHPLACE OF MOTHER (State or Country) Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ida D. Ramsey
(Address) 1013 E. Bannock

15. Filed Jun 18 1921 — [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 14 - 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 6 1921, to May 14 1921 that I last saw her alive on May 14 1921, and that death occurred on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:
Mitral stenosis

(Duration) 10 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. H. Tallman M. D.
5/14 1921 (Address) Boise

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence Boise, Idaho.

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 5/18 1921

20. UNDERTAKER: Schreiber & Sidenfaden — ADDRESS: Boise Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34036
Registered No. 147

1. PLACE OF DEATH

Registration District No. 2
Primary Registration District No. 1004

County of Ada
City of Boise (No. 1921 Idaho Ave / Hotel St.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
JUN 3 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME Alexander Palmer Jacobs

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6. DATE OF BIRTH: May (Month) 23 (Day) 1878 (Year)

7. AGE: 42 Yrs. 11 Mos. 24 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Boise Idaho

10. NAME OF FATHER: Agnus Jacobs.

11. BIRTHPLACE OF FATHER (State or Country): Penn

12. MAIDEN NAME OF MOTHER: Mary Ellen Palmer

13. BIRTHPLACE OF MOTHER (State or Country): Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Editte Rodway
(Address): Caldwell Idaho

15.
Filed May 21 19 21
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 17 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I ~~attended~~ saw deceased ~~from~~
May 17 1921 ~~to~~ 19
~~that I last saw h~~ alive on 19
and that death occurred on the date stated above, at 5.30 a M.

The CAUSE OF DEATH* was as follows:
Suicide, Jumped from 3rd story window of Idaho Hotel
(Duration) Yrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) Clyde E. Summers Coroner M. D.
5/17 1921 (Address) Boise Idaho Ada County

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Masonic Cemetery
DATE OF BURIAL: May 18 21

20. UNDERTAKER: Summers & Trefz
ADDRESS: Boise Idaho,

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34038
Registered No. 179

1. PLACE OF DEATH

County of Ada
City of Boise
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2
Primary Registration District No. 1 255
Warm Springs Ave

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

RECEIVED
JUN 3 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME Edward Laurence Wassler

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Aug (Month) 16 (Day) 1917 (Year)

7. AGE: 4 Yrs. ... Mos. ... ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Silver City Idaho

10. NAME OF FATHER: Alphonse Wassler

11. BIRTHPLACE OF FATHER (State or Country): Elsass Lorraine

12. MAIDEN NAME OF MOTHER: Barbara Schaller

13. BIRTHPLACE OF MOTHER (State or Country): Elsasse Lorraine

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Alfons Wassler
(Address) Boise Ida

15. Filed May 21 1921 — [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 19 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 16 1921 to May 19 1921 that I last saw h. alive on May 19 1921 and that death occurred on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:
Convulsions as following Scarlet fever - accompanied with Meningitis -
(Duration) ... Yrs. ... mos. ... ds.
Contributory (Secondary)
(Duration) ... yrs. ... mos. ... ds.

(Signed) A. Lee Beck M. D.
5-20 1921 (Address) Boise Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: St Johns Cemetery — DATE OF BURIAL: May 21 1921
20. UNDERTAKER: Schreiber & Anderson — ADDRESS: Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

Boise

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34039
Registered No. 151

RECEIVED JUN 3 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 2
Primary Registration District No. 1004

County of Ada
City of Boise (If outside city limits, give township.) 10 E Bannock St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Hubert Oscar Eggleston

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	White	divorced

6. DATE OF BIRTH: July (Month) 23 (Day) 1869 (Year)

7. AGE: 51 Yrs. 9 Mos. 27 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Blacksmith
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Elgin Ill.

10. NAME OF FATHER: Eggleston

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Roman H. Eggleston
(Address) Emmett, Idaho

15. Filed May 21 1921 R. H. Pratt Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 20 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 4 1921, to May 20 1921, that I last saw him alive on May 19 1921 and that death occurred on the date stated above, at 4 A. M.

The CAUSE OF DEATH* was as follows:

Pancreatitis and Cholocystitis

(Duration) ..... Yrs. ..... mos. 16 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) P. R. French M. D.

May 21 1921 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: May 23 1921

20. UNDERTAKER: Summers & Tate — ADDRESS: Boise Idy.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED JUN 3 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Ada Registration District No. 7
City of Boise Primary Registration District No. 1004
(If outside limits, give township) No. St Lukes Hospital St.)
If death occurs away from usual residence, give facts called for under special information.

File No. 3404
Registered No. 152

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Chin Tip.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M.	Yellow	Single

6. DATE OF BIRTH — — 1852
(Month) (Day) (Year)

7. AGE 68 Yrs. — Mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Miner
(b) General nature of industry, business or establishment in which employed (or employer) —

9. BIRTHPLACE (State or Country) China.

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (State or Country) China.

12. MAIDEN NAME OF MOTHER Unknown.

13. BIRTHPLACE OF MOTHER (State or Country) China.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chas. L. Emory
(Address) .....

15. Filed May 25 1921 R. H. Smith
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
May 23 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 13 1921 to May 23 1921
that I last saw him alive on May 23 1921
and that death occurred on the date stated above, at 5:30 P.M.

The CAUSE OF DEATH* was as follows:
Urinary Calculus.

(Duration) 3 Yrs. mos. ds.
Contributory (Secondary) Septic Infection
(Duration) yrs. mos. 21 ds.

(Signed) T. N. Braxton M. D.
May 24 1921 (Address) Boise Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Chinese Cemetery — DATE OF BURIAL May 25 1921

20. UNDERTAKER Summers & Gebs. — ADDRESS Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JUN 3 19.. BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Frazier,

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34042

Registered No. 154

1. PLACE OF DEATH

County of Ada — Registration District No. 2

City of Boise — Primary Registration District No. 1005

(No. 2005 N. 19 St. St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Carrie June Brown

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F	White.	Married

6. DATE OF BIRTH: July (Month) 11 (Day) 1867 (Year)

7. AGE: 53 Yrs. 10 Mos. 16 ds. — IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Minnesota

10. NAME OF FATHER: Stephen Pettis

11. BIRTHPLACE OF FATHER (State or Country): Ill

12. MAIDEN NAME OF MOTHER: Ersula French

13. BIRTHPLACE OF MOTHER (State or Country): Minn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Alfred E Brown
(Address) Tenmile Idaho.

15. Filed May 25 1921 — P. H. Peck, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 27 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 19th 1921 to May 21 1921 that I last saw h[illegible] alive on May 21 1921 and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Diabetes
as per history about
(Duration) 12 Yrs. ... mos. ... ds.
Contributory (Secondary) Acidosis
(Duration) # yrs. 4 mos. ... ds.

(Signed) W L [illegible] M. D.
5/27 1921 (Address) 515 Overland Bldg

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: May 28 1921

20. UNDERTAKER: Summers & Turbe — ADDRESS: Boise Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED JUN 3 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34043

1. PLACE OF DEATH
County of Ada. Registration District No. 2
City of Boise (No. 13 18 Maintain St.) Ordinary Registration District No. 1004
Registered No. 155

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Catherine Bronson.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widow (Write the word.)

6. DATE OF BIRTH: Aug. 19 — 1849
(Month) (Day) (Year)

7. AGE: 71 Yrs. 9 Mos. 7 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ill.

10. NAME OF FATHER: David Hall

11. BIRTHPLACE OF FATHER (State or Country): Indiana

12. MAIDEN NAME OF MOTHER: Sarah McCrary

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wm McBratney
(Address) Boise Idaho.

15. Filed May 27 1921 D. H. Peate Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 26 — 1921
(Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h.m alive on May 9 1921
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Cancer of breast

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Chas. V. Germany M. D.
5/27 1921 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 5/28 1921

20. UNDERTAKER: W. McBratney — ADDRESS: Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34044

Registered No. 196

RECEIVED
JUN 3 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 2

Primary Registration District No. 2004

County of Ada

City of Boise (No. St Alphonsus Hospital.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Cinzelia Van Dyne

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widow

6. DATE OF BIRTH: April 3 (Month) (Day) 1835 (Year)

7. AGE: 86 Yrs. 1 Mos. 24 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER: Rokhamus

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Julia Beaver

13. BIRTHPLACE OF MOTHER (State or Country): New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C Van Dyne

(Address) Barber Idaho

15. Filed May 27 1921 P. H. Pratt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 27 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 18 1921, to May 27 1921, that I last saw h[illegible] alive on May 25 1921, and that death occurred on the date stated above, at 8 A.M.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

(Duration) 15 Yrs. mos. ds.

Contributory (Secondary) General arteriosclerosis

(Duration) 10 yrs. mos. ds.

(Signed) Ernest E. Tarbet M. D.

June 7 1921 (Address) Boise, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. 4 days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence Barber, Idaho.

19. PLACE OF BURIAL OR REMOVAL: Poughkeepsie N. Y. DATE OF BURIAL: June 1 1921

20. UNDERTAKER: Summers & Trefz ADDRESS: Boise Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JUN 3 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2

Primary Registration District No. 1004

File No. 34045

Registered No. 357

1. PLACE OF DEATH

County of Ada

City of Boise (No. 316 Bannock St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Marguerite Cecile Wolfe

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Female	White	Single (Write the word.)

6. DATE OF BIRTH Feb (Month) 26 (Day) 1909 (Year)

7. AGE 12 Yrs. 3 Mos. 4 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Student

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Eagle Ida

10. NAME OF FATHER Anthony M. Wolfe

11. BIRTHPLACE OF FATHER (State or Country) Iowa

12. MAIDEN NAME OF MOTHER Maud Thompson

13. BIRTHPLACE OF MOTHER (State or Country) Pa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A Schreiber

(Address) Boise

15. Filed May 31 1921 C. A. Strode Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 30 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 20 1920, to May 29 1921, that I last saw h.r alive on May 29 1921, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Sub-phrenic abscess following appendicitis

(Duration) ..... Yrs. 3 mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A A Riggs M. D.

6-3 1921 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
St Johns Cemetery	6/1 1921
20. UNDERTAKER	**ADDRESS**
Schreiber & Hidenfelder	Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED
JUN 9 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34047

Registered No. 11

1. PLACE OF DEATH

Registration District No.....

County of Ada

Registration District No.....

City of Meridian (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information. R. D. 1

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Charles S Ayers

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Oct. (Month) 4 (Day) 1874 (Year)

7. AGE: 46 Yrs. 6 Mos. 5 ds.

IF LESS than 1 day how many.....hrs. or .....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: Samuel Ayers

11. BIRTHPLACE OF FATHER (State or Country): Indiana

12. MAIDEN NAME OF MOTHER: Luvilda Ogle

13. BIRTHPLACE OF MOTHER (State or Country): Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John S Ayers

(Address) Meridian Idaho

15. Filed 6-4 1921 H. F. Mus Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr. (Month) 9 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 1 1920, to Apr. 9 1921, that I last saw him alive on Apr. 9 1921, and that death occured on the date stated above, at 1:20 P.M.

The CAUSE OF DEATH* was as follows:

Bronchitis Disease

.....(Duration) Yrs. 6 mos. ..... ds.

Contributory (Secondary) Influenza

.....(Duration) ..... yrs. ..... mos. 10 ds.

(Signed) C. L. Dutton M. D.

Apr. 9 1921 (Address) Overland Bldg. Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Meridian Idaho

DATE OF BURIAL: Apr 11 1921

20. UNDERTAKER: W. S. Maher

ADDRESS: Meridian Id.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24854

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED JUN 6 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH. Registration District No. .....
Primary Registration District No. 11
File No. 34048
County of Ada
City of Meridian (If outside limits of city or village, give township) St.)
Registered No. 9
If death occurs away from usual residence, give facts called for under special information.
2. FULL NAME Clark Irvin Clapp
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married.

6. DATE OF BIRTH: July (Month) 2. (Day) 1853 (Year)

7. AGE: 67 yrs. 10 mos. ..... ds. IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, professsion, or particular kind of work: Farmer
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Penn.

10. NAME OF FATHER: Edward C. Clapp

11. BIRTHPLACE OF FATHER (State or Country): N.Y.

12. MAIDEN NAME OF MOTHER: Eliza A. Graves

13. BIRTHPLACE OF MOTHER (State or Country): Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Elton Clapp
(Address) Meridian Idaho

15. Filed 6-4 1921. H F Kay Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 1 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4-19-M 1921, to 4-1 P.M. 1921
that I last saw h..... alive on 4-1- 1921,
and that death occurred on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:
Acute Indigestion
.....
.....
(Duration) ..... yrs. ..... mos. 1 ds.
Contributory (Secondary) Arterial Sclerosis
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H F Kay M. D.
4-2 1921 (Address) Meridian Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Meridian Cemetery
DATE OF BURIAL: 4-3 1921

20. UNDERTAKER: W S Mallet
ADDRESS: Meridian Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34050

Registration District No. 9 & 10

Primary Registration District No.

(No. ..... St.)

Registered No.

1. PLACE OF DEATH

County of Ada

City of Parma Dist Star Eagle

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Frithiof Carlson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: wid (Write the word.)

6. DATE OF BIRTH: August (Month) 10 (Day) 1852 (Year)

7. AGE: 68 Yrs. 9 Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business or establishment in which employed (or employer) Farmer

9. BIRTHPLACE (State or Country) Sweden

10. NAME OF FATHER Carl Johnson

11. BIRTHPLACE OF FATHER (State or Country) Sweden

12. MAIDEN NAME OF MOTHER Unknown.

13. BIRTHPLACE OF MOTHER (State or Country) Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Alma McConnel

(Address) Eagle Idaho R.1

15. Filed May 16 1921

Gardner K. Lewis
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 16 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 16 1921, to May 16 1921

that I last saw h— alive on April 30 1921,

and that death occurred on the date stated above, at 4:30 P.M.

The CAUSE OF DEATH* was as follows: Chronic Nephritis (Arthritis)

(Duration) Several yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Allen M. D.

5/16 1921 (Address) Caldwell Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cem. Boise-Ida — DATE OF BURIAL: May 18 1921

20. UNDERTAKER: Mc Bratney — ADDRESS: Boise Ida.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

34051

1. PLACE OF DEATH

County of Ada — Registration District No. 124

City of Kuna R R 2 (No. ..... St.) — Primary Registration District No. 2202

File No. 1

Registered No. 35

If death occurs away from usual residence, give facts called for under special information.

RECEIVED JUN 11 1921 BUREAU OF VITAL STATISTICS

2. FULL NAME Clara B. Wood

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Married

6. DATE OF BIRTH: December 12 (Month) (Day) 1863 (Year)

7. AGE: 51 Yrs. ..... Mos. ..... ds. — IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: John Whennett

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Nancy Hunt

13. BIRTHPLACE OF MOTHER (State or Country): Ind.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Oscar W. Wood
(Address): Kuna Idaho

15. Filed April 13 1921 — W B Stevens, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 12 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h.r alive on April 12 1921,
and that death occurred on the date stated above, at 12 P. M.
The CAUSE OF DEATH* was as follows:
Cardiac Failure -
(cause of death determined by investigation of circumstances)
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) R W Bowell M. D.
April 13 1921 (Address) Kuna Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL, OR REMOVAL: Star Cemetery — DATE OF BURIAL: April 16 - 21

20. UNDERTAKER: Fred K Robuck — ADDRESS: Nampa Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34053

Registered No.

RECEIVED
JUN 11 1921
BUREAU OF VITAL STATISTICS

PLACE OF DEATH

County of Bannock

City of Bancroft

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 84

Primary Registration District No. 2161

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Dan Burket

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
male	white	married

6. DATE OF BIRTH: October 27th, (Month) (Day) 1887 (Year)

7. AGE: 33 Yrs. 4 Mos. 1 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: manager of Pool-Hall.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Pulaski Co., Ky.

10. NAME OF FATHER: James Burket

11. BIRTHPLACE OF FATHER (State or Country): Tenn.

12. MAIDEN NAME OF MOTHER: Sadie( )

13. BIRTHPLACE OF MOTHER (State or Country): Tenn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Irene Burns Burket (wife)
(Address) Bancroft Idaho.

15. Filed March 1 19 21. O W Pinkerton Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: February 27th (Month) (Day) 19 21. (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Gun Shot Wound
(Accidental)

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) S S Ferguson Coroner M. D.

3/1-1921 (Address) Pocatello Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Bancroft Idaho. DATE OF BURIAL: March 3, 19 21.

20. UNDERTAKER: Schumacher & Hall ADDRESS: Pocatello

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

28 34054 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED JUN 9 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Bannock
City of Pocatello (If outside limits of city or village give township) Registration District No. 3761 (Ward No. Hospital St.)
If death occurs away from usual residence, give facts called for under special information.

File No. 40
Registered No. 3572
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lena Frazier

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: Colored
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6. DATE OF BIRTH: March 24 1883 (Month) (Day) (Year)

7. AGE: 38 Yrs. 1 Mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Chattanooga Tenn

10. NAME OF FATHER: Thomas Bowan

11. BIRTHPLACE OF FATHER (State or Country): Georgia

12. MAIDEN NAME OF MOTHER: /

13. BIRTHPLACE OF MOTHER (State or Country): /

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Charlie Chambers
(Address) 436 East Halliday

15. Filed 5/6 1921 J. H. Young Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 5 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 2 1921 to May 5 1921 that I last saw her alive on May 5th 1921 and that death occurred on the date stated above, at 10 P.M.
The CAUSE OF DEATH* was as follows:
Surgical Kidney
Pyo nephrosis
(Duration) Yrs. 1 mos. ds.
Contributory (Secondary) Fibroid (Hysterectomy
(Duration) 3 yrs. mos. ds.
(Signed) J. H. Young M. D.
May 6 1921 (Address) Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mt View Cemetery
20. UNDERTAKER: W. W. Walker

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of this form.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JUN 9 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

34055

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bannock Registration District No. 28

City of Pocatello (No. 525 E. Hayden St.) Primary Registration District No. 2141

File No. 40

Registered No. 3573

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary Rogers.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: Colored

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (If married, widowed or divorced, how long?): Married

6. DATE OF BIRTH: Oct (Month) 5 (Day) 1876 (Year)

7. AGE: 41 Yrs. 7 Mos. ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House Wife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): St Louis Mo.

10. NAME OF FATHER: Turner.

11. BIRTHPLACE OF FATHER (State or Country): ✓

12. MAIDEN NAME OF MOTHER: ✓

13. BIRTHPLACE OF MOTHER (State or Country): ✓

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Joseph Rogers.
(Address) 524 E Hayden St. Pocatello, Ida

15. Filed May 5 1921 J. H. Young Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 4 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 4 1921, to May 4 1921, that I last saw her alive on May 4 5:30 PM 1921, and that death occurred on the date stated above, at 5:35 P.M.

The CAUSE OF DEATH* was as follows:

Myocarditis.

(Duration) Yrs. 2 mos. ds.

Contributory (Secondary) Chronic alcoholism

(Duration) about 3 yrs. mos. ds.

(Signed) Asa. Newton M. D.

May 6 1921 (Address) Pocatello, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 8 yrs. mos. days. In the State 8 yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence Chicago, Ill.

19. PLACE OF BURIAL OR REMOVAL: Mt View Cem. DATE OF BURIAL: May 8 1921

20. UNDERTAKER: H. L. McClaran ADDRESS: Pocatello Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19. RECEIVED JUN 9 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

34057

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 28

County of Bannock Primary Registration District No. 2161 File No. 40

City of POCATELLO, IDAHO (No. General Hosp. St.) Registered No. 3575

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mirt Jackson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	White	Married

6. DATE OF BIRTH March 8 1895
(Month) (Day) (Year)

7. AGE 26 Yrs. 2 Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Soldier U.S.A.
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Utah.

10. NAME OF FATHER S. G. Jackson

11. BIRTHPLACE OF FATHER (State or Country) Utah.

12. MAIDEN NAME OF MOTHER Ellen Sandserson

13. BIRTHPLACE OF MOTHER (State or Country) California

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Frances Hardwick
(Address) Oxford, Idaho

15. Filed May 9 1921 J. P. Young, Local Registrar.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 7 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 1920 19 ..., to May 7 1921, that I last saw h[illegible] alive on 2nd May 7 1921, and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:
Diabetes Mellitus

(Duration) 2 Yrs. ... mos. ... ds.

Contributory (Secondary) Pneumonia

(Duration) ... yrs. ... mos. 3 ds.

(Signed) O. J. Gray M. D.

May 9 1921 (Address) POCATELLO, IDAHO

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 1 yrs. ... mos. ... days. In the State 1 yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence Driggs Idaho

19. PLACE OF BURIAL OR REMOVAL Driggs, Ida. DATE OF BURIAL May 11 1921

20. UNDERTAKER H. L. McHAN ADDRESS POCATELLO, IDAHO

POCATELLO, IDAHO

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JUN 9 1921 BUREAU OF VITAL STATISTICS POCATELLO, IDAHO

CERTIFICATE OF DEATH

34058

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 28

County of Bannock

Primary Registration District No. 2141

File No. 40

City of Pocatello (No.) General Hosp. St.)

Registered No. 3576

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Frank Wong

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Male	Chinese	Widower

6. DATE OF BIRTH: Not Known (Month) (Day) 1847 (Year)

7. AGE: 74 Yrs. Mos. ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laundryman
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): China

10. NAME OF FATHER: Not Known

11. BIRTHPLACE OF FATHER (State or Country): China

12. MAIDEN NAME OF MOTHER: Not Known

13. BIRTHPLACE OF MOTHER (State or Country): China

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Miss Dora Swift of
(Address) POCATELLO, IDAHO General Hospital

15. Filed May 9 1921 J. P. Young (Local Registrar)

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 7 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 1921, to May 7 1921, that I last saw him alive on May 7 1921, and that death occurred on the date stated above, at 5:30 P. M.

The CAUSE OF DEATH* was as follows:
Myocarditis ,

(Duration) Yrs. 2 mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) W. S. Weaver M. D.
May 8 1921 (Address) POCATELLO, IDAHO

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 1 yrs. mos. days. In the State 1 yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence Pocatello, Idaho

19. PLACE OF BURIAL OR REMOVAL: Mt View POCATELLO, IDAHO | DATE OF BURIAL: May 9 1921

20. UNDERTAKER: H. L. McClain | ADDRESS: POCATELLO, IDAHO

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED JUN 9 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

34059

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 28

Registration District No. 746

File No. 40

Registered No. 3577

County of Bannock

City of Pocatello (No.) General Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME J. J. London

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Unknown (Write the word.)

6. DATE OF BIRTH: Unknown (Month) (Day) 1869 (Year)

7. AGE: 52 Yrs. — Mos. — ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Unknown

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Supt. General Hospital

(Address) Pocatello

15. Filed 6/10 1921

J. W. Young
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 8th 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 8 1921, to May 8 1921 that I last saw h— alive on May 8 1921 and that death occurred on the date stated above, at ....M.

The CAUSE OF DEATH* was as follows:

Tuberculosis.

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) H. L. Wagener M. D.

May 9 1921 (Address) Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain View Cem — DATE OF BURIAL: May 10 1921

20. UNDERTAKER: Schumacher Hall — ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A--25 M. 1-19.

RECEIVED JUN 9 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

34060 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 28
Primary Registration District No. 2161
File No. 40
Registered No. 3578

County of Bannock
City of Pocatello (If outside limits, give ward or St.) St. Anthony Hospital

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Patrick Powe

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	white	Single

6. DATE OF BIRTH: March (Month) 16 (Day) 1834 (Year)

7. AGE: 87 Yrs. 1 Mos. 20 Ds. IF LESS than 1 day how many..... hrs. or.....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ireland

10. NAME OF FATHER: Patrick Powe

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: unknown

13. BIRTHPLACE OF MOTHER (State or Country): unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Martha Sills
(Address) 340 N. Tenth

15. Filed 5/10 1921 J. Young Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 6 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1 1921, to May 6 1921, that I last saw h[illegible] alive on May 6 1921, and that death occurred on the date stated above, at 11:50 A.M.

The CAUSE OF DEATH* was as follows:
Lobar pneumonia

(Duration) ..... Yrs. ..... mos. 5 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A.M. Newton M. D.

May 7 1921 (Address) Pocatello, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain View — DATE OF BURIAL: May 10 1921

20. UNDERTAKER: Edwards Drug — ADDRESS: Pocatello Idaho

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

34062

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 40

Registered No. 3580

Registration District No. 28

Primary Registration District No. 216

RECEIVED
JUN 9 19
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Bannock

City of Pocatello (If outside limits, give township) St. No. 711 N. Arthur Ave.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Fannie Bell Johnson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: Colored

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word)

6. DATE OF BIRTH: Dec 20 1864
(Month) (Day) (Year)

7. AGE: 56 Yrs. 4 Mos. 25 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Kentucky

10. NAME OF FATHER: — Beggs

11. BIRTHPLACE OF FATHER (State or Country): /

12. MAIDEN NAME OF MOTHER: /

13. BIRTHPLACE OF MOTHER (State or Country): /

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Orusby By Johnson
(Address) 717 So 3rd Ave

15. Filed 5/16 1921

J. P. Young
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 14 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 12 1921, to May 14 1921 that I last saw her alive on May 14 1921, and that death occurred on the date stated above, at 12 Noon

The CAUSE OF DEATH* was as follows:

Chronic Nephritis & Myocarditis

(Duration) 2 Yrs. mos. ds.

Contributory (Secondary) Large uterine fibroid

(Duration) 3 yrs. mos. ds.

(Signed) A M Newton M. D.

May 16 1921 (Address) Kane Bldg Pocatello Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: N P View Cemetery — DATE OF BURIAL: 5/18 1921

20. UNDERTAKER: J T Craven — ADDRESS: Pocatello

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

34063 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED JUN 9 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 28
Primary Registration District No. 2161
File No. 40
Registered No. 9581

County of Bannock
City of Pocatello (If outside limits give township) 505 So Johnson St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James Grundy Hopkins

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write Word)
male	white	married

6. DATE OF BIRTH: Dec (Month) 27 (Day) 1878 (Year)

7. AGE: 43 Yrs. 4 Mos. 19 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Plasterer
(b) General nature of industry, business or establishment in which employed (or employer): M

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: Stephen Hopkins

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Sarah Mason

13. BIRTHPLACE OF MOTHER (State or Country): Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Roswell S. Hopkins
(Address) 350 N. Grant st.

15. Filed May 16 1921 J. Young. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 14 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mch 26 1921, to May 14 1921, that I last saw him alive on May 14 1921, and that death occurred on the date stated above, at 6 A.M.

The CAUSE OF DEATH* was as follows:
Chronic Valvular Heart Disease (Myocarditis) Mitral insufficiency and Stenosis
(Duration) several Yrs. mos. ds.
Contributory (Secondary) Oedema Lungs
(Duration) yrs. mos. 2 ds.

(Signed) W. J. Howard M. D.
5/16 1921 (Address) Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 10 yrs. mos. days. In the State 10 yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence Iowa.

19. PLACE OF BURIAL OR REMOVAL: Mt View Cem. Pocatello DATE OF BURIAL: May 16 1921

20. UNDERTAKER: A. L. McHaw ADDRESS: Pocatello Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO. PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

34064

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 28

County of Bannock

Primary Registration District No. 2161

File No. 40

City of Pocatello (No.) 883 Wayne Ave (St.)

Registered No. 3182

If death occurs away from usual residence, give facts called for under special information.

RECEIVED JUN 9 1921 BUREAU OF VITAL STATISTICS

2. FULL NAME Elvira Cushman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widowed

6. DATE OF BIRTH: Feb (Month) 9th (Day) 1850 (Year)

7. AGE: 71 Yrs. 3 Mos. 6 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kentucky

10. NAME OF FATHER: James Musick

11. BIRTHPLACE OF FATHER (State or Country): Kentucky

12. MAIDEN NAME OF MOTHER: Ann Stanburn

13. BIRTHPLACE OF MOTHER (State or Country): Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) James Cushman

(Address) Pocatello Idaho

15. Filed 5/17 1921

J. Myers
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 15 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....

that I last saw h..... alive on ..... 19.....,

and that death occurred on the date stated above, at 10 A. M.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D D Ferguson Coroner M. D.

5/16 1921 (Address) Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Clear Missouri	May 21 1921
20. UNDERTAKER	ADDRESS
J Shumaker & Son	Pocatello Idaho

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

34065 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED JUN 9 1921 BUREAU OF STATISTICS

Registration District No. 28
Primary Registration District No. 2161
File No. 40
Registered No. 3583

1. PLACE OF DEATH
County of Bannock
City of Pocatello (If not in incorporated city or village give township) No. 207 So. Johnson St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Grace Minette Buchanan
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	white	Single

6. DATE OF BIRTH
October 4 1918
(Month) (Day) (Year)

7. AGE
2 Yrs. 8 Mos. 12 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) New York City N.Y.

10. NAME OF FATHER Wm Buchanan

11. BIRTHPLACE OF FATHER
(State or Country) Penn.

12. MAIDEN NAME OF MOTHER Grace E. Wilson

13. BIRTHPLACE OF MOTHER
(State or Country) New York N.Y.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wm Buchanan
(Address) 525 E. 157th St N.Y. City N.Y.

15.
Filed May 17 1921
J. F. Young
Local Registrar

SYMS-YORK CO. PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
May 16 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 14 1921, to May 16 1921, that I last saw h.w alive on May 16 1921 and that death occurred on the date stated above, at 5 30 P.M.

The CAUSE OF DEATH* was as follows:
Broncho-pneumonia
(Duration) Yrs. mos. 4 ds.
Contributory (Secondary) Emfysema of lung
(Duration) yrs. 3 mos. ds.

(Signed) A.M. Merton M. D.
May/1924 (Address) Kunkeldy Pocatello Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. 10 days. In the State yrs. mos. 10 days
Where was disease contracted if not at place of death? N.Y. City N.Y.
Former or usual residence N.Y. City New York

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Mt View Cem	May 18 1921

20. UNDERTAKER	ADDRESS
H.L. McHan	Pocatello Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

34066

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 28

County of Bannock — Primary Registration District No. 2161 — File No. 40

City of Pocatello (7 S. Main St.) — Registered No. 3584

If death occurs away from usual residence, give facts called for under special information.

RECEIVED JUN 9 1921 BUREAU OF VITAL STATISTICS

2. FULL NAME John Vaughn Sr

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	white	married

6. DATE OF BIRTH: Aug 27 1854 (Month) (Day) (Year)

7. AGE: 66 Yrs. 8 Mos. 20 ds. — IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Michael Vaughn

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Ann M.c Cann

13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs John Vaughn
(Address) Pocatello Idaho

15. Filed 6/18 1921 — J. Young, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 17 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 5 1920 to May 16 1921 that I last saw h.im alive on May 16 1921, and that death occurred on the date stated above, at 7.30 P.M.

The CAUSE OF DEATH* was as follows:
Senile dementia

(Duration) Yrs. 6 mos. ds.
Contributory (Secondary) Bronchiectasis
(Duration) yrs. 2 mos. ds.

(Signed) E. [illegible] M. D.
5/17 1921 (Address) Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain View — DATE OF BURIAL: May 20 1921

20. UNDERTAKER: D Chamachan & Son — ADDRESS: City of Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 7-19.

CERTIFICATE OF DEATH

34068

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
JUN 9 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Bannock — Registration District No. 25

City of POCATELLO, IDAHO — Primary Registration District No. 3161

(No.) Pocatello General Hosp. (St.)

File No. 40

Registered No. 3586

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Benjamin Franklyn Yehle

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	white	Single

6. DATE OF BIRTH: April (Month) 30 (Day) 1891 (Year)

7. AGE: 30 Yrs. — Mos. 23 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: R.R. Fireman
(b) General nature of industry, business or establishment in which employed (or employer): & Engineer. O.S.L.

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: Frank Yehle

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Rachel Siders

13. BIRTHPLACE OF MOTHER (State or Country): Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Frank Yehle.
(Address) Crowley Colorado.

15. Filed May 24 1921 — J. Young, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 23 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5-17 1921, to 5-23 1921, that I last saw h.. alive on 5-23 1921, and that death occurred on the date stated above, at 6 45 A.M.

The CAUSE OF DEATH* was as follows:

Septic peritonitis

(Duration) ... Yrs. ... mos. 7 ds.

Contributory (Secondary): Perforated appendix

(Duration) ... Yrs. ... mos. 7 ds.

(Signed) F. E. Powell M. D.

May 24 1921 (Address) POCATELLO, IDAHO

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death — yrs. — mos. 7 days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence: Colorado

19. PLACE OF BURIAL OR REMOVAL: Pueblo. Colorado — DATE OF BURIAL: May 25 1921

20. UNDERTAKER: H. L. McHARG — ADDRESS: POCATELLO, IDAHO

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO. PRINTERS & BINDERS, BOISE 51088

34069

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bannock

City of Pocatello

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 28

Primary Registration District No. 2161

(No.) St. Anthony Hospital

File No. 41

Registered No. 3587

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Vera Faun Wilhite

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: May 14 1905 (Month) (Day) (Year)

7. AGE: 16 Yrs. 1 Mos. 13 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Student

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kansas

10. NAME OF FATHER: C. H. Wilhite

11. BIRTHPLACE OF FATHER (State or Country): Kansas

12. MAIDEN NAME OF MOTHER: Bertha Bigler

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C. H. Wilhite

(Address) Hahem Idaho

15. Filed 5/27 1921 J. P. Young, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 27 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 14 1921, to May 27 1921, that I last saw h.w. alive on May 27 1921, and that death occurred on the date stated above, at 10:50 a M.

The CAUSE OF DEATH* was as follows:

Streptococcic cerebro-spinal-meningitis

(Duration) ..... Yrs. ..... mos. 4 ds.

Contributory (Secondary) Streptococcic respiratory infection

(Duration) ..... yrs. 1 mos. ..... ds.

(Signed) A. M. Newton M. D.

May 27 1921 (Address) Pocatello, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Hahem Ida — DATE OF BURIAL: May 30 1921

20. UNDERTAKER: Schumacher Hall — ADDRESS: Pocatello Idaho

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5A—25 M. 1-19.

34070

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED JUN 9 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 28

Primary Registration District No. 15-2161

File No. 41

Registered No. 3588

County of Bannock

City of Pocatello (No. Stephens Bros Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME David Mosho

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Indian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1 (Year)

7. AGE: About 37 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Fort Hall reservation

10. NAME OF FATHER: Brooks Mosho

11. BIRTHPLACE OF FATHER (State or Country): Fort Hall reservation

12. MAIDEN NAME OF MOTHER: /

13. BIRTHPLACE OF MOTHER (State or Country): /

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Della Mosho
(Address) Fort Hall reservation

15. Filed 5/30 1921 J. P. Haney Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 30 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1 1921, to May 30 1921, that I last saw him alive on May 30 1921, and that death occurred on the date stated above, at 5 a. M.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

(Duration) ..... Yrs. ..... Mos. ..... ds.

Contributory (Secondary): Hemorrage of Bowels

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Wm Lynn M. D.

5/30 1921 (Address) Pocatello Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Fort Hall Reservation

DATE OF BURIAL: 5/31 1921

20. UNDERTAKER: J. P. Haney

ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
JUN 9 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

34071

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 28
Registration District No. 2141
File No. 41
Registered No. 3589

1. PLACE OF DEATH
County of Bannock
City of Pocatello (If outside limits of city or village, write the name of township.) Gen. Hosp. St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Manuel Delator
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: Mexican
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): single

6. DATE OF BIRTH: Not Known (Month) (Day) (Year)

7. AGE: 27 Yrs. Mos. ds. — If LESS than 1 day, how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business or establishment in which employed (or employer): County patient

9. BIRTHPLACE (State or Country): Mexico

10. NAME OF FATHER: Not Known

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Miss Pond. Supt
(Address) Pocatello. Gen. Hosp

15. Filed May 31 1921 — J. P. Young, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 29 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 18, 1921 to May 29 1921 that I last saw him alive on May 29 1921 and that death occurred on the date stated above, at 7.50 A.M.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis
(Duration) Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. 11 ds.

(Signed) H. S. Wood M. D.
May 31 1921 (Address) Pocatello, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. 20 days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence Pocatello, Ida

19. PLACE OF BURIAL OR REMOVAL: Mt View Cem — DATE OF BURIAL: May 31 1921

20. UNDERTAKER: H. L. McHan — ADDRESS: Pocatello Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO. PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

34073

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 63

Primary Registration District No. .....

File No. 6

Registered No. .....

RECEIVED
JUN 14 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH.

County of Bear Lake

City of Paris (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Leroy Ringel.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. May (Month) Third (Day) 1920 (Year)

7. AGE: 1 Yrs. 3 Mos. 17 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country) Paris Bear Lake Co.

10. NAME OF FATHER: Fredrick L Ringel

11. BIRTHPLACE OF FATHER (State or Country) Paris Bear Lake Co. Idaho

12. MAIDEN NAME OF MOTHER: Lotta Price

13. BIRTHPLACE OF MOTHER (State or Country) Paris Bear Lake Co Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Fredrick L Ringel

(Address) Paris Idaho

15.

Filed May 23 1921

Mrs. J. L. Skinner
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 20 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 19 1921 to May 20 1921, that I last saw h alive on May 20 1921 and that death occured on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia
Following Measles

(Duration) ..... Yrs. ..... mos. 8 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. O. Moore M. D.

May 22 1921 (Address) Paris Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Paris Idaho — DATE OF BURIAL: May 23 1921

20. UNDERTAKER: Bishop Lowe — ADDRESS: Paris Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

34074

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 5-3

County of Bear Lake

Primary Registration District No.

File No. 6

City of Paris. St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
JUN 14 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME Raymond Webb.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married.

6. DATE OF BIRTH. Sept. (Month) 23 (Day) 1894 (Year)

7. AGE: 26 Yrs. 8 Mos. 7 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Lake Town.

10. NAME OF FATHER: George H. Webb

11. BIRTHPLACE OF FATHER (State or Country): England.

12. MAIDEN NAME OF MOTHER: Lucy Hodes.

13. BIRTHPLACE OF MOTHER (State or Country): England.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Jim Webb
(Address) Lake Town

15. Filed May 30th 1921 Mrs. J. L. Skinner Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 30 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 28, 1921, to May 30 1921, that I last saw h[illegible] alive on May 30 1921, and that death occured on the date stated above, at 5:50 P.M.

The CAUSE OF DEATH* was as follows:
Peritonitis fro. Appendecitis

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [signature] M. D.

5/30/21 (Address) Paris Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence Lake Town

19. PLACE OF BURIAL OR REMOVAL: Lake Town.

DATE OF BURIAL: May 1921

20. UNDERTAKER

ADDRESS

SYMS - YORK CO., PTRS. & BORS. 24654

34075

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED JUN 14 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH. Registration District No. 53
County of Bear Lake Primary Registration District No.
City of Paris (No. St.) File No. 4
Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Henry Nathaniel Rogers

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Sep. (Month) 7 (Day) 1861 (Year)

7. AGE: 59 Yrs. 8 Mos. 7 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Painter & Decorator
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) South Hampton, England

10. NAME OF FATHER Frederic Rogers

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER Emma E. Shepherd

13. BIRTHPLACE OF MOTHER (State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Elizabeth H. Rogers
(Address) Paris Idaho

15. Filed May 17th 1921 Mrs. J. L. Strauss Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 14 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 13 1921, to May 14 1921, that I last saw him alive on May 14 1921, and that death occured on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:
Uremic Poisoning
Brights Disease

(Duration) ..... Yrs. 1 mos. ..... ds.
Contributory (Secondary) Convulsions
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) C. O. Moore M. D.
5/14 1921 (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL [redacted] Paris Idaho — DATE OF BURIAL May 17 1921

20. UNDERTAKER Bishop Low. — ADDRESS Paris Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 24654

M V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED MAY 20 1921 BUREAU OF VITAL STATISTICS

Registration District No. 32
Primary Registration District No. 2136
File No. 34076
Registered No.

PLACE OF DEATH
Bear Lake
Montpelier
(If outside city limits, give hours away from residence, give facts for identification under special instructions.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Dorothy Stephens

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Girl
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Jan. 11 (Month) (Day) 1913 (Year)

7. AGE: 7 Yrs. 27 Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Going to school
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Bear Lake

10. NAME OF FATHER: Thomas N. Stephens

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Clara Welker

13. BIRTHPLACE OF MOTHER (State or Country): Bear Lake, Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Elmer E. Hinckley
(Address) Montpelier, Ida.

15. Filed Mar 10 1921
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. 6, 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 5 1921, to Feb. 6, 1921, that I last saw her alive on Feb. 6, 1921, and that death occurred on the date stated above, at 1 A. M.

THE CAUSE OF DEATH* was as follows:

(Sporadic) Pneumonia

(Duration) Yrs. mos. 2 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Elmer E. Hinckley (M. D.)
2/7, 1921 (Address) Montpelier, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Montpelier
DATE OF BURIAL: Feb 9, 1921

20. UNDERTAKER: F. M. Williams
ADDRESS: Montpelier Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should write in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-12 M. 6-15-17.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34077
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

RECEIVED MAY 20 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Bear Lake
City of Montpelier
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 32
Primary Registration District No. 2136
....., ... St.)

2. FULL NAME Mary J. Harding

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female.

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Dec. (Month) 22. (Day) 1894 (Year)

7. AGE: 26 Yrs. 3 Mos. 25 ds.
IF LESS than 1 day how many .... hrs. or .....min.?'

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Francis M. Wales

11. BIRTHPLACE OF FATHER (State or Country): Idaho ~~Chloe Tippets~~

12. MAIDEN NAME OF MOTHER: Chloe Tippets

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Robert G. Harding
(Address) Montpelier, Idaho

15. Filed April 20 1921 N. V. Kemp Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 20 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 18 1921 to April 20 1921
that I last saw h[illegible]alive on 4-20 1921
and that death occurred on the date stated above, at 7 15 P.M.
The CAUSE OF DEATH* was as follows:
Pulmonary Edema
.....
.....
.....(Duration) ..... Yrs..... mos..... ds.
Contributory (Secondary) .....
.....(Duration) ..... Yrs..... mos..... ds.
(Signed) [illegible] M. D.
4-21 1921 (Address) [illegible]

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the ,State....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Salt Lake City Utah — DATE OF BURIAL: Apr. 22 1921

20. UNDERTAKER: T. M. Williams — ADDRESS: Montpelier Idaho

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34078
Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Bear Lake. Registration District No. 32

City of Montpelier. Primary Registration District No. 2136

If death occurs away from usual residence, give facts called for under special information. ....., ... St.)

RECEIVED MAY 20 1921 BUREAU OF VITAL STATISTICS

2. FULL NAME John Flynn.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married.

6. DATE OF BIRTH. August (Month) 15 (Day) 1888. (Year)

7. AGE: 32 Yrs. 8 Mos. 24 ds.

IF LESS than 1 day how many .... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Hotel Manager.
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Minnesota.

10. NAME OF FATHER: Wm. Flynn.

11. BIRTHPLACE OF FATHER (State or Country): Ireland.

12. MAIDEN NAME OF MOTHER: Elizabeth Sullivan.

13. BIRTHPLACE OF MOTHER (State or Country): Ireland.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. John Flynn
(Address) Montpelier, Idaho

15. Filed 5-15- 1921 ..... Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 9 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 6 1921 to May 9 1921
that I last saw h[illegible] alive on May 9 1921
and that death occurred on the date stated above, at 3 1 M.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Acute Dilatation Heart

..... (Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.

5-11- 1921 (Address) [illegible]

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Belle Plaine, Minnesota — DATE OF BURIAL: May 15. 1921.

20. UNDERTAKER: F. M. Williams — ADDRESS: Montpelier, Id

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34079
Registered No.

1. PLACE OF DEATH
County of Bear Lake
City of Montpelier (No. of ..... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 32
Primary Registration District No. 2136

RECEIVED MAY 12 BUREAU OF VITAL STATISTICS

2. FULL NAME Susan G. Henrie

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widow (Write the word.)

6. DATE OF BIRTH: June (Month) 17 (Day) 1828 (Year)

7. AGE: 91 Yrs. 10 Mos. 12 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: James Duncan

11. BIRTHPLACE OF FATHER (State or Country): Penn.

12. MAIDEN NAME OF MOTHER: Hilda Jones

13. BIRTHPLACE OF MOTHER (State or Country): Penn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Robert M. Birch
(Address) Thomas Place

15. Filed May 9th 19 21 — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 9 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 8 1921, to May 8 1921, that I last saw h.. alive on May 8 1921, and that death occurred on the date stated above, at 7 P.M.
The CAUSE OF DEATH* was as follows:
Senility
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) W. P. Gaylord M. D.
5/6 1921 (Address) Montpelier

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Montpelier — DATE OF BURIAL: 5-11-1921

20. UNDERTAKER: J. McCracken — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34080
Registered No.

RECEIVED
MAY 20 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Bear Lake Registration District No. 3-3
City of Bloomington (If outside limits, give township) Primary Registration District No.
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Albert Dunford Jarvis

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	

6. DATE OF BIRTH: November (Month) 14 (Day) 1920 (Year)

7. AGE: Yrs. 5 Mos. 10 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Albert Edwin Jarvis

11. BIRTHPLACE OF FATHER (State or Country) Idaho

12. MAIDEN NAME OF MOTHER Florence Mae Dunford.

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant)
(Address)

15. Filed April 24 1921 Mrs. J. L. Skinner Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 24 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 23 1921, to April 24 1921; that I last saw h... alive on April 23 1921, and that death occurred on the date stated above, at 3 A.M.
The CAUSE OF DEATH* was as follows:
Pneumonia
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) D. L. Sutton M. D.
April 1921 (Address) Paris, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Bloomington	April 25 1921
20. UNDERTAKER	ADDRESS
Bishop Hart	Bloomington

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
JUN 14 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 32
Primary Registration District No. 2049

County of Benewah
City of St Maries (No. ..... St.)

File No. 34082
Registered No. 23

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Joan White

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Dec. (Month) 25 (Day) 1920 (Year)

7. AGE: Yrs. 3 Mos. 1 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: X
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Wash. B. White

11. BIRTHPLACE OF FATHER (State or Country): Kentuckey

12. MAIDEN NAME OF MOTHER: Ada B Utter

13. BIRTHPLACE OF MOTHER (State or Country): Wis.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wash. B White
(Address) St Marias

15. Filed May 27 1921 H E Hunt Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 26 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 2nd 1921, to May 26 1921, that I last saw her alive on May 26 1921, and that death occurred on the date stated above, at 12 45 P.M.

The CAUSE OF DEATH* was as follows:
Pulmonary and Bronchial Pneumonia

(Duration) ..... Yrs. ..... mos. 15 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A D Platt M. D.
5/27/1921 (Address) St Maries Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Woodlawn
DATE OF BURIAL: May 28 1921

20. UNDERTAKER: H E Hunt Co
ADDRESS: St Maries

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
JUN 14 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 32
Primary Registration District No. 2049
File No. 34083
Registered No. 29

1. PLACE OF DEATH

County of Bennah
City of St Maries
(If not in city or town give township)
No. (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Barbara Ann Infant Cummins

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Infant

6. DATE OF BIRTH: May (Month) 9 (Day) 1921 (Year)

7. AGE: ..... Yrs. ..... Mos. 17 ds.
IF LESS than 1 day how many 17 hrs. or 55 min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): St. Maries, Idaho

10. NAME OF FATHER: Wm Edward Cummins

11. BIRTHPLACE OF FATHER (State or Country): Minnesota

12. MAIDEN NAME OF MOTHER: Lillian Ann Scroggins

13. BIRTHPLACE OF MOTHER (State or Country): Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C A Robins
(Address) St Maries Idaho

15. Filed May 10 1921 H E Hurst Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 10 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 9 1921, to May 10 1921 that I last saw her alive on May 10 1921, and that death occurred on the date stated above, at 4.55 P.M.

The CAUSE OF DEATH* was as follows:

Atalectasis

(Duration) ..... Yrs. ..... mos. 1 ds.
Contributory (Secondary) Imperforate anus
(Duration) ..... yrs. ..... mos. 1 ds.

(Signed) C A Robins M. D.
5/10 1921 (Address) St Maries, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. 1 days. In the State ..... yrs. ..... mos. 1 days
Where was disease contracted if not at place of death? —
Former or usual residence —

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Woodlawn	5/11 1921
20. UNDERTAKER	ADDRESS
Mitchell & Mercer	St Maries

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34084

Registered No. 22

Registration District No. 32

Primary Registration District No. 2049

RECEIVED
JUN 14 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Benewah

City of Santa (or Village of) St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mr Samuel Holmes.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	white	Widowed

6. DATE OF BIRTH: May (Month) 29th (Day) 1835 (Year)

7. AGE: 85 Yrs. 11 Mos. 10 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer.

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Lincolnshire, Eng.

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Geo Holmes

(Address) Santa Id.

15. Filed May 12 1921

H E Hunt
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 10 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 9 19..., to May 10 1921, that I last saw him alive on May 8 1921, and that death occurred on the date stated above, at 3 P M.

The CAUSE OF DEATH* was as follows:

Senile Gangrene

(Duration) — Yrs. 1 mos. — ds.

Contributory (Secondary) Age

(Duration) — yrs. — mos. — ds.

(Signed) D Kinsolving M. D.

5/12 1921 (Address) St Maries Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Santa Id. DATE OF BURIAL: 5-12 1921

20. UNDERTAKER: H E Hunt Co ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34085

Registered No. 18

RECEIVED
JUN 14 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 92

Primary Registration District No. 2049

County of Benewah

City of St. Maries (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sarah L. Cornwall

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widowed

6. DATE OF BIRTH: April (Month) 18 (Day) 1858 (Year)

7. AGE: 63 Yrs. — Mos. 14 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife (Retired)

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wisconsin.

10. NAME OF FATHER: — Slater

11. BIRTHPLACE OF FATHER (State or Country): Not known

12. MAIDEN NAME OF MOTHER: — Gray

13. BIRTHPLACE OF MOTHER (State or Country): Not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) L. Cornwall

(Address) St Maries Idaho

15. Filed May 9 1921 H E Lynch Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 2 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 27 1921, to May 2 1921, that I last saw her alive on May 2 1921 and that death occurred on the date stated above, at 8-30 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

15 minutes.

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) O. A. Robinson M. D.

5/3 1921 (Address) St. Maries, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. 6 days. In the State 32 yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? ——

Former or usual residence Moscow, Idaho.

19. PLACE OF BURIAL OR REMOVAL: Moscow Id — DATE OF BURIAL: 5-5-1921

20. UNDERTAKER: H E Lynch Co — ADDRESS: St Maries

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
JUN 14 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 32
Primary Registration District No. 2049
File No. 34086
Registered No. 20

1. PLACE OF DEATH

County of Bonneville
City of Ririe 2
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Marion Frederick Martin

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	white	single

6. DATE OF BIRTH: Apr. (Month) 11 (Day) 1921 (Year)

7. AGE: ..... Yrs. ..... Mos. 23 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: X
(b) General nature of industry, business or establishment in which employed (or employer): X

9. BIRTHPLACE (State or Country): Bonneville Co Idaho

10. NAME OF FATHER: Levi Martin

11. BIRTHPLACE OF FATHER (State or Country): Wisconsin

12. MAIDEN NAME OF MOTHER: Minnie Hamont

13. BIRTHPLACE OF MOTHER (State or Country): Montana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Fred Shafer
(Address) Ririe 2

15. Filed May 5 1921 St Maries Idaho
H E Hunt
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 3 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 11 1921 to Apr 11 1921
that I last saw ~~he~~ alive on Apr 11 1921,
and that death occurred on the date stated above, at Not Known M.

The CAUSE OF DEATH* was as follows:
Smothered, Either accidental or intentional, Mother in room at back and denies to do it
(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Owen V. Platt M. D.
May 5 1921 (Address) St Maries Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Woodlawn	5-6 1921
20. UNDERTAKER	ADDRESS
Mitchell & Manager	St Maries

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34087
Registered No. 19

1. PLACE OF DEATH

Registration District No. 2

Primary Registration District No. 2 0 1 2

County of Benewah

City of St. Maries (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED JUN 14 1921 BUREAU OF VITAL STATISTICS

2. FULL NAME Donald Rockwell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Male	White	Single (Write the word.)

6. DATE OF BIRTH: January (Month) 4 (Day) 1914 (Year)

7. AGE: 7 Yrs. 4 Mos. — ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: School-boy
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Frank D. Rockwell

11. BIRTHPLACE OF FATHER (State or Country): Minnesota

12. MAIDEN NAME OF MOTHER: Clara L Shearer

13. BIRTHPLACE OF MOTHER (State or Country): Minnesota

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Frank D. Rockwell
(Address) St Maries, Idaho

15. Filed May 4 1921 H. E. Knox Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 4 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 29 1921, to May 4 1921, that I last saw him alive on May 3 1921, and that death occurred on the date stated above, at 12-15 P.M.

The CAUSE OF DEATH* was as follows:

Streptococcus Meningitis

(Duration) ... yrs. ... mos. 6 ds.

Contributory (Secondary) Acute Otitis Media Purulent

(Duration) ... yrs. ... mos. ... ds.

5/4 1921 (Signed) C. A. Robins M. D.
(Address) St Maries, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Coeur d Alene	5-5- 1921
20. UNDERTAKER	**ADDRESS**
Mitchell & Mercuger	St Maries

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

46

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34088

Registered No. 4

1. PLACE OF DEATH.

County of Benewah Registration District No.

City of Plummer Primary Registration District No. 2173

(No. St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ada Read

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH. Nov. (Month) 10 (Day) 1874 (Year)

7. AGE: 46 Yrs. 5 Mos. 11 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): Texas Co., Mo.

10. NAME OF FATHER: Daniel Rhodes

11. BIRTHPLACE OF FATHER (State or Country): Mo.

12. MAIDEN NAME OF MOTHER: Nancy Jarrett

13. BIRTHPLACE OF MOTHER (State or Country): Tenn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. W. Barnes
(Address) Worley, Idaho

15. Filed June 9 1921 H. S. Jaeger Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Apr. (Month) 21 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 20 1921, to Apr. 21 1921, that I last saw her alive on a.m. Apr. 21 1921, and that death occured on the date stated above, at p. M.

The CAUSE OF DEATH* was as follows:
Bronchopneumonia

(Duration) Yrs. mos. 30 ds.
Contributory (Secondary) General Debility
(Duration 1 Yrs. mos. ds.

(Signed) J. J. Hirrington M. D.
4/22 1921 (Address) Worley, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Plummer — DATE OF BURIAL: Apr. 23 1921

20. UNDERTAKER: H. S. Jaeger — ADDRESS: Plummer

Held for complete information.

EVANS-YORK CO., PTRS. & STRS. 24658

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 1 34089

RECEIVED
JUN 9 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 37

Primary Registration District No.

County of Bannock

City of Dewmet (No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Gotlieb Luzann

Registered No. 38

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F.	Indian	Widowed

6. DATE OF BIRTH

(Month) (Day) 1 (Year)

7. AGE 85 about Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Not known

11. BIRTHPLACE OF FATHER (State or Country) " "

12. MAIDEN NAME OF MOTHER " "

13. BIRTHPLACE OF MOTHER (State or Country) " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Gotlieb

(Address) Dewmet Ida.

15. Filed May 27 1921

J. E. Bihan
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51083

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May (Month) 25 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....19...., to ....19....

that I last saw h.... alive on ....19....,

and that death occurred on the date stated above, at ....M.

The CAUSE OF DEATH* was as follows:

Cancer

(Duration) ....Yrs. ....mos. ....ds.

Contributory (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) ....M. D.

....19.... (Address) ....

*State the **Disease Causing Death**; or in deaths from **Violent Causes**, state (1) **Means of Injury**; and (2) whether **Accidental, Suicidal or Homicidal.**

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs. ....mos. ....days. In the State ....yrs. ....mos. ....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Dewmet	May 27 1921

20. UNDERTAKER	ADDRESS
J. Falen	Dewmet

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 1 34090
Registered No. 39

RECEIVED
JUN 9 1921
BUREAU OF VITAL STATISTICS

1. **PLACE OF DEATH**

County of Benewah — Registration District No. 21

City of Wesmet — Primary Registration District No. ____ (St.)

If death occurs away from usual residence, give facts called for under special information.

2. **FULL NAME** Henry J. Falcon

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	Indian	

6. **DATE OF BIRTH** Sept 11 1919 (Month) (Day) (Year)

7. **AGE** 1 Yrs. 8 Mos. 17 ds. — IF LESS than 1 day how many ____ hrs. or ____ min.?

8. **OCCUPATION**
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. **BIRTHPLACE** (State or Country) Idaho

10. **NAME OF FATHER** Joseph Falcon

11. **BIRTHPLACE OF FATHER** (State or Country) Idaho

12. **MAIDEN NAME OF MOTHER** Mary Anne Masserla

13. **BIRTHPLACE OF MOTHER** (State or Country) Idaho

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**
(Informant) Joseph Falcon
(Address) Wesmet, Idaho

15. Filed May 28 1921 — J. E. Bihan, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH** May 27 1921 (Month) (Day) (Year)

17. **I HEREBY CERTIFY, That I attended deceased from** ____ 19____, to ____ 19____ that I last saw h____ alive on ____ 19____, and that death occurred on the date stated above, at ____ M.
The CAUSE OF DEATH* was as follows:

Heart disease

(Duration) ____ Yrs. ____ mos. ____ ds.

Contributory (Secondary) ____

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) ____ M. D.

____ 19____ (Address) ____

*State the **Disease Causing Death**; or in deaths from **Violent Causes**, state (1) **Means of Injury**; and (2) whether **Accidental, Suicidal** or **Homicidal.**

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL ~~OR REMOVAL~~	DATE OF BURIAL
Wesmet	May 28 1921
20. UNDERTAKER J. Falcon	**ADDRESS** Wesmet

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34091
Registered No. 66

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

RECEIVED JUN 14 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH. Registration District No. 121
County of Bingham Primary Registration District No. 2194
City of Blackfoot (If outside limits give township) (Ward) (St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Peter Raymond Noble

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): widower
6. DATE OF BIRTH. Oct. (Month) 17 (Day) 1877 (Year)
7. AGE: 43 Yrs. 6 Mos. 1 ds. IF LESS than 1 day how many ..... hrs. or ..... min.
8. OCCUPATION
(a) Trade, profession or particular kind of work: Pool hall manager
(b) General nature of industry, business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Texas
10. NAME OF FATHER: Unknown
11. BIRTHPLACE OF FATHER (State or Country): Unknown
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (State or Country): Unknown
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) acct Asylum Records Matthew E. High - Bookkeeper
(Address) Blackfoot, Ida.
15. Filed April. 5 1921 Wm Wallis E. Patrick Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 16 (Day) 1921 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Sept 28 1920, to April 16 1921, that I last saw h[im] alive on April 16 1921, and that death occured on the date stated above, at 11:30 A.M.
The CAUSE OF DEATH* was as follows:
Status Epilepticus
(Duration) — Yrs. — mos. — ds.
Contributory (Secondary) Epilepsy
(Duration) — yrs. 7 mos. — ds.
(Signed) Carl A. Loomis M. D.
4/17 19 21 (Address) Blackfoot Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. 6 mos. 19 days. In the State ..... yrs. 18 mos. ..... days
Where was disease contracted if not at place of death? Dont Know
Former or usual residence Idaho Falls, Idaho

19. PLACE OF BURIAL OR REMOVAL: Asylum Cemetery — DATE OF BURIAL: Apr. 18, 1921
20. UNDERTAKER: Chas. J. Wright — ADDRESS: Blackfoot Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & STRS. 24658

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34092
Registered No. 67

1. PLACE OF DEATH
County of Bingham
City of Blackfoot (If not in incorporated limits, give township.) St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 121
Primary Registration District No. 2174
RECEIVED
JUN 14 1921
BUREAU OF VITAL STATISTICS

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Patrick Lonergan

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH
(Month) (Day) 1860 (Year)

7. AGE
61 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Illinois

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (State or Country) Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) according to asylum records Asylum Supt.
(Address) Blackfoot Ida.

15.
Filed [illegible] 1921 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
April (Month) 17 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from February 11, 1921 to April 17 1921
that I last saw him alive on April 16, 1921,
and that death occurred on the date stated above, at 1 a. M.
The CAUSE OF DEATH* was as follows:

Cerebral Arteriosclerosis
(Duration) Yrs. mos. ds.
Contributory (Secondary) Epileptic Dementia
(Duration) 1 yrs. 2 mos. 6 ds.

(Signed) Chas. Thorn M. D.
4-16 1921 (Address) [illegible]

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 1 yrs. 2 mos. 6 days. In the State 5 yrs. mos. days
Where was disease contracted if not at place of death? Not known
Former or usual residence Twin Falls, Idaho.

19. PLACE OF BURIAL OR REMOVAL Asylum Cemetery — DATE OF BURIAL Apr. 19 1921

20. UNDERTAKER Chas. J. Wright — ADDRESS Blackfoot Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JUN 14 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34093

Registered No. 68

1. **PLACE OF DEATH**

Registration District No. 121

Primary Registration District No. 2194

County of Bingham

City of Blackfoot (St.)

If death occurs away from usual residence, give facts called for under special information.

2. **FULL NAME** John Sinclair

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. **SEX**: Male

4. **COLOR OR RACE**: White

5. **SINGLE, MARRIED, WIDOWED OR DIVORCED** (Write the word.): Single

6. **DATE OF BIRTH**: February (Month) 27 (Day) 1854 (Year)

7. **AGE**: 67 Yrs. 1 Mos. 27 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. **OCCUPATION**

(a) Trade, profession or particular kind of work: Saw mill worker

(b) General nature of industry, business or establishment in which employed (or employer):

9. **BIRTHPLACE** (State or Country): Columbia, S.C. ~~Unknown~~

10. **NAME OF FATHER**: Unknown

11. **BIRTHPLACE OF FATHER** (State or Country): Unknown

12. **MAIDEN NAME OF MOTHER**: Unknown

13. **BIRTHPLACE OF MOTHER** (State or Country): Unknown

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**

(Informant) asylum Regds Marsha E. Wright-Bookkeeper

(Address) Blackfoot, Idaho

15. Filed April 25 1921 Mrs Walter E. Pabrie Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH**: April (Month) 24 (Day) 1921 (Year)

17. **I HEREBY CERTIFY, That I attended deceased from** March 12 1919, to April 24 1921 that I last saw him alive on April 23 1921, and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

(Parenchymatous), Nephritis

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Psychosis Depressive

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E. A. Lowen M. D.

4/25 1921 (Address) Blackfoot, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 6 yrs. 1 mos. 8 days. In the State ..... yrs. ..... mos. 7 days

Where was disease contracted if not at place of death? Don't Know

Former or usual residence Linton, Ore

19. **PLACE OF BURIAL OR ~~REMOVAL~~**: Asylum Cemetery — **DATE OF BURIAL**: Apl. 25 1921

20. **UNDERTAKER**: Chas. J. Wright — **ADDRESS**: Blackfoot, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34094
Registered No. 69

BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
Registration District No. 121
Primary Registration District No. 2194
County of Bonneville
City of Shelby (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Peter Hulk

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	Caucasian	Married

6. DATE OF BIRTH: 7 (Month) 6 (Day) 1873 (Year)

7. AGE: 48 Yrs. 2 Mos. 3 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER: Andrew Hulk

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Carie Smith

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) [illegible]
(Address) [illegible]

15. Filed May 2 1921 Mrs Hattie E. Waters Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 1 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 27 1921, to May 1 1921, that I last saw h— alive on Apr. 27 1921, and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) ..... Yrs. ..... mos. 3 ds.

Contributory (Secondary) None

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F. W. Roberts M. D.

5/2 1921 (Address) Shelby - Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Shelby, Idaho.	19
20. UNDERTAKER	ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

Registration District No. 127

Primary Registration District No. 2196

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34095

Registered No. 90

1. **PLACE OF DEATH**

County of Bingham

City of Blackfoot (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

BUREAU OF VITAL STATISTICS

2. **FULL NAME** Francisco Ncolalde

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Male	White	Married (Write the word.)

6. **DATE OF BIRTH** ..... (Month) ..... (Day) 1871 (Year)

7. **AGE** 50 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. **OCCUPATION**

(a) Trade, profession or particular kind of work Sheep herder

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. **BIRTHPLACE** (State or Country) Spain

10. **NAME OF FATHER** Unknown

11. **BIRTHPLACE OF FATHER** (State or Country) Unknown

12. **MAIDEN NAME OF MOTHER** Unknown

13. **BIRTHPLACE OF MOTHER** (State or Country) Unknown

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**

(Informant) asylum Records By - Marika E. Hight - Bookkeeper

(Address) Blackfoot Idaho

15. Filed May 5 1921 Mrs Julia E. Patterson Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH** May (Month) 4 (Day) 1921 (Year)

17. **I HEREBY CERTIFY, That I attended deceased from** April 8 1919 to May 4 1921 that I last saw him alive on May 4 1921, and that death occurred on the date stated above, at 9:30 P. M.

The CAUSE OF DEATH* was as follows:

Parenchymatous, Nephritis

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Pneumonia Lobar

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Dr V. Coren M. D.

..... 19..... (Address) .....

*State the **Disease Causing Death**; or in deaths from **Violent Causes**, state (1) **Means of Injury**; and (2) whether **Accidental, Suicidal** or **Homicidal**.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 2 yrs. ..... mos. 28 days. In the State — yrs. — mos. — days

Where was disease contracted if not at place of death? not known

Former or usual residence Nampa, Idaho

19. **PLACE OF BURIAL OR REMOVAL** Asylum Cemetery — **DATE OF BURIAL** May 5 1921

20. **UNDERTAKER** Chas. J. Wright — **ADDRESS** Blackfoot, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

RECEIV
JUN 14 1
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 2194
File No. 34096
Registered No. 71

1. PLACE OF DEATH
County of Bingham
City of Blackfoot (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Robert Swarm.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH
..... (Month) ..... (Day) 1860 (Year)

7. AGE
61 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Telegrapher
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE
(State or Country) Island of Jersey

10. NAME OF FATHER
Unknown

11. BIRTHPLACE OF FATHER
(State or Country) Unknown

12. MAIDEN NAME OF MOTHER
Unknown

13. BIRTHPLACE OF MOTHER
(State or Country) Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) asylum records By Martha E. Higbe, bookkeeper
(Address) Blackfoot, Idaho

15.
Filed May 10 1921 Mrs Mabel E. Fabens
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
May (Month) 10, (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 6 1920, to May 10 1921 that I last saw him alive on May 9 1921, and that death occurred on the date stated above, at 3:30 P.M.
The CAUSE OF DEATH* was as follows:

Embolism

..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Paralysis Dementia
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) C. A. Foran M. D.
5/10 1921 (Address) Blackfoot Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. 7 mos. 4 days. In the State 12 yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? Unknown
Former or usual residence Paris, Idaho

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Asylum Cemetery	May 10, 1921
20. UNDERTAKER	ADDRESS
Chas. J. Enright	Blackfoot, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34097

Registered No. 72

1. PLACE OF DEATH

RECEIVED
JUN 14 1921
BUREAU OF VITAL STATISTICS

Registration District No. 121

Primary Registration District No. 2194

County of Bingham

City of Kimball (or Village of, or Township of, or Precinct of, and St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Francis Reed Landon

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: May (Month) 15 (Day) 1919 (Year)

7. AGE: 1 Yrs. 11 Mos. 27 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: at home

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kimball Idaho

10. NAME OF FATHER: Francis Samuel Landon

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Eldora Mortensen

13. BIRTHPLACE OF MOTHER (State or Country): Nevada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Francis S. Landon.

(Address) Kimball - Idaho.

15. Filed May 13 1921 Mrs Nalin E. Paton Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 11 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 2 1921 to May 11 1921 that I last saw him alive on May 11 1921, and that death occurred on the date stated above, at 6 P M.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar

(Duration) ..... Yrs. ..... mos. 9 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Edward Reed M. D.

May 13 1921 (Address) Firth Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Firth - Idaho. DATE OF BURIAL: May 13 1921

20. UNDERTAKER: W. B. Taylor ADDRESS: Bfoot - R 3

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 121

County of Bingham

Primary Registration District No. 2194

File No. 34098

City of Pleasant View (No. ..... St.)

Registered No. 573

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
JUN 14 1921
BUREAU OF VITAL STATISTICS

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ida Drusilla Hall

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Jan (Month) 25 (Day) 1921 (Year)

7. AGE: ..... Yrs. 3 Mos. 20 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Pocatello Ida

10. NAME OF FATHER: Roy Hall

11. BIRTHPLACE OF FATHER (State or Country): Ky

12. MAIDEN NAME OF MOTHER: Jenera Ellicott

13. BIRTHPLACE OF MOTHER (State or Country): Ky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Roy Hall

(Address) Blackfoot Route 5

15. Filed May 17 1921 Mrs Nalvin E. Peterce
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 15 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I ~~attended deceased from~~ Immediately

..... 19....., to ..... 19.....

~~that I last saw her alive on~~ ..... 19.....,

and that death occurred on the date stated above, at 7 A.M.

The CAUSE OF DEATH* was as follows: Sudden death from

Cause unknown

Found dead in bed

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

May 19 21 (Address) Blackfoot Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Moreland Idaho — DATE OF BURIAL: May 19 21

20. UNDERTAKER: Roy Hall — ADDRESS: .....

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JUN 14 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34099

Registered No. 7

1. PLACE OF DEATH

County of Bingham

City of Blackfoot

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 121

Registration District No. 2194

(No. ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Joseph Merrell

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Sept (Month) 22 (Day) 1847 (Year)

7. AGE: 73 Yrs. 7 Mos. 26 ds.

IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Council Bluffs Iowa

10. NAME OF FATHER: Charles Merrell

11. BIRTHPLACE OF FATHER (State or Country): U. S.

12. MAIDEN NAME OF MOTHER: Sara L Finley

13. BIRTHPLACE OF MOTHER (State or Country): U S.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Martha A Merrell

(Address) East Blackfoot

15. Filed May 19 1921 Mrs Nadine E. Patrick Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 18 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 25 1920, to May 18 1921, that I last saw him alive on Feb 20 1921, and that death occurred on the date stated above, at 5P. M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Rectum

(Duration) 2 Yrs. — mos. — ds.

Contributory (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) C W Beck M. D.

May 19 1921 (Address) Blackfoot Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Grove City Cemetery

DATE OF BURIAL: May 20 1921

20. UNDERTAKER: Ed L Egli

ADDRESS: Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-17

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34100
Registered No. 70

JUN 1 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH.
Registration District No. 101
Primary Registration District No. 2174
County of Bingham
City of Moreland (If outside limits, give township) (No. St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sylvia Wray

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH. August 21 1921 (Month) (Day) (Year)

7. AGE 3 Yrs. 8 Mos. 27 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... At home
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Moreland Idaho

10. NAME OF FATHER John Vernon Wray

11. BIRTHPLACE OF FATHER (State or Country) Hyrum Utah

12. MAIDEN NAME OF MOTHER Eva Christensen

13. BIRTHPLACE OF MOTHER (State or Country) Hyrum Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. Vernon Wray
(Address) Moreland Idaho

15. Filed May 19 1921 Mrs Walter E. Pate Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 18 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 20 1921, to May 18 1921, that I last saw her alive on May 18 1921, and that death occured on the date stated above, at 9:35 P.M.

The CAUSE OF DEATH* was as follows:
Empyema

(Duration) ..... Yrs. ..... mos. 15 ds.
Contributory (Secondary) measles
(Duration ..... yrs. 1 mos. ..... ds.

(Signed) H. J. Simmons M. D.
5/19 1921 (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Moreland Ida	May 20 1921

20. UNDERTAKER	ADDRESS
Ed L. Egli	Blackfoot Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SVMS - YORK CO., PTRS. & PBRS. 24658

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (b) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers,* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, *septicemia,*" "PUERPERAL *peritonitis,*" etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

Form V. S. No. 1-15 M. 7-19.

CERTIFICATE OF DEATH

1. PLACE OF DEATH — RECEIVED — Registration District No. 2007 — Reg. No. 47

JUN 14 1921

BUREAU OF VITAL STATISTICS

County of Bingham — Primary Registration District No. — Certificate No.

City of Blackfoot (If outside limits of city or village, give township) — No. 60 East Pacific St.) — Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Isaac Stewart

If death occurred in hospital, institution or other place, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE in terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: October (Month) 9 (Day) 1850 (Year)

7. AGE: 70 Yrs. 6 Mos. 27 ds. — IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farming
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Indiana

10. NAME OF FATHER: James M. Stewart

11. BIRTHPLACE OF FATHER (State or Country): Pennsylvania

12. MAIDEN NAME OF MOTHER: Susan Mason

13. BIRTHPLACE OF MOTHER (State or Country): Pennsylvania

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Frank S. Stewart
(Address): 174 North Main Salt Lake, Utah

15. May 24 Mar Undertaking Co

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 6 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 15 1921, to May 6 1921, that I last saw he alive on May 5 1921, and that death occurred on the date stated above, at 12.25 P.M.

The CAUSE OF DEATH* was as follows:

Cardiac insufficiency

(Duration) — Yrs. 6 mos. — ds.

Contributory (Secondary): Exophthalmic Goitre

(Duration) 1 yrs. 6 mos. — ds.

(Signed) C W Beck M. D.

5/6 1921 (Address) Blackfoot, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Ferm Cal Cemetery — DATE OF BURIAL: 5/8 1921

ADDRESS

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34102
Registered No. 77

1. PLACE OF DEATH. Registration District No. 121
County of Bingham Primary Registration District No. 2194
City of Blackfoot (If not in city give township) St.)
If death occurs away from usual residence, give facts called for under special information.

RECEIVED
JUN 14 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME Ricardo Cabrera

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Mexican
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH. April (Month) 4 (Day) 1921 (Year)
7. AGE ..... Yrs. 1 Mos. 2 ds. IF LESS than 1 day how many .....hrs. or .....min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Idaho
10. NAME OF FATHER: Maximiano Cabrera
11. BIRTHPLACE OF FATHER (State or Country): Mexico
12. MAIDEN NAME OF MOTHER: Toney Barleto
13. BIRTHPLACE OF MOTHER (State or Country): Mexico
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) K Nishida
(Address) Blackfoot, Idaho
15. Filed May 7 1921 Wm Wallace E Fall Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 7 (Day) 1921 (Year)
17. I HEREBY CERTIFY, That I attended deceased from May 7 1921, to May 7 1921, that I last saw him alive on May 7 1921, and that death occured on the date stated above, at 7:00 A. M.
The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) — Yrs. — mos. 3 ds.
Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) W. W. Beck M. D.
May 7 1921 (Address) Blackfoot, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL 191.....
20. UNDERTAKER | ADDRESS
Wilson & Wilson

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SVMS - YORK CO., PTRS. & SUPP. 24854

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34103

Registered No. 78

RECEIVED
JUN 14 1921
BUREAU OF VITAL STATISTICS

Registration District No. 121

Primary Registration District No. 2194

1. PLACE OF DEATH

County of Bingham

City of ..... (If outside limits of city or village, write the word "Not.")

No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ronald G. Bankhead

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH: January (Month) 14 (Day) 1912 (Year)

7. AGE: 9 Yrs. 3 Mos. 26 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At school
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Nyrum Utah

10. NAME OF FATHER: George Bankhead

11. BIRTHPLACE OF FATHER (State or Country): Ashley Utah

12. MAIDEN NAME OF MOTHER: Agnes Jensen

13. BIRTHPLACE OF MOTHER (State or Country): Nyrum Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) George Bankhead
(Address) Blackfoot R D # 2

15. Filed May 14 1921 Mrs Nolie E. Peterson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 10 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 10 1921 to May 10 1921 that I last saw him alive on May 10 1921 and that death occurred on the date stated above, at 3 30 P. M.

The CAUSE OF DEATH* was as follows:

Fracture of Skull

(Duration) ..... yrs. ..... mos. 1 ds.

Contributory (Secondary) Thrombosis Sinus

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. C. Mitchell M. D.

5/17 1921 (Address) Blackfoot Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL ..... 19.....

20. UNDERTAKER Ed D'Eglise | ADDRESS Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34104

Registered No. 79

1. PLACE OF DEATH

County of Bingham

City of Kimball (St.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED JUN 14 1921 BUREAU OF VITAL STATISTICS

Registration District No. 121

Primary Registration District No. 219

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Melda Floy Nielsen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Feb (Month) 20 (Day) 1921 (Year)

7. AGE: Yrs. 2 Mos. 23 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: at home

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kimball Idaho

10. NAME OF FATHER: Ammon E. Nielsen

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Thera Frandsen

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Leslie M. Nielsen

(Address) Kimball Idaho

15. Filed May 13 1921 Mrs Hattie E. Tibbs Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 13 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 11 1921, to May 13 1921, that I last saw her alive on May 13 1921, and that death occurred on the date stated above, at 2 A.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ..... Yrs. ..... mos. 3 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Edward Reed M. D.

May 13 1921 (Address) Firth Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Basalt — DATE OF BURIAL: 5-15 1921

20. UNDERTAKER acting: Leslie M. Nielsen — ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
JUN 14 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34105

Registered No. 80

1. PLACE OF DEATH

County of Bingham Registration District No. 121

City of Riverside Primary Registration District No. 2194

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Violate Gertrude Kalian

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: July (Month) 3 (Day) 1896 (Year)

7. AGE: 24 Yrs. 10 Mos. 20 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Salt Lake City Utah

10. NAME OF FATHER: Anson Kessler

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Anna Wixey

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Geo W. Kalian

(Address) Blackfoot Idaho

15. Filed May 24 1921 Mrs Walter E. Pate Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 23 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ——— 19—, to ——— 19.....

that I last saw h..... alive on ..... 19.....,

and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Arsenical poisoning accidently taken

Coroners Jury verdict

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Ed L. Egli Coroner M. D.

5/24 1921 (Address) Blackfoot Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Salt Lake City Ut — DATE OF BURIAL: 5/26/1921

20. UNDERTAKER: Ed L Egli — ADDRESS: Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED
JUN 14 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34106

Registered No. 61

1. PLACE OF DEATH.

Registration District No. 121

County of Bingham Primary Registration District No. 2194

City of Pingree (If not in city give township) St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ellen Brown

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): Married

6. DATE OF BIRTH. Dec (Month) 27 (Day) 1854 (Year)

7. AGE: 66 Yrs. 5 Mos. 1 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Lehi Utah

10. NAME OF FATHER: John Wood

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Ellen Smith

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary E Burriston

(Address) Dividend Utah

15. Filed May 24 1921 Mrs Hallie E Tibbets Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 28 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 20 1921, to May 28 1921, that I last saw her alive on May 23 1921 and that death occured on the date stated above, at 3:00 P.M.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) Yrs. mos. 8 ds.

Contributory (Secondary)

(Duration yrs. mos. ds.

(Signed) W W Beck M. D.

5/28 1921 (Address) Blackfoot, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Thomas Riverside — DATE OF BURIAL: May 30 1921

20. UNDERTAKER: McEwan & Elliott — ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24654

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JUN 14 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34107
Registered No. 82.

1. PLACE OF DEATH

County of Bingham Registration District No. 121
City of Shelley Primary Registration District No. 2194
(If outside limits of city or village, give township, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Peter Parker Parsons

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH August 21 (Month) (Day) 1879 (Year)

7. AGE 40 Yrs. 9 Mos. 8 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Isham A Parsons

11. BIRTHPLACE OF FATHER (State or Country) North Carolina

12. MAIDEN NAME OF MOTHER Elizabeth Hendricks

13. BIRTHPLACE OF MOTHER (State or Country) Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Isham A Parsons
(Address) Blackfoot

15. Filed May 31 1921 Mrs Nellie E Parsons Local Registrar

SUNS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 29 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows: Drowning in Snake River accidental

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Ed L Egli Coroner M. D.
5/31 1921 (Address) Blackfoot Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Thomas & Riverside — **DATE OF BURIAL** June 1 1921

20. UNDERTAKER Ed L Egli — **ADDRESS** Blackfoot

Form V. S. No. 5. 10M. 6-20-11. RECEIVED JUN 14 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34108
Registered No. 83

1. PLACE OF DEATH. Registration District No. 121
County of Bingham Primary Registration District No. 2194
City of Blackfoot (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Hudson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: f
4. COLOR OR RACE: w
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: May (Month) 29 (Day) 1921 (Year)

7. AGE: ..... yrs. ..... mos. ..... ds. IF LESS than 1 day how many 1 hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession, or particular kind of work: Infant
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Blackfoot. Idaho

10. NAME OF FATHER: Samuel P. Hudson

11. BIRTHPLACE OF FATHER (State or Country): Tenn

12. MAIDEN NAME OF MOTHER: Rachel Alice Wheeler

13. BIRTHPLACE OF MOTHER (State or Country): Ills

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R. H. Jackson
(Address) Blackfoot. Idaho

15. Filed May 30 1921 Mrs Walter E. Fatzer Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 29 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 29 1921, to May 29 1921, that I last saw her alive on May 29 1921, and that death occurred on the date stated above, at 5-30 P. M.

The CAUSE OF DEATH* was as follows:

Infantile Debility
1 hour
(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) R. H. Jackson M. D.
May 30 1921 (Address) Blackfoot. Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place ..... In the 1 hour
of death ..... yrs. ..... mos. ..... ds. State ..... yrs. ..... mos. ..... ds.
Where was Disease contracted, ...
If not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Moreland
DATE OF BURIAL: May 30 1921

20. UNDERTAKER: Ed L Eyli
ADDRESS: Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

Form V. S. No. 5. 10M. 6-20-[illegible] RECEIVED JUN 1 [illegible] BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 121
County of Bingham Primary Registration District No. 2194
City of Blackfoot (No. ....., ... St.)
File No. 34109
Registered No. 84
If death occurs away from usual residence, give facts called for under special information.
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Oscar Hudson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	W	Single

6. DATE OF BIRTH May 29 1921 (Month) (Day) (Year)

7. AGE ..... yrs. ..... mos. ..... ds. IF LESS than 1 day how many 8 hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession, or particular kind of work Infant.
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Blackfoot Ida

10. NAME OF FATHER Samuel P. Hudson

11. BIRTHPLACE OF FATHER (State or Country) Tenn

12. MAIDEN NAME OF MOTHER Rachel Alice Wheeler

13. BIRTHPLACE OF MOTHER (State or Country) Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R. L. Jackson
(Address) Blackfoot, Idaho.

15. Filed May 30 1921 Mrs Nalor E. Pabst Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 30 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 29 1921, to May 30 1921 that I last saw him alive on May 29 1921, and that death occurred on the date stated above, at 12 30 P. M.

The CAUSE OF DEATH* was as follows:
Infantile Debility
8 hours
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) R. L. Jackson M. D.
May 30 1921 (Address) Blackfoot Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Moreland — DATE OF BURIAL May 30 1921

20. UNDERTAKER Ed L Egli — ADDRESS Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & RULERS, BOISE 16672

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
JUN 14 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 121

Primary Registration District No. 1007

File No. 34110

Registered No. 85

County of Bingham

City of Blackfoot (28 So University St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Emmer Thorne Cobbley

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widow (Write the word.)

6. DATE OF BIRTH: March (Month) 16 (Day) 1848 (Year)

7. AGE: 73 Yrs. 2 Mos. 14 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: At home

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): London England

10. NAME OF FATHER: David Thorne

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Elizabeth Reeves

13. BIRTHPLACE OF MOTHER (State or Country): England.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Geo. J. Cobbley

(Address) Wapello

15. Filed May 31 1921 Mc Nalie C. Patrick
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 30 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 17 1921, to May 30 1921 that I last saw her alive on May 30 1921 and that death occurred on the date stated above, at 10 40 A M.

The CAUSE OF DEATH* was as follows:

Abscess of Lung

(Duration) ..... Yrs. 1 mos. ..... ds.

Contributory (Secondary) Valvular Disease Heart

(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) M. E. Patrick M. D.

May 31 1921 (Address) Blackfoot Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Pleasant Grove — DATE OF BURIAL: June 1

20. UNDERTAKER: Ed L. Eyle — ADDRESS: Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 121

Primary Registration District No. 2194

File No. 34111

Registered No. 55

County of Bingham

City of Blackfoot (St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

RECEIVED
APR 20 1921
BUREAU OF VITAL STATISTICS
STATE OF IDAHO

2. FULL NAME Alvin Levi Bruce

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: January (Month) 6 (Day) 1920 (Year)

7. AGE: 1 Yrs. 2 Mos. 26 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Wm Franklin Bruce

11. BIRTHPLACE OF FATHER (State or Country): Texas

12. MAIDEN NAME OF MOTHER: Nellie May Beasley

13. BIRTHPLACE OF MOTHER (State or Country): Colorado

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) William Franklin Bruce

(Address) Blackfoot Ida April 11, 1921

15. Filed April 3 1921 Mrs Nalie E. Patrick Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 1 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 1 1921, to April 1 1921, that I last saw h[illegible] alive on April 1 1921 and that death occurred on the date stated above, at 1 P M.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(Duration) 1 Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F C Nibbeck M. D.

4/2 1921 (Address) Blackfoot Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Fairview City Cemetery — DATE OF BURIAL: April 3 1921

20. UNDERTAKER: E J Funk — ADDRESS: Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED MAY 20 BUREAU OF STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 1007
File No. 3412
Registered No. 56

1. PLACE OF DEATH
County of Bingham
City of Blackfoot (238 No Stout St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William H. Boomgardner (Boomgarner)
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Widowed

6. DATE OF BIRTH: Not known (Month) (Day) 1 (Year)

7. AGE: about 76 Yrs. Mos. ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Pa.

10. NAME OF FATHER: Not known

11. BIRTHPLACE OF FATHER (State or Country): Not known

12. MAIDEN NAME OF MOTHER: Not known

13. BIRTHPLACE OF MOTHER (State or Country): Not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Julia L Young
(Address) Shelley

15. Filed April 4 1921 Mrs Wales E. Patrie Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr (Month) 1 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 29 1921 to Apr 1 1921 that I last saw h[illegible] alive on Apr 1 1921 and that death occurred on the date stated above, at 11 P M.

The CAUSE OF DEATH* was as follows: Pneumonia Influenza

(Duration) Yrs. mos. 10 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) W. E. Patrie M. D.

4/2 1921 (Address) Blackfoot Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. 3 days. In the State 20 yrs. mos. days
Where was disease contracted if not at place of death? Shelley
Former or usual residence Shelley Ida

19. PLACE OF BURIAL OR REMOVAL: Grove City Cemetery — DATE OF BURIAL: Apr 4 1921

20. UNDERTAKER: Ed L Eyli — ADDRESS: Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
MAY 20 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Bingham
City of Shelley (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 171
Primary Registration District No. 2194
File No. 34113
Registered No. 57
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ruth Nelson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Infant (Write the word.)

6. DATE OF BIRTH: Apr. (Month) 8 (Day) 1921 (Year)

7. AGE: ..... Yrs. ..... Mos. Infant ds. 4 hrs.
IF LESS than 1 day how many 4 hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant.
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Shelley Ida

10. NAME OF FATHER: Charles Nelson

11. BIRTHPLACE OF FATHER (State or Country): California

12. MAIDEN NAME OF MOTHER: Lillie Nelson

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Charles A. Nelson
(Address) Shelley Ida.

15. Filed April 8 1921 Mrs Nellie E. Pitts Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 8 (Day) 19 21 (Year)

17. I HEREBY CERTIFY, That I attended deceased from from birth, 19..... to 19....., that I last saw h..... alive on 19....., and that death occurred on the date stated above, at .....M.
The CAUSE OF DEATH* was as follows:

Prematurity — 5½ months

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D. P. Egbert M. D.
Apr. 9 1921 (Address) Shelley Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Green City Cem. Blackfoot — DATE OF BURIAL: Apr 9 1921

20. UNDERTAKER: Charles A Nelson — ADDRESS: Shelley Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
MAY 20 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 121

Primary Registration District No. 1007

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34114

Registered No. 5-8

1. PLACE OF DEATH

County of Bingham

City of Blackfoot (No. ..... East Court St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Hanna Emmy Carlson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Fem	White	Married

6. DATE OF BIRTH: Oct (Month) 21 (Day) 1857 (Year)

7. AGE: 63 Yrs. 5 Mos. 18 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER: Rundquist

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Jarnquist

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A. E. Carlson
(Address):

15. Filed April 11 1921 Mrs Hazel E. Fabre
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 9 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 9 1921, to April 9 1921, that I last saw her alive on April 9 1921, and that death occurred on the date stated above, at 4:40 P.M.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(Duration) 10 Yrs. ~ mos. ~ ds.

Contributory (Secondary)

(Duration) ~ yrs. ~ mos. ~ ds.

(Signed) F. L. Mitchell M. D.

4/10 1921 (Address) Blackfoot Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Firm City Cemetery | DATE OF BURIAL: April 11 1921

20. UNDERTAKER: E. J. Funk | ADDRESS: Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
MAY 20 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 121

Primary Registration District No. 2194

File No. 34115

Registered No. 37

County of Bingham

City of Blackfoot (No. 616 4 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Margot Paulsen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Jan (Month) 23 (Day) 1921 (Year)

7. AGE: Yrs. 7 Mos. 18 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Erling K. Paulsen

11. BIRTHPLACE OF FATHER (State or Country): Norway

12. MAIDEN NAME OF MOTHER: Mary P Eldredge

13. BIRTHPLACE OF MOTHER (State or Country): Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) Erling K. Paulsen

15. Filed April 11 1921 Mrs Walter E Peters Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 10 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 10 1921, to Apr 10 1921 that I last saw her alive on Jan 23 1921 and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Baby was dead when I was called

Cardiac insufficiency (Duration) Unknown ds.

Contributory (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W W Beck M. D.

4/11 1921 (Address) Blackfoot, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Fem City Cemetery — DATE OF BURIAL: 4/11 1921

20. UNDERTAKER: E J Funk — ADDRESS: Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34116
Registered No. 60

1. PLACE OF DEATH.

RECEIVED MAY 20 1921 BUREAU OF VITAL STATISTICS

Registration District No. 131
Primary Registration District No. 2194
County of Bingham
City of Blackfoot (or) ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Rachael Lloyd

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1862 (Year)

7. AGE: 59 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: Henry Wilson

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) By the Asylum Records Martha E. Higgs
(Address) Blackfoot Idaho

15. Filed April 17 1921 Mrs Walter E. Fisher Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 12 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 22 1920, to April 12 1921, that I last saw h[illegible] alive on April 11 1921, and that death occured on the date stated above, at 10:10 a. M.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
.....
.....
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Arterio sclerosis
(Duration) ..... Yrs. ..... mos. ..... ds.
(Signed) C. A. Hoppe M. D.
4.12.1921 (Address) Blackfoot. Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. 8 mos. 20 days. In the State 29 yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? Unknown
Former or usual residence Elva, Idaho

19. PLACE OF BURIAL OR REMOVAL: Elba Idaho — DATE OF BURIAL: 191

20. UNDERTAKER: Ed L. Egli — ADDRESS: Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & ENGS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 171
Primary Registration District No. 2194
File No. 34117
Registered No. 61

1. PLACE OF DEATH.

County of Bingham RECEIVED MAY 20 1921
City of Blackfoot (If outside limits, give township) St.)
If death occurs away from usual residence, give facts called for under special information.

BUREAU OF VITAL STATISTICS

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Henry Smalley

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Divorced

6. DATE OF BIRTH. (Month) (Day) 1834 (Year)

7. AGE 87 Yrs. Mos. ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... None - Has been farmer
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) England

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (State or Country) Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) according to asylum Records Manika E. High - Bookkeeper
(Address) Blackfoot, Idaho.

15. Filed Apr 16 1921 Mrs Nellie E. Patrick Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 15 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 13 1920 to April 15 1921, that I last saw him alive on April 15, 1921, and that death occured on the date stated above, at 6, P. M.

The CAUSE OF DEATH* was as follows: Exhaustion, due to Senility and Arterial Sclerosis

(Duration) Yrs. 3 mos. ds.
Contributory (Secondary) Senility & Sclerosis
(Duration 1 Yrs. 2 mos.) ds.

(Signed) A. F. Hoover M. D.
4-16 1921 (Address) Blackfoot, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 1 yrs. 1 mos. 2 days. In the State yrs. mos. days
Where was disease contracted if not at place of death? Capt says
Former or usual residence Buhl, Idaho

19. PLACE OF BURIAL OR REMOVAL Asylum Cemetery — DATE OF BURIAL 4-16 1921

20. UNDERTAKER C. J. Wright — ADDRESS Blackfoot, Ida

PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

YORK CO. PTG. & BOOK. 24653

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

Registration District No. 121

Primary Registration District No. 2194

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34118

Registered No. 62

RECEIVED
MAY 20 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Bingham

City of Pingree (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Martha Ellen Chappell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Married

6. DATE OF BIRTH: Dec. (Month) 16 (Day) 1880 (Year)

7. AGE: 40 Yrs. 4 Mos. 1 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: Hyrum Lunsford

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Melissa Jane Dickson

13. BIRTHPLACE OF MOTHER (State or Country): Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Edward M Chappell
(Address) Pingree

15. Filed April 8 1921 Mrs Nalie E. Patrick
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 16 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 14 1921, to April 15 1921 that I last saw h— alive on April 15 1921 and that death occurred on the date stated above, at 9.30 P. M.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(Duration) 1 Yrs. — mos. — ds.

Contributory (Secondary)

(Duration) — yrs. — mos. — ds.

(Signed) J. A. Mitchell M. D.

4/16 1921 (Address) Blackfoot Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Springfield Ida — DATE OF BURIAL: April 18 1921

20. UNDERTAKER: Ed L'Egli — ADDRESS: Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 127
Primary Registration District No. 1007
File No. 34119
Registered No. 63

RECEIVED
MAY 20 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Bingham
City of Blackfoot (No. 417 Parish Cleveland St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Francis Ray

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR, DIVORCED (Write the word.)
Male	White	Widow

6. DATE OF BIRTH: April (Month) 7 (Day) 1838 (Year)

7. AGE: 83 Yrs. — Mos. 13 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Joseph Jeffers

11. BIRTHPLACE OF FATHER (State or Country): U. S.

12. MAIDEN NAME OF MOTHER: Sophia Browning

13. BIRTHPLACE OF MOTHER (State or Country): Maryland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Alice Conkle
(Address) Blackfoot Idaho

15. Filed Apr 22 19 21 Mrs Nalee E. Patrick
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 20 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 10 1921, to April 20 1921, that I last saw h[illegible] alive on April 20 1921, and that death occurred on the date stated above, at 6:30 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... Yrs. ..... mos. 16 ds.

Contributory (Secondary) —

(Duration) — yrs. — mos. — ds.

(Signed) F. W. Mitchell M. D.

4/21 1921 (Address) Blackfoot, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Fremont City Cemetery	April 22 1921

20. UNDERTAKER	ADDRESS
E J Funk	Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED MAY 20 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Bingham — Registration District No. 121
City of Blackfoot — Primary Registration District No. 1007
(If outside limits of city or village, give township) — (No. 215 North Ash St.)
File No. 34120
Registered No. 64

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elvira Ransom Hill

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Married

6. DATE OF BIRTH: February (Month) 28 (Day) 1891 (Year)

7. AGE: 30 Yrs. 1 Mos. 28 ds. — IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Trenton Utah

10. NAME OF FATHER: James R Ransom

11. BIRTHPLACE OF FATHER (State or Country): Salt Lake City

12. MAIDEN NAME OF MOTHER: Agnes E Austin

13. BIRTHPLACE OF MOTHER (State or Country): Logan Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) David Earl Hill
(Address) 20 71 Ash St

15. Filed Apr 27 1921 — Mrs Nellie E. Pate, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr (Month) 26 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from February 12 1921, to April 26 1921, that I last saw h.se alive on April 26 1921, and that death occurred on the date stated above, at 5-30 P.M.

The CAUSE OF DEATH* was as follows:

Acute Parenchymatous Nephritis

(Duration) 1 Yrs. 2 mos. ..... ds.

Contributory (Secondary): Pregnancy

(Duration) ..... yrs. 9 mos. ..... ds.

(Signed) A W Beck M. D.

Apr 27 1921 (Address) Blackfoot, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Grove City Cemetery	Apr 29 1921

20. UNDERTAKER	ADDRESS
Ed L Eyli	Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY; PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

RECEIVED MAY 20 1921 BUREAU OF VITAL STATISTICS

Registration District No. 121

County of Bingham — Primary Registration District No. 2177

City of Blackfoot (St.)

File No. 34121

Registered No. 65

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jas. Marks

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Male.	W.	Single (Write the word.)

6. DATE OF BIRTH: June (Month) 18 (Day) ~~19~~ 1905 (Year)

7. AGE: 15 Yrs. 10 Mos. 12 ds. — IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: School boy
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Louis Mark

11. BIRTHPLACE OF FATHER (State or Country): Italy

12. MAIDEN NAME OF MOTHER: Jennie Lang

13. BIRTHPLACE OF MOTHER (State or Country): Italy.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jacob Marks
(Address) Pingree

15. Filed May 1 1921 — Mrs Nellie E. Petrie, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 30 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 29 1921, to April 30 1921, that I last saw h.im alive on April 30 1921, and that death occurred on the date stated above, at 10 P M.

The CAUSE OF DEATH* was as follows:

Gun-shot wound through liver

(Duration) \ Yrs. \ mos. 1 ds.

Contributory (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W W Beck M. D.

May 1 1921 (Address) Blackfoot, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Salt Lake City — DATE OF BURIAL: 5-2 1921

20. UNDERTAKER: E. S. Funk — ADDRESS: Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34122 4
Registered No. 53

RECEIVED
JUN 3 1921
BUREAU OF VITAL STATISTICS

Registration District No. 116
Primary Registration District No. 2155

1. PLACE OF DEATH.
County of Bingham
City of Aberdeen (If outside limits, give township) St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Carolina Schmidtgall

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: widowed (Write the word.)

6. DATE OF BIRTH. Jan (Month) 21. (Day) 1847 (Year)

7. AGE: 74 Yrs. 3 Mos. 14 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Russia

10. NAME OF FATHER Johannes Baer

11. BIRTHPLACE OF FATHER (State or Country) Russia

12. MAIDEN NAME OF MOTHER Marie Musschel

13. BIRTHPLACE OF MOTHER (State or Country) Russia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Albert Schmidtgall
(Address) Aberdeen Ida

15. Filed May 6 21 191 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 5 21 191
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 16 1920, to May 5 1921, that I last saw her alive on May 5 1921, and that death occured on the date stated above, at 12 A. M.

The CAUSE OF DEATH* was as follows:
Cerebral Hacimorrhage

(Duration) 1 Yrs. 2 mos. ds.

Contributory (Secondary)
(Duration yrs. mos. ds.

(Signed) M. C. McGuinn M. D.
May 5 1921 (Address) Aberdeen Ida

State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Pleasant Valley — DATE OF BURIAL: May 8 1921

20. UNDERTAKER: Reeds — ADDRESS: —

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STDRS. 24658

FORM V. S. No. 5-25 M. 1-19.

34123

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 116
Primary Registration District No. 2195
File No. 4
Registered No. 54

RECEIVED JUN 3 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Bingham
City of Aberdeen (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Nora May Stone

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Single

6. DATE OF BIRTH: August 1 (Month) (Day) 1904 (Year)

7. AGE: 16 Yrs. 9 Mos. 13 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At school
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Salem Utah

10. NAME OF FATHER: David A Stone

11. BIRTHPLACE OF FATHER (State or Country): Salem Utah

12. MAIDEN NAME OF MOTHER: Aurelia Jackman

13. BIRTHPLACE OF MOTHER (State or Country): Deamond Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): David A Stone
(Address): Aberdeen

15. Filed May 14 19 21 M. C. Mortimer
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 14 (Month) (Day) 19 21 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 7 19 21 to May 14 19 21
that I last saw h. alive on May 13 19 21
and that death occurred on the date stated above, at 2 A.M.
The CAUSE OF DEATH* was as follows:
Bronchio-pneumonia

(Duration) Yrs. 1 mos. 7 ds.
Contributory (Secondary) myocarditis
(Duration) — yrs. — mos. 4 ds.

(Signed) M. C. Mortimer M. D.
May 14 1921 (Address) Aberdeen Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Salem Utah	May 19

20. UNDERTAKER	ADDRESS
Blanford Undertaking Co	Blanford Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

GUMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

34124 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 4

Registered No. 55

RECEIVED JUN 3 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH.

Registration District No. 116

County of Bingham

Primary Registration District No. 2155

City of Aberdeen (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Alsia Ann Buckner

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH. Aug (Month) 1 (Day) 1845 (Year)

7. AGE: 75 Yrs. 9 Mos. 14 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Georgia

10. NAME OF FATHER: Young Abercrombie

11. BIRTHPLACE OF FATHER (State or Country): Georgia

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John M Buckner

(Address) Aberdeen Ida

15. Filed May 16 21 M C Martinson Local Registrar

SYMS - YORK CO., PTRS. & ENGRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 15 (Day) 21 (Year) 191

17. I HEREBY CERTIFY, That I attended deceased from May 191 9, to May 15 191 21, that I last saw h alive on May 15 191 21, and that death occured on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Rheumatism
(Articular)

(Duration) 2 Yrs. — mos. — ds.

Contributory (Secondary): Pneumonia (Broncho)

(Duration 3 yrs. mos. ds.

(Signed) M. C. Martinson M. D.

5/16 19 21 (Address) Aberdeen Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: I.O.O.F. Cemetery Aberdeen Ida

DATE OF BURIAL: May 17 191 21

20. UNDERTAKER: Friends

ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

34125 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 116
Primary Registration District No. 2150
File No. 4
Registered No. 56

1. PLACE OF DEATH.
County of Bingham
City of Aberdeen
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Viola Lorena Seefried

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. March 7 1920 (Month) (Day) (Year)

7. AGE: 1 Yrs. 2 Mos. 16 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: William Seefried

11. BIRTHPLACE OF FATHER (State or Country): Russia

12. MAIDEN NAME OF MOTHER: Christina Seefried

13. BIRTHPLACE OF MOTHER (State or Country): Russia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) William Seefried
(Address) Aberdeen Ida

15. Filed May 24 21 Mcmartinn
Local Registrar

SYMS - YORK CO., PTRS. & BOES. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
May (Month) 23 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 21 1921, to May 23 1921 that I last saw her alive on May 23 1921 and that death occured on the date stated above, at 12 05 P.M.

The CAUSE OF DEATH* was as follows:
Acute nephritis

(Duration) ..... Yrs. ..... mos. 10 ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Jos. C. Martinn M. D.
May 24 1921 (Address) Aberdeen Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Pleasant Valley — DATE OF BURIAL: May 25 1921

20. UNDERTAKER: Friends — ADDRESS:

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19-22

RECEIVED JUN 16 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 57
County of Blaine Primary Registration District No. 2022
City of Hailey (No. ....., ... St.)
File No. 34127
Registered No. 13
If death occurs away from usual residence, give facts called for under special information.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.
2. FULL NAME Mrs. Harold J. Torrence

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed
6. DATE OF BIRTH. May (Month) 31 (Day) 1855 (Year)
7. AGE: 65 Yrs. 10 Mos. 5 ds. IF LESS than 1 day how many ..... hrs. or ..... min.
8. OCCUPATION
(a) Trade, profession or particular kind of work: Married Woman
(b) General nature of industry, business, or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): Wisconsin
10. NAME OF FATHER: Wm. L. Bacon
11. BIRTHPLACE OF FATHER (State or Country): .....
12. MAIDEN NAME OF MOTHER: Martha Daughtery
13. BIRTHPLACE OF MOTHER (State or Country): .....
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. Lena Daughtery
(Address) Hailey, Idaho
15. Filed 6-10 1921 R. H. Wright Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (Month) March (Day) 6 (Year) 1921
17. I HEREBY CERTIFY, That I attended deceased from March 14 1921, to Apr. 6 1921, that I last saw h ed alive on Apr. 6 1921, and that death occured on the date stated above, at 4:30 P.M.
The CAUSE OF DEATH* was as follows:
Cirrhosis of the Liver
(Duration) 2 Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) Robert A. Wright M. D.
4/7 1921 (Address) Hailey, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Hailey Ida. DATE OF BURIAL: April 8. 1921
20. UNDERTAKER: R. D. Harris ADDRESS: .....

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

WIRE - VORK CO., PTRS. & STNRS. 24658

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JUN 16 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34128
Registered No. 14

1. PLACE OF DEATH
County of Blaine Registration District No. 57
City of Bellevue (or Township) Registration District No. 2022 St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ada Florence Martin.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): married.

6. DATE OF BIRTH: Sept. (Month) 11 (Day) 1878 (Year)

7. AGE: 42 Yrs. 5 Mos. 29 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Indiana.

10. NAME OF FATHER: Mr. Trout.

11. BIRTHPLACE OF FATHER (State or Country): Indiana.

12. MAIDEN NAME OF MOTHER: Martha Smith.

13. BIRTHPLACE OF MOTHER (State or Country): Indiana.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) X A W Martin
(Address) Bellevue Ida.

15. Filed 6-10 1921 R. H. Wright Local Registrar

MEDICAL CERTIFICATE OF DEATH

Plumer. April 4.

16. DATE OF DEATH: April 9. (Month) (Day) 1921. (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 4 1921, to ——— 19—
that I last saw her alive on April 4 1921,
and that death occurred on the date stated above, at 1 P.M.
The CAUSE OF DEATH* was as follows:
Gall Stones

(Duration) — Yrs. mos. ds.
Contributory (Secondary) —
(Duration) yrs. mos. ds.
(Signed) J. J. Plumer M. D.
19 (Address) Hailey Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Bellevue Ida. DATE OF BURIAL: April 10 1921

20. UNDERTAKER: R. D. Harris ADDRESS:

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
MAY 7 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34129
Registered No.

1. PLACE OF DEATH
County of Bonner Registration District No.
City of La Clede (No. St.) Primary Registration District No.
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Vera Dodge

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: May (Month) 3 (Day) 1895 (Year)

7. AGE: 25 Yrs. 11 Mos. 12 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer): Housewife

9. BIRTHPLACE (State or Country): Minn.

10. NAME OF FATHER: F. H. Hill

11. BIRTHPLACE OF FATHER (State or Country): Mich.

12. MAIDEN NAME OF MOTHER: Nellie Frank

13. BIRTHPLACE OF MOTHER (State or Country): Penn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) F. H. Hill
(Address) La Clede Ida.

15. Filed Apr 30 1921 F W Dibler Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 15 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 1 1920, to Apr 15 1921, that I last saw her alive on Apr 15 1921, and that death occurred on the date stated above, at 1100 P.M.
The CAUSE OF DEATH* was as follows:
Phthisis Pulmonalis
(Duration) One Yrs. — mos. — ds.
Contributory (Secondary) Toxaemia
(Duration) — yrs. — mos. 2 ds.
(Signed) F W Dibler M. D.
Apr 15 1921 (Address) Laclede Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Coeur d ' Alene Ida. DATE OF BURIAL: 4/17 1921
20. UNDERTAKER: B. W. Pugh, Sandpoint. ADDRESS: Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED JUN 9 1921 BUREAU OF VITAL STATISTICS

34130

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 25

County of Boun

Primary Registration District No. 2185

File No. 1.

City of [redacted] RIVER, IDAH (St.)

Registered No. 39

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Owen Wallace Holmes.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH: Sept (Month) 6 (Day) 1910 (Year)

7. AGE: 10 Yrs. 9 Mos. 25 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wash.

10. NAME OF FATHER: John W. Holmes.

11. BIRTHPLACE OF FATHER (State or Country): Ill.

12. MAIDEN NAME OF MOTHER: Mattie Long

13. BIRTHPLACE OF MOTHER (State or Country): Tenn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) [redacted]

(Address) [redacted]

15. Filed June 1 1921 [redacted] Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 30 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 30, 1921, to May 30 1921 that I last saw h[redacted] alive on May 30 1921 and that death occurred on the date stated above, at 5.45 P.M.

The CAUSE OF DEATH* was as follows:

Accidental revolver wound of abdomen

(Duration) — Yrs. — mos. — ds.

Contributory (Secondary) —

(Duration) — yrs. — mos. — ds.

(Signed) [redacted] M. D.

June, 1921 (Address) Priest River Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL ~~OR REMOVAL~~: Priest River | DATE OF BURIAL: June 1 1921

20. UNDERTAKER: Wm. Dow | ADDRESS: Priest River

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

34131 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED JUN 9 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 10

Primary Registration District No. 2185

File No. 1

County of Bonner

City of Newport (St.)

Registered No. 40

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Frances Eylar

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F	White	Married.

6. DATE OF BIRTH: Sept (Month) 1st (Day) 1859 (Year)

7. AGE: 61 Yrs. 9 Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: House-wife

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kansas.

10. NAME OF FATHER: Jazzy Porr

11. BIRTHPLACE OF FATHER (State or Country): X

12. MAIDEN NAME OF MOTHER: X

13. BIRTHPLACE OF MOTHER (State or Country): X

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Frank Eylar

(Address) Newport, Ida.

15. Filed Jun 6 1921 E. P. Gentle Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 31st (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 31 1921, to May 31 1921, that I last saw her alive on May 31 1921 and that death occurred on the date stated above, at 6.10 P.M.

The CAUSE OF DEATH* was as follows:

Cancer of Stomach

(Duration) 3 Yrs. 2 mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) D. V. C. Overland M. D.

May 31 1921 (Address) Newport-

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence /

19. PLACE OF BURIAL OR REMOVAL: Sandpoint, Idaho. DATE OF BURIAL 19

20. UNDERTAKER: Wm Davis ADDRESS Newport

Wash

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34132
Registered No.

RECEIVED
MAY 27 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
Registration District No. 78
County of Bonner
Primary Registration District No. 2155
City of Sandpoint
No. 23 Milltown St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Krasovec

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: ~~Married~~ (write word.)

6. DATE OF BIRTH: Dec. (Month) 26 (Day) 1873 (Year)

7. AGE: 47 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Woodsman
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Austria

10. NAME OF FATHER: Marcus Krasovec

11. BIRTHPLACE OF FATHER (State or Country): Austria

12. MAIDEN NAME OF MOTHER: Mary Abreze

13. BIRTHPLACE OF MOTHER (State or Country): Austria

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Mary Krasovec.
(Address) Sandpoint, Ida.

15. Filed Mar 16 1921 Floyd E Wendt
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: ~~Mar~~ March (Month) 12 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan-10 1921, to Mar-12 1921, that I last saw him alive on Mar-07 1921, and that death occurred on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis

(Duration) 2 Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Floyd E Wendt M. D.

3/16 1921 (Address) Sandpoint, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Sandpoint, Ida.	3/16 1921
20. UNDERTAKER	ADDRESS
B. W. Pugh, Sandpoint,	Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34133
Registered No.

1. PLACE OF DEATH

RECEIVED MAY 27 1921 BUREAU OF VITAL STATISTICS

Registration District No. 78
Primary Registration District No. 2158

County of Bonner
City of Sandpoint (No. 16 Milltown. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME (Infant) Heien.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH: Mch. 31, -21. 1 (Month) (Day) (Year)

7. AGE: ....Yrs....Mos....ds. IF LESS than 1 day how many....hrs. or....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work....
(b) General nature of industry, business or establishment in which employed (or employer)....

9. BIRTHPLACE (State or Country) Ida.

10. NAME OF FATHER: Albert Heien.

11. BIRTHPLACE OF FATHER (State or Country) No. Dak.

12. MAIDEN NAME OF MOTHER: Gladys McGuire.

13. BIRTHPLACE OF MOTHER (State or Country) Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Albert Heien,
(Address) Sandpoint, Ida.

15. Filed April 8 1921 Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April, I, -21. 19 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar-31 1921 to April-1 1921 that I last saw him alive on April. 1 1921 and that death occurred on the date stated above, at 4P.M.

The CAUSE OF DEATH* was as follows:
Premature Birth
7 mo Gestation

(Duration) ....Yrs....mos....ds.

Contributory (Secondary)....

(Duration) ....yrs....mos....ds.

(Signed) Floyd E. Vandeberg M. D.

April, 19 21. (Address) Sandpoint, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death....yrs....mos....days. In the State....yrs....mos....days

Where was disease contracted if not at place of death?....

Former or usual residence....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Sandpoint, Ida.	April, I 1921.

20. UNDERTAKER	ADDRESS
B.W.Pugh,	Sandpoint, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34134
Registered No.

RECEIVED
MAY 27 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 7 P
Primary Registration District No. 2133
County of Bonnner
City of Sandpoint (No. 219 Church St. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Matilda Courser.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Feb. 2 1850. (Month) (Day) (Year)

7. AGE: 71 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer): At Home.

9. BIRTHPLACE (State or Country): Canada.

10. NAME OF FATHER: Unknown.

11. BIRTHPLACE OF FATHER (State or Country): Canada.

12. MAIDEN NAME OF MOTHER: Unknown.

13. BIRTHPLACE OF MOTHER (State or Country): Canada.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Byron Courser.
(Address) Sandpoint, Ida.

15. Filed April 8 1921 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb., 22, 1921. (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2-21 1921, to 2-22 1921, that I last saw h.. alive on 2-22 1921, and that death occurred on the date stated above, at ..M.
The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency

(Duration) Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) E. T. Anderson M. D.
Mar, 19 21. (Address) Sandpoint, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..yrs. ..mos. ..days. In the State ..yrs. ..mos. ..days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Sandpoint, Ida. DATE OF BURIAL: Mar, 9, 1921.

20. UNDERTAKER: B.W. Pugh, ADDRESS: Sandpoint, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34135
Registered No.

RECEIVED
MAY 27 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 78
Primary Registration District No. 2155

County of Bonner
City of Sandpoint (If not in incorporated city or village give township) (Ward of city) Sandpoint City Hospital (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Samuel Wesley Cowen.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widowed (Write the word.)

6. DATE OF BIRTH: Dec. 28, 1828 (Month) (Day) (Year)

7. AGE: 93 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Placer Miner.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mo.

10. NAME OF FATHER: -- Cowen.

11. BIRTHPLACE OF FATHER (State or Country): Mo.

12. MAIDEN NAME OF MOTHER: Unknown.

13. BIRTHPLACE OF MOTHER (State or Country): "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Tom Turnbull.
(Address) Sagle, Ida.

15. Filed April 8 1921

Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mch. 29 -21. (Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar-24 1921 to Mar-29 1921 that I last saw him alive on Mar-29 1921 and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Senility

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) [signature] M. D.

Apr, 1921. (Address) Sandpoint, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Westmond, Ida. DATE OF BURIAL: Apr, 1, 1921.

20. UNDERTAKER: B.W.Pugh, ADDRESS: Sandpoint, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
MAY 27 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 79
Primary Registration District No. 2185
File No. 34136
Registered No.

County of Bonner
City of Sandpoint (Or Hospital, Sandpoint St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Chas. Bradbury

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
M	White	Single (Write the word.)

6. DATE OF BIRTH Unknown (Month) (Day) 1852 (Year)

7. AGE 69 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Lumber Worker
(b) General nature of industry, business or establishment in which employed (or employer) Millman

9. BIRTHPLACE (State or Country) Unknown

10. NAME OF FATHER Bradbury

11. BIRTHPLACE OF FATHER (State or Country) Unknown

12. MAIDEN NAME OF MOTHER "

13. BIRTHPLACE OF MOTHER (State or Country) "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ed Bradbury
(Address) Rathdrum, Ida.

15. Filed May 10 1921 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
April (Month) 9 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 6 1921, to April 9 1921, that I last saw h. in alive on April 9 1921, and that death occurred on the date stated above, at 11 A M.

The CAUSE OF DEATH* was as follows: -
Acute Septicemia

(Duration) Yrs. mos. 12 ds.
Contributory (Secondary) Sewer in hand.
(Duration) yrs. mos. ds.

(Signed) O. F. Page, M. D.
4/II 1921 (Address) Sandpoint, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence Jackson, Ida.

19. PLACE OF BURIAL OR REMOVAL Rathdrum, Ida. DATE OF BURIAL Apr. 12, 1921.

20. UNDERTAKER B. W. Pugh, Sandpoint. ADDRESS Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 1-25 M-1-19

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

RECEIVED
MAY 7 1921
BUREAU OF STATISTICS

Registration District No. 19

County of Bonner

Primary Registration District No. 2137

File No. 3137

City of Sandpoint (If outside city limits, give township) No. 6 No. Ella St.)

Registered No.

If death occurred away from usual residence, give facts called for under special information.

2. FULL NAME John D. McCormick

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: March 8 1851 (Month) (Day) (Year)

7. AGE: 70 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kentucky

10. NAME OF FATHER: Wm McCormick

11. BIRTHPLACE OF FATHER (State or Country): Va.

12. MAIDEN NAME OF MOTHER: Lucy Bloomfield

13. BIRTHPLACE OF MOTHER (State or Country): Va.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Jno. D. McCormick
(Address) Sandpoint, Ida.

15. Filed May 10 1921 Floyd Ellsworth Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April 28 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 6 1921, to April 28 1921, that I last saw him alive on April 6 — 1921, and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Paralysis

(Duration) Yrs. 6 weeks ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) M. R. Wallentine M. D.

4-30 1921. (Address) Sand Point, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Sandpoint Ida. DATE OF BURIAL: 4/30 1921

20. UNDERTAKER: B. N. Pugh, Sandpoint, Ida. ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 2-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34138

Registered No.

1. PLACE OF DEATH Mendell

Registration District No. 78

Primary Registration District No. 2153

County of Bonner

City of Sandpoint (If outside city limits, give township) No. On Ranch St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

RECEIVED MAY 27 1921 BUREAU OF VITAL STATISTICS

2. FULL NAME Frank Cosart

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Jan. 19, (Month) (Day) 1852 (Year)

7. AGE: 69 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Miner (Retired)

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Michigan

10. NAME OF FATHER: John Cosart

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Katherine Bird

13. BIRTHPLACE OF MOTHER (State or Country): New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Frank Cosart

(Address) Sandpoint, Ida.

15. Filed May 10 1921

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 24 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 10 1921, to April 24 1921, that I last saw him alive on April 24 1921, and that death occurred on the date stated above, at 4 A M.

The CAUSE OF DEATH* was as follows:

1a Grippe, X

(Duration) Yrs. mos. 14 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.

May 21 1921 (Address) Sandpoint.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Sandpoint, Ida.

DATE OF BURIAL: 4/26 1921

20. UNDERTAKER: B. W. Pugh, Sandpoint,

ADDRESS: Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34139

Registered No.

RECEIVED
MAY 27 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Bonner Registration District No. 78

City of Sandpoint Primary Registration District No. 2135

(If not in hospital or institution, give street address or location) City Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Alice Palmer

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: March (Month) 15 (Day) 1895 (Year)

7. AGE: 26 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): South Dak.

10. NAME OF FATHER: James Murphy

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Alice Vanvaulberg

13. BIRTHPLACE OF MOTHER (State or Country): New York.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Thomas Palmer

(Address) Sandpoint, Ida.

15. Filed May 10 1921

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 30 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 23 1921, to April 29 1921, that I last saw her alive on April 29 1921, and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows: Puerperal Septicemia

(Duration) Yrs. mos. 35 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) O. H. Payne M. D.

19 (Address) Sandpoint Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Sandpoint — DATE OF BURIAL: 5/3 1921

20. UNDERTAKER: B. N. Pugh, Sandpoint, Ida. — ADDRESS

per mst. B. N. P.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34140

Registered No. 36

RECEIVED JUN 18 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 73

Primary Registration District No. 21 A-0

County of Bonneville

City of Ucon (If outside limits, give township.) St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME George Brown

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Widower

6. DATE OF BIRTH: Sep (Month) 18 (Day) 1859 (Year)

7. AGE: 61 Yrs. 7 Mos. 21 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farming
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: ?

11. BIRTHPLACE OF FATHER (State or Country): ?

12. MAIDEN NAME OF MOTHER: ?

13. BIRTHPLACE OF MOTHER (State or Country): ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Valentine Brown
(Address) Ucon, Ida

15. Filed May 20 1921 [signature] Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 11 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19....., that I last saw h..... alive on ..... 19....., and that death occurred on the date stated above, at 11 a M.

The CAUSE OF DEATH* was as follows: Gun shot wound - Suicide

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C E Dunwoody Coroner M. D.

5/12 1921 (Address) Ida Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Ucon, Ida	5/13 1921
20. UNDERTAKER. C E Dunwoody	ADDRESS Ida Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M—1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
JUN 14 1921
BUREAU OF VITAL STATISTICS

RECEIVED
JUN 14 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Bannock

City of Mcon

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 23

Primary Registration District No. 2 1 1

No. [redacted]

File No. [redacted]

Registered No. 38

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME George Beason

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Widower

6. DATE OF BIRTH Sept (Month) 18 (Day) 1859 (Year)

7. AGE 61 Yrs. 7 Mos. 24 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farming

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Germany

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Valentine Beason

(Address) Mcon Ida

15. Filed May 23 1921 [signature] Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 11 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....

that I last saw h..... alive on ..... 19.....,

and that death occurred on the date stated above, at 11a M.

The CAUSE OF DEATH* was as follows:

Gun shot wound

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C E Dunwoody M. D.

5/17 1921 (Address) Ida Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Mcon — **DATE OF BURIAL** 5/13 1921

20. UNDERTAKER C E Dunwoody — **ADDRESS** Ida Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD of HEALTH
Bureau of Vital Statistics
File No. 34141
Registered No. 39

1. PLACE OF DEATH

Registration District No. 73

County of Bonneville

Primary Registration District No. 21 V-0

City of Idaho Falls (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
JUN 15 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME Paula Torres de Garcia

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: Mexican

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1899 (Year)

7. AGE: 22 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Mexico

10. NAME OF FATHER: Not known

11. BIRTHPLACE OF FATHER (State or Country): Mexico

12. MAIDEN NAME OF MOTHER: Not known

13. BIRTHPLACE OF MOTHER (State or Country): Mexico

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jesus Garcia
(Address) Idaho Falls R.D. 3

15. Filed June 6 1921 W. E. Williamson Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 6, 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 3 1921 to June 6, 1921 that I last saw her alive on June 6, 1921, and that death occurred on the date stated above, at 6 A. M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) Indefinite yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John O. Miller M. D.

6/6 1921 (Address) Idaho Falls, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Lincoln Cem. DATE OF BURIAL: June 6 1921

20. UNDERTAKER: Summers & Co. ADDRESS: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34142
Registered No. 40

Registration District No. 73
Primary Registration District No. 2110

RECEIVED
JUN 13 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Bannock
City of Idaho Falls (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Gordon Lamar Gray

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Child

6. DATE OF BIRTH July (Month) 7 (Day) 1912 (Year)

7. AGE 8 Yrs. 9 Mos. 23 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Ogden, Ut

10. NAME OF FATHER Loren Gray

11. BIRTHPLACE OF FATHER (State or Country) St George, Ut

12. MAIDEN NAME OF MOTHER Mabel Stagg

13. BIRTHPLACE OF MOTHER (State or Country) Provo, Ut

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C E Dunwoody

(Address) Blackfoot, Idaho

15. Filed May 3 1921 C E Dunwoody Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 1 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19....., that I last saw h..... alive on ..... 19....., and that death occurred on the date stated above, at 6 P M.

The CAUSE OF DEATH* was as follows:

Wounds caused by being run into by automobile.

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C E Dunwoody M.D.

5/3 1921 (Address) Idaho Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence Ship

19. PLACE OF BURIAL OR REMOVAL Ogden, Ut. DATE OF ~~BURIAL~~ 5/3 1921

20. UNDERTAKER C E Dunwoody ADDRESS Idaho Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JUN 13 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 23
Primary Registration District No. 2 1 1 - 0
File No. 34144
Registered No. 4 -

1. PLACE OF DEATH
County of Bonneville
City of Idaho Falls (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Eugene Owen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Male	White	~~Single~~ (Write the word.)

6. DATE OF BIRTH: June (Month) 28 (Day) 1900 (Year)

7. AGE: 20 Yrs. 10 Mos. 10 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farming
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Wm F Owens

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Lucinda E. Rawson

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wm F. Owens
(Address) Idaho Falls, Ida

15. Filed May 11 1921 Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 8 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 4 1921, to May 8 1921, that I last saw him alive on May 8 1921, and that death occurred on the date stated above, at 9 P.M.

The CAUSE OF DEATH* was as follows:

Meningitis
to

(Duration) ..... Yrs. 1 mos. ..... ds.

Contributory (Secondary) Pneumonia

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J R Rogers M. D.

5/10 1921 (Address) Idaho Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Idaho Falls, Ida	5/11 1921

20. UNDERTAKER E E Linnwoodey ADDRESS Ida Falls

J R Rogers.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3415
Registered No. 43

1. PLACE OF DEATH
County of Bonneville
City of Idaho Falls
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 73
Primary Registration District No. 2170
(No. St.)

2. FULL NAME John Thomas Parker

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: April 25 1883 (Month) (Day) (Year)

7. AGE: 38 Yrs. 1 Mos. 0 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farming
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Salt Lake, Utah.

10. NAME OF FATHER: Fred Parker

11. BIRTHPLACE OF FATHER (State or Country): Salt Lake, Utah.

12. MAIDEN NAME OF MOTHER: Mary Thomas

13. BIRTHPLACE OF MOTHER (State or Country): Wales

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Fred Parker
(Address): Rexburg, Ida

15. Filed May 24 1921 [signature] Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 25 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 24 1921, to May 26 1921 that I last saw h.. alive on May 26 1921, and that death occurred on the date stated above, at 9 P M.

The CAUSE OF DEATH* was as follows:
Fracture of base of skull accidental

(Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H Ray Hatch M. D.
5/26 1921 (Address) Idaho Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence Ship

19. PLACE OF BURIAL OR REMOVAL: Rexburg, Ida. DATE OF BURIAL: 5/26 1921

20. UNDERTAKER: E Dunwoody ADDRESS: Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 [redacted] CERTIFICATE OF DEATH

34146

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. [redacted]

Registered No.

JUN 3 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH. [illegible] tion District No. 36

County of Elmore Primary Registration District No. 2021

City of Glenn's Ferry, ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Unnamed

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH: May (Month) 11th (Day) 1921 (Year)

7. AGE: ....yrs. ....mos. ....ds. IF LESS than 1 day how many 1 hrs. or ....min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry business or establishment in which employed (or employer): ....

9. BIRTHPLACE (State or Country): America

10. NAME OF FATHER: Alvi V. Rice

11. BIRTHPLACE OF FATHER (State or Country): America

12. MAIDEN NAME OF MOTHER: Effie King

13. BIRTHPLACE OF MOTHER (State or Country): America

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Alvi V. Rice

(Address) Glenn's Ferry Idaho

15.

Filed May 12 1921 J. W. Davis Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 11th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 11 1921, to May 11th 1921 that I last saw him alive on May 11 1921, and that death occurred on the date stated above, at 6:45 P M.

The CAUSE OF DEATH* was as follows:

Asphyxia

(Duration) ....yrs. ....mos. 1 hr. ds.

Contributory (Secondary) Premature birth

(Duration) ....yrs. ....mos. — ds.

(Signed) J. W. Davis M. D.

May 12 1921 (Address) Glenn's Ferry Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?....

Former or usual residence....

19. PLACE OF BURIAL OR REMOVAL: Mountain Home Idaho — DATE OF BURIAL: May 12 1921

20. UNDERTAKER: Alvi V. Rice — ADDRESS: Glenn's Ferry Idaho

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3417
Registered No. 37

1. PLACE OF DEATH
County of Bonneville
City of Ida Falls
(No. ... St.)
If death occurs away from usual residence, give facts called for under special information.

RECEIVED
MAY 20 1921
BUREAU OF VITAL STATISTICS

Registration District No. 73
Primary Registration District No. 21 N-0

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Virgie Esthy Prestgard

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Infant

6. DATE OF BIRTH: April (Month) 13 (Day) 1921 (Year)

7. AGE: 0 Yrs. 0 Mos. 14 ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Idaho Falls

10. NAME OF FATHER: Torjus A. Prestgard

11. BIRTHPLACE OF FATHER (State or Country): Norway

12. MAIDEN NAME OF MOTHER: Virgie C. Poulter

13. BIRTHPLACE OF MOTHER (State or Country): ~~Utah~~ Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) T. A. Prestgard
(Address) Idaho Falls, Ida.

15. Filed May 30 1921 — Wm. Kinnaird, Local Registrar
L. Rogers

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr. (Month) 27 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 13 1921, to Apr 27 1921, that I last saw h. alive on Apr 26 1921, and that death occurred on the date stated above, at 8 P M.
The CAUSE OF DEATH* was as follows:

Intestinal Intoxication

(Duration) ... Yrs. ... mos. ... ds.
Contributory (Secondary)
(Duration) ... yrs. ... mos. ... ds.

(Signed) L. Rogers D.O. M. D.
May 27 1921 (Address) Idaho Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Idaho Falls, Ida	4/29 1921
20. UNDERTAKER	ADDRESS
C. E. Linnwoodey	Ida Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
MAY 20 1921
BUREAU OF VITAL STATISTICS

Registration District No. 73
Primary Registration District No. 21 J-0
File No. 34148
Registered No. 36

1. PLACE OF DEATH
County of Bonneville
City of Ida Falls (No.) St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME. Samuel T Robinson
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Male	White	Married (Write the word.)

6. DATE OF BIRTH
Dec 22 1882
(Month) (Day) (Year)

7. AGE
38 Yrs. 4 Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Mechanic
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Tenn.

10. NAME OF FATHER Benj F Robinson

11. BIRTHPLACE OF FATHER (State or Country) Tenn.

12. MAIDEN NAME OF MOTHER Eliz. Roddy

13. BIRTHPLACE OF MOTHER (State or Country) Tenn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Robinson
(Address) Ida Falls

15.
Filed May 30 1921
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
April 22 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 1 1921, to April 22 1921
that I last saw h-m alive on April 22 1921,
and that death occurred on the date stated above, at 10 P M.
The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) 2 Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) [signature] M. D.
4/29 1921 (Address) Idaho Falls, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence Ship

19. PLACE OF BURIAL OR REMOVAL Idaho Falls, Idaho | DATE OF BURIAL 3/22 1921

20. UNDERTAKER E. E. Dunwoody | ADDRESS Ida Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

L. C. McClure

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34149
Registered No. 31

1. PLACE OF DEATH

Registration District No. 73
Primary Registration District No. 21-0
County of Bonneville
City of Idaho Falls (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

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MAY 20 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME Violet Belle Mdell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: Colored

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Child

6. DATE OF BIRTH: Oct (Month) 12 (Day) 1914 (Year)

7. AGE: 0 Yrs. 5 Mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho Falls

10. NAME OF FATHER: Chester Mdell

11. BIRTHPLACE OF FATHER (State or Country): Washington

12. MAIDEN NAME OF MOTHER: Bertha Stevens

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chester Mdell
(Address) City

15. Filed Jan 30 1921 C. Truman Local Registrar
Dr. Hollister

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 23 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 8-21- 1921, to 3-23- 1921, that I last saw her alive on 3-21- 1921, and that death occurred on the date stated above, at 3 P.M.
The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. C. Hollister M. D.
3/24 1921 (Address) Ida Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Idaho Falls Ida — DATE OF BURIAL: 3/25 1921

20. UNDERTAKER: G. E. Summerdes — ADDRESS: Ida Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3415
Registered No. 34

1. PLACE OF DEATH

Registration District No. 73
Primary Registration District No. 21-0

County of Bonneville
City of Idaho Falls (No. ..... St.)

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MAY 20 1921
BUREAU OF VITAL STATISTICS

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jesse Vaughn Hansen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Infant (Write the word.)

6. DATE OF BIRTH: June (Month) 3 (Day) 1917 (Year)

7. AGE: 4 Yrs. 2 Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: /
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Ed. A Hansen

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Katie Knowlin

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ed C. Hansen
(Address) Idaho Falls Ida

15. Filed May 3 1921
Local Registrar
D. Nelson

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 4 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 28 1921, to April 4 1921
that I last saw h.... alive on April 1 1921,
and that death occurred on the date stated above, at 7 A M.
The CAUSE OF DEATH* was as follows:

Brain Abscess.
Duration not known as child has been sick
& was taken to hospital just seen —
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Meningitis
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Harry L. Williams M. D.
4/8/21 (Address) Idaho Falls, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Idaho Falls Ida	4-7 1921
20. UNDERTAKER	ADDRESS
C. E. Greenwood	Ida Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 21-0
File No. 34151
Registered No. 33

1. PLACE OF DEATH
County of Bannock
City of Ida Falls
(No. St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Genevieve Mangum

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

RET MAR BUREAU OF VITAL STATISTICS

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Infant (Write the word.)

6. DATE OF BIRTH: March 27 1921 (Month) (Day) (Year)

7. AGE: 0 Yrs. 0 Mos. 7 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho Falls

10. NAME OF FATHER: Wm Mangum

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Lovina Thurston

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Emma Collings
(Address) R.D. 4 — City

15. Filed Apr 30 1921
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 18 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 27, 1921 to Apr. 18, 1921 and that I last saw h.. alive on Apr. 17, 1921 and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Ileocolitis
(Duration) From birth Yrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) John O Mellar M. D.
4/19/21 (Address) Idaho Falls, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Woodville Idy. DATE OF BURIAL: 4/18/1921

20. UNDERTAKER: C E Dunwoody ADDRESS: Ida Falls

Dr Mellar

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3415
Registered No. 3

1. PLACE OF DEATH

County of Bonner — Registration District No. 73
City of Idaho Falls — Primary Registration District No. 21-0
(No.) 169 3rd St. (St.)

If death occurs away from usual residence, give facts called for under special information.

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MAY 20 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME James Riggs

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH: May 10 1851 (Month) (Day) (Year)

7. AGE: 69 Yrs. Mos. ds. — IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ill.

10. NAME OF FATHER: Jess Riggs

11. BIRTHPLACE OF FATHER (State or Country): Ky

12. MAIDEN NAME OF MOTHER: Elizabeth Newman

13. BIRTHPLACE OF MOTHER (State or Country): Don't Know.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Bert Riggs
(Address) Idaho Falls Ida

15. Filed Apr. 29 1921 — Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr. (Month) 18 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 12 1921, to Apr. 18 1921, that I last saw h[illegible] alive on Apr. 15 1921 and that death occurred on the date stated above, at 1.00 P.M.

The CAUSE OF DEATH* was as follows:

Paralysis Vasomotor area
(Duration) Yrs. mos. ds.
Contributory (Secondary) Hemiplegia
(Duration) yrs. mos. 6 ds.

(Signed) [signature] M. D.
4/29 1921 (Address) Idaho Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rose Hill Idaho Falls Ida — DATE OF BURIAL: Apr 20 1921

20. UNDERTAKER: Clifford C Hayes — ADDRESS: Idaho Falls Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3415 3

RECEIVED
JUN 11 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH. Registration District No. 79.
County of Boundary Primary Registration District No. 216.
City of Bonners Ferry (If not in city give township) St.)
Registered No.
If death occurs away from usual residence, give facts called for under special information.
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Mammie Mc Dougall

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married
6. DATE OF BIRTH: Oct (Month) 27 (Day) 1854 (Year)
7. AGE: 66 yrs. 6 mos. 6 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Iowa
10. NAME OF FATHER: Wm Ditto
11. BIRTHPLACE OF FATHER (State or Country): Kentucky
12. MAIDEN NAME OF MOTHER: ?
13. BIRTHPLACE OF MOTHER (State or Country):
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A. D. Mc Dougall
(Address) Bonners Ferry Ida
15. Filed May 4 1921 E. E. Fry. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 3 (Day) 1921 (Year)
17. I HEREBY CERTIFY, That I attended deceased from April 25 1921, to May 3 1921 that I last saw h[illegible] alive on May 3 1921, and that death occurred on the date stated above, at 3 P. M.
The CAUSE OF DEATH* was as follows:
Lobar Pneumonia
(Duration) ..... yrs. ..... mos. 7 ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) E. E. Fry M. D.
5/4/1921 (Address) Bonners Ferry, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Bonners Ferry Ida
DATE OF BURIAL: May 5 1921
20. UNDERTAKER: O R Stookey
ADDRESS: Bonners Ferry Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & RINDERS, BOISE 16872

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34154

1. PLACE OF DEATH. Registration District No. 79
County of Boundary Registered District No. 315-6
City of Bonners Ferry (No. St.)
Registered No.
If death occurs away from usual residence, give facts called for under special information.
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

RECEIVED
JUN 11 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME. Mrs. Campbell

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH: Oct 9 1863 (Month) (Day) (Year)

7. AGE: 57 yrs. 7 mos. 3 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Anthony Brodrick

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. H. Campbell
(Address) Bonners Ferry, Ida.

15. Filed 5/13/1921 E E Fry Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 12 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 21 1921, to May 12 1921, that I last saw h[illegible] alive on May 12 1921, and that death occurred on the date stated above, at 10 A. M.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) yrs. mos. 14 ds.

Contributory (Secondary) Influenza -

(Duration) yrs. mos. 7 ds.

(Signed) E E Fry M. D.

5/13/1921 (Address) Bonners Ferry, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Bonners Ferry Ida. DATE OF BURIAL: May 13 1921

20. UNDERTAKER: O R Stookey ADDRESS: Bonners Ferry

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

YMS-YORK CO., PRINTERS & RINDERS, BOISE 16872

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 29

Primary Registration District No. 215-6.

File No. 34155

Registered No.

County of Boundary

City of Bonners Ferry

If death occurs away from usual residence, give facts called for under special information.

(No. John Winterbottom St.)

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH

Dec (Month) 18 (Day) 1864 (Year)

7. AGE

56 yrs. 4 mos. 38 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry business, or dstablishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Mich.

10. NAME OF FATHER Robert Winterbottom

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER Lora McKinnon

13. BIRTHPLACE OF MOTHER (State or Country) Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. George P. Gray

(Address) Bonners Ferry, Idaho

15.

Filed May 27- 1931

E E Fry
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

May (Month) 26 (Day) 1931 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 1931, to May 26 1931, that I last saw him alive on May 18 1931, and that death occurred on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Carcinoma of the mesentery.

(Duration) 2 mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) E E Fry M. D.

5/27 1931 (Address) Bonners Ferry, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL — DATE OF BURIAL

Kootenai Co. — May 28 1931

20. UNDERTAKER — ADDRESS

O B Stookey — Bonners Ferry

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JUN 14 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 59

County of Butte

Primary Registration District No. 3129

File No. 34156

City of Arco (If outside limits, give township) (St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Warren Amazias Jammett

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6. DATE OF BIRTH: Aug. 28, 1890 (Month) (Day) (Year)

7. AGE: 30 Yrs. 9 Mos. 1 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Gilbert Jammett

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Mary Howe

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Gilbert Jammett
(Address) Arco Ida

15. Filed 5/31 1921 F M Naumon Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 29 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5-24 — 1921, to 5-29 — 1921, that I last saw him alive on 5-29 — 1921, and that death occurred on the date stated above, at 8.45 A.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ..... Yrs. ..... mos. 5 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F M Naumon M. D.

5/31 1921 (Address) Arco Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Arco

DATE OF BURIAL: 5/31 1921

20. UNDERTAKER: Weedbridge

ADDRESS: Arco

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-18

RECEIVED JUN 13 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34157

Registered No. 9

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No. 9

Primary Registration District No. 1007

County of Canyon

City of Parma, (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Harry D Smith

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. ~~SINGLE~~, MARRIED, ~~WIDOWED OR DIVORCED~~. (Write the word.): m

6. DATE OF BIRTH. June (Month) 21 (Day) 1877 (Year)

7. AGE: 43 Yrs. 10 Mos. 20 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Brick mason

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ill

10. NAME OF FATHER: Harry Smith

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Anna Duncan

13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Maurice D Smith

(Address) Parma Idaho

15.

Filed 6-1 1921

Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 11 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 15 1920 to May 11 1921, that I last saw h.m alive on May 11 1921 and that death occured on the date stated above, at 10:30 A.M.

The CAUSE OF DEATH* was as follows:

Apoplexy.

(Duration) Yrs. mos. 7 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) O. M. Mitchell M. D.

19..... (Address) Parma

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL ~~OR REMOVAL~~: Parma Idaho — DATE OF BURIAL: May 12 1921

20. UNDERTAKER: Peckham Bros — ADDRESS: Parma

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED JUN 13 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3

Primary Registration District No. 2007

File No. 34158

Registered No. 16

1. PLACE OF DEATH

County of Canyon

City of Roswell (If outside limits of village or city, write the name of township.) St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Adoniram Judson Rockwood

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	white	married

6. DATE OF BIRTH: Jan (Month) 6 (Day) 1867 (Year)

7. AGE: 54 Yrs. 4 Mos. 12 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Vermont

10. NAME OF FATHER: Joseph Rockwood

11. BIRTHPLACE OF FATHER (State or Country): Vermont

12. MAIDEN NAME OF MOTHER: Rhoda Heed

13. BIRTHPLACE OF MOTHER (State or Country): Vermont

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mary D. Rockwood
(Address) Caldwell, Ida.

15. Filed 6-1 1921 Ruby Waldron Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 18 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 18 1921, to May 18 1921, that I last saw h[illegible] alive on May 18 1921 and that death occurred on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Uremic poisoning

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Acute Bright's disease

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. B. Mueller M. D.

May 6 1921 (Address) Parma, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Roswell	5-21 1921

20. UNDERTAKER	ADDRESS
C. V. Beckham	Caldwell, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A--25 M. 1-19.

CERTIFICATE OF DEATH

RECEIVED
JUN 10 1921
BUREAU OF VITAL STATISTICS

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 1004
File No. 34159
Registered No.

1. PLACE OF DEATH
County of Canyon
City of Nampa (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Dovie May

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6. DATE OF BIRTH: Apr (Month) 20 (Day) 1905 (Year)

7. AGE: 16 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At School
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wash

10. NAME OF FATHER: C B May

11. BIRTHPLACE OF FATHER (State or Country): Tenn

12. MAIDEN NAME OF MOTHER: Hanna Furr

13. BIRTHPLACE OF MOTHER (State or Country): Tenn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C B May
(Address) Tekoa Wash

15. Filed June 10 1921 Pearle Dodds Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 5 (Month) 19 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5-19 1921, to 5-27 1921 that I last saw her alive on 5-26 1921 and that death occurred on the date stated above, at 8:40 A.M.

The CAUSE OF DEATH* was as follows:
Chronic Appendicitis, &
Lobar Pneumonia

(Duration) 2 Yrs. mos. ds.
Contributory (Secondary) Lobar Pneumonia
(Duration) yrs. mos. 12 ds.

(Signed) H C Robinson M. D.
5-27 1921 (Address) Nampa

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Farmington
DATE OF BURIAL: 6 1921

20. UNDERTAKER
ADDRESS: Wash

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED
JUN 13 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. ....

County of Canyon — Primary Registration District No. 10

City of Nampa (No. ...., ...St.)

File No. 34160

Registered No. ....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Samual Perry

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Male	White	Married (Use word.)

6. DATE OF BIRTH: May (Month) 23 (Day) 1872 (Year)

7. AGE: 49 Yrs. 16 Mos. .... ds. IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: R.R. Service
(b) General nature of industry, business or establishment in which employed (or employer): ....

9. BIRTHPLACE (State or Country): Penn.

10. NAME OF FATHER: Samual Perry Sr.

11. BIRTHPLACE OF FATHER (State or Country): Ire.

12. MAIDEN NAME OF MOTHER: Margaret Donovan

13. BIRTHPLACE OF MOTHER (State or Country): Unknown Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Margaret Cochrane
(Address) Nampa Ida

15. Filed June 10 192 Teire & Todd Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 7th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 4th 1921 to June 7th 1921, that I last saw him alive on June 6th 1921, and that death occurred on the date stated above, at 4 A.M.

The CAUSE OF DEATH* was as follows:
Perforation of Duodenal ulcer.

(Duration) 0 Yrs. 0 mos. 3 ds.

Contributory (Secondary) Hemorrhage peritonitis

(Duration) — yrs. — mos. 3 ds.

(Signed) Geo. D. A. Kellogg M. D.

19.... (Address) Nampa Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs. ....mos. ....days. In the State ....yrs. ....mos. ....days

Where was disease contracted if not at place of death? ....

Former or usual residence ....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Lanky Utah	6-9 1921
20. UNDERTAKER	**ADDRESS**
Fred A Robinson	Nampa

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

A
K.

FORM V. S. No. 5-A—25 M. 1-19. RECEIVED JUN 13 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34161

1. PLACE OF DEATH
County of Canyon Registration District No. 7
City of Nampa Primary Registration District No. 1006
(No. ....., ... St.)
Registered No. .....
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Helen M Carlett

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Fem	White	Single

6. DATE OF BIRTH: Sep (Month) 25 (Day) 1897 (Year)

7. AGE: 24 Yrs. ..... Mos. ..... ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: In School
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Nebraska

10. NAME OF FATHER: C E Carlett

11. BIRTHPLACE OF FATHER (State or Country): Wis

12. MAIDEN NAME OF MOTHER: Frances Romuel

13. BIRTHPLACE OF MOTHER (State or Country): Wis

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): C E Carlett
(Address): Nampa Ida

15. Filed June 6 1921 Pearle Dodds Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 16 (Day) 21 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5-12 1921, to 5-16 1921 that I last saw her alive on 5-16 1921 and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Acute cystic endocarditis with Mitral regurgitation

..... (Duration) ..... Yrs. ..... mos. 5 ds.
Contributory (Secondary) Gangrenous Appendicitis
..... (Duration) ..... yrs. 2 mos. ..... ds.

(Signed) H. E. Robinson M. D.
5-17 1921 (Address) Nampa Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Old Nebraska	5/ 19
20. UNDERTAKER	**ADDRESS**
Fred K Robinson	Nampa Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
JUN 13 1921
BUREAU OF VITAL STATISTICS

Registration District No. 7
Primary Registration District No. 1006
File No. 34162
Registered No.

1. PLACE OF DEATH
County of Canyon
City of Nampa (No. St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lora Garrett

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem.
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Feb. (Month) 24 (Day) 1879 (Year)

7. AGE: 42 Yrs. 3 Mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mo. (Wright Co.)

10. NAME OF FATHER: Jas. Bolian

11. BIRTHPLACE OF FATHER (State or Country): Mo.

12. MAIDEN NAME OF MOTHER: Ripsey

13. BIRTHPLACE OF MOTHER (State or Country): Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chas. Garrett
(Address) Nampa R 4

15. Filed June 7 1921 Pearle Dodds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 6 (Month) 2 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 31 1921 to June 7 1921 that I last saw her alive on May 24 1921 and that death occurred on the date stated above, at 1 P. M.
The CAUSE OF DEATH* was as follows:

Acute heart failure

(Duration) 1 Yrs. 0 mos. 9 ds.
Contributory (Secondary) Chronic Myocarditis
(Duration) 1 yrs. 0 mos. 9 ds.

(Signed) Marion A. Funk M. D.
June 6 1921 (Address) Nampa Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Burial Star Cem. | DATE OF BURIAL: 6/4 1921

20. UNDERTAKER: Fred R. Robinson | ADDRESS: Nampa

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED
JUN 12 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 1006
File No. 3416
Registered No.

1. PLACE OF DEATH
County of Canyon
City of Nampa (No. 5th Ave S St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Katie Stocton Day
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: May (Month) 24 (Day) 1864 (Year)

7. AGE: 57 Yrs. — Mos. — ds.
IF LESS than 1 day how many..... hrs. or..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Penn.

10. NAME OF FATHER: —

11. BIRTHPLACE OF FATHER (State or Country): Penn

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) K K Day
(Address) Nampa Ida

15. Filed June 10 1921 Pearle Dodds Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 20 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 12 1921 to May 20 1921 that I last saw her alive on May 18 1921, and that death occurred on the date stated above, at — P.M.

The CAUSE OF DEATH* was as follows:
Metastatic carcinoma of left lung and pleura from Ca. of left mammary gland - removed 3 years ago (Duration) 1 Yrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) George R. Proctor M. D.
June 6 1924 (Address) Nampa Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Nampa Ida — DATE OF BURIAL: 5/24/19 24

20. UNDERTAKER: Fred R Robinson — ADDRESS: Nampa Ida

Dr Proctor

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34164

1. PLACE OF DEATH

Registration District No. 7

County of Canyon

Primary Registration District No. 1006

City of Nampa (No. ..... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
JUN 13 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME Lillian Clara Lowe

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: (Write the word.) Single

6. DATE OF BIRTH: May (Month) 19 (Day) 1874 (Year)

7. AGE: 47 Yrs. — Mos. 13 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housekeeper

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): South Africa

10. NAME OF FATHER: Wm. J. Lowe

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Frances Wiggill

13. BIRTHPLACE OF MOTHER (State or Country): South Africa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. L. Lowe

(Address) R.R. #1 Kuna, Idaho

15. Filed June 10 1921 Pearl Dodds, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 6 (Month) 2 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 24 1921 to June 1st 1921 that I last saw h.. alive on June 1 1921, and that death occurred on the date stated above, at 5 A.M.

The CAUSE OF DEATH* was as follows:

Septicemia

.....

.....

(Duration) ..... Yrs. 5 mos. ..... ds.

Contributory (Secondary) Carbuncle

(Duration) ..... yrs. 6 mos. ..... ds.

(Signed) Leo W Chilton M. D.

6/6 1921 (Address) Nampa, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Fohlenbaum

DATE OF BURIAL: 6/5 1921

20. UNDERTAKER: Fred W Robinson

ADDRESS: Nampa

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3416

1. PLACE OF DEATH

County of Canyon — Registration District No. 7

City of Nampa — Primary Registration District No. 1006 — St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

RECEIVED JUN 15 1921 BUREAU OF VITAL STATISTICS

2. FULL NAME Infant Gallimore

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): ✓

6. DATE OF BIRTH: June (Month) 7 (Day) 1921 (Year)

7. AGE: ... Yrs. ✓ Mos. ✓ ds. ✓

IF LESS than 1 day how many Dul hrs. or ... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work ...

(b) General nature of industry, business or establishment in which employed (or employer) ✓

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Samuel D. Gallimore

11. BIRTHPLACE OF FATHER (State or Country): Virginia

12. MAIDEN NAME OF MOTHER: Dovella B. Murphy

13. BIRTHPLACE OF MOTHER (State or Country): North Carolina

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) ...

(Address) ...

15. Filed June 10 1921 Pearle Dodds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 7 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 7 1921, to June 7 1921, that I last saw him alive on ... 1921, and that death occurred on the date stated above, at 5 A. M.

The CAUSE OF DEATH* was as follows:

Premature birth

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary) ...

(Duration) ... yrs. ... mos. ... ds.

(Signed) Geo. R. Proctor M. D.

19... (Address) Nampa

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death? ...

Former or usual residence ...

19. PLACE OF BURIAL OR REMOVAL: Nampa — DATE OF BURIAL: June 7 1921

20. UNDERTAKER: None — ADDRESS ✓

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

RECEIVED JUN 13 19 BUREAU OF VITAL STATISTICS

Registration District No. 7
Primary Registration District No. 2006
File No. 34166

County of Canyon
City of Nampa (No. ..... St.)
Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Infant C. F. Miller Jr.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH: June (Month) 3 (Day) 1921 (Year)

7. AGE: ..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many 14 hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: Chas. F. Miller

11. BIRTHPLACE OF FATHER (State or Country): Neb

12. MAIDEN NAME OF MOTHER: Lillie Olson

13. BIRTHPLACE OF MOTHER (State or Country): Neb.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. F. Miller
(Address) Nampa Ida.

15. Filed June 16 1921 Pearle Dodds Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 3 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from during birth. 19..., to ..... 19.....
that I last saw h... alive on ..... 19....,
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Stillborn. Probable cause in utero was strangulation of the cord.
.....(Duration) — Yrs. — mos. — ds.
Contributory (Secondary) —
.....(Duration) — yrs. — mos. — ds.

(Signed) Jos. A. A. Kelly M. D.
19..... (Address) Nampa Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Fairview — DATE OF BURIAL: 6-3-1921

20. UNDERTAKER: Fred R. Robinson — ADDRESS: Nampa

K.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34167
Registered No.

1. PLACE OF DEATH

Registration District No. 7
Primary Registration District No. 2006

County of Canyon
City of Nampa (St.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
JUN 13 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME Elsie M Mank

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Fem	white	Married

6. DATE OF BIRTH — — 1888
(Month) (Day) (Year)

7. AGE 32 Yrs. — Mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Bohemia

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (State or Country) "

12. MAIDEN NAME OF MOTHER "

13. BIRTHPLACE OF MOTHER (State or Country) "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Frank M
(Address) Bowmont Ida

15. Filed June 10 1921 Pearle Dodds
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
May (Month) 27 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 10 1920 to Sep. 26 1920
that I last saw her alive on Sep. 26 1920
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Carcinoma of Uterus.

(Duration) 1 Yrs. 6 mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) J. B. Smith M. D.
6/6 1921 (Address) Nampa Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Kohlerlawn Cem	5/29 1921
20. UNDERTAKER Fred H. Robinson	ADDRESS Nampa

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH RECEIVED
County of Canyon JUN 13 1921
City of Nampa BUREAU OF VITAL STATISTICS
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 7
Primary Registration District No. 2006
File No. 34168
Registered No.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Edward Walt Stumbaugh

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Mar 21 1867 (Month) (Day) (Year)

7. AGE: 54 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Wm H Stumbaugh

11. BIRTHPLACE OF FATHER (State or Country): Penn

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Bert Stumbaugh
(Address) Nampa Ida

15. Filed June 10 1921 Pearle Dodds Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 13 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from at time of death 19 to 19
that I last saw h[illegible] alive on May 14 1921
and that death occurred on the date stated above, at 4:30 P.M.
The CAUSE OF DEATH* was as follows:
Supposed to be heart failure
Died very suddenly
(Duration) Yrs. mos. ds.
Contributory (Secondary) Had Rheumatism for several years previously
(Duration) yrs. mos. ds.
(Signed) J H Murray M. D.
5/14 1921 (Address) Nampa Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Nampa Idaho
DATE OF BURIAL: 5/17 1921
20. UNDERTAKER: Frank Robinson
ADDRESS: Nampa Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 3

Primary Registration District No. 2005 (2005)

File No. 34170

County of Canyon

City of Caldwell (No. ..... St.)

Registered No. 60

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Fletcher Groome

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

RECEIVED
JUN 11 19
BUREAU OF VITAL STATISTICS

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): married

6. DATE OF BIRTH: Oct (Month) 12 (Day) 1848 (Year)

7. AGE: 72 Yrs. 7 Mos. 24 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Retired Farmer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Wm S. Groome

11. BIRTHPLACE OF FATHER (State or Country): Ohio.

12. MAIDEN NAME OF MOTHER: Eliza J. Woolweaver

13. BIRTHPLACE OF MOTHER (State or Country): Penn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Chas Groome

(Address) Caldwell, Ida.

15. Filed June 7- 1921 John S. Meyers Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 6 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Post Mortem, to Jun June 6 1921, that I last saw h..... alive on ..... 19....., and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Heart failure - Angina

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Chronic Nephritis

(Duration) ..... yrs. 6 mos. ..... ds.

(Signed) S O S Dudley M. D.

19..... (Address) Caldwell Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill

DATE OF BURIAL: 6-8 19

20. UNDERTAKER: CASE FURNITURE CO.

ADDRESS: Caldwell

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
JUN 11 1921
BUREAU OF VITAL STATISTICS

Registration District No. 9
Primary Registration District No. 2005
File No. 34171
Registered No. 59

1. PLACE OF DEATH
County of Canyon
City of Caldwell (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ella A. Ingraham

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: ~~Write the word.~~ widow

6. DATE OF BIRTH: July (Month) 4 (Day) 1854 (Year)

7. AGE: 66 Yrs. 11 Mos. 0 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housework.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio.

10. NAME OF FATHER: Chester.

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Dorothy Lorenz

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) O. R. Ingraham
(Address) Caldwell, Ida.

15. Filed June 5 - 1921 John L. Sawyer. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 4 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 30 1920, to June 3 1921, that I last saw h.. alive on June 2 1921 and that death occurred on the date stated above, at 2:45 P.M.
The CAUSE OF DEATH* was as follows: Carcinoma Uterine

..... (Duration) 1 Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) M Kelley M. D.
6-11 1921 (Address) Caldwell Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill — DATE OF BURIAL: 6-5 1921

20. UNDERTAKER: J. V. Beckham — ADDRESS: Caldwell

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34172
Registered No. 58

1. PLACE OF DEATH

County of Canyon
City of Caldwell (No. ..... St.)

RECEIVED JUN 11 1921 BUREAU OF VITAL STATISTICS

Registration District No. 3
Primary Registration District No. 2005

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ora Hogue

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
male	white	Married

6. DATE OF BIRTH: November (Month) 10 (Day) 1893 (Year)

7. AGE: 27 Yrs. 6 Mos. 23 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Arkansas.

10. NAME OF FATHER: A. F. Hogue.

11. BIRTHPLACE OF FATHER (State or Country): Illinois.

12. MAIDEN NAME OF MOTHER: Martha Brown

13. BIRTHPLACE OF MOTHER (State or Country): Illinois.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. F. Hogue
(Address) Caldwell, Ida.

15. Filed June 4 1921 John S. Meyer Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 3 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 5 1920, to May 26 1921 that I last saw h... alive on May 26 1920 and that death occurred on the date stated above, at 3 a. M.

The CAUSE OF DEATH* was as follows:

Uraemia - Brights
Cystitis
..... (Duration) 1 Yrs. ..... mos. ..... ds.
Contributory (Secondary) Duremia Toxis
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. F. Miller M. D.
1921 (Address) Caldwell Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Canyon Hill	6-5 1921
20. UNDERTAKER E. V. Peckham	ADDRESS Caldwell

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

RECEIVED
JUN 11 1921
BUREAU OF VITAL STATISTICS

Registration District No. 3
Primary Registration District No. 2005
File No. 34173
Registered No. 57

County of Canyon
City of Caldwell (No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John C. Simpson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
male	white	married

6. DATE OF BIRTH: Dec. (Month) 16 (Day) 1857 (Year)

7. AGE: 63 Yrs. 5 Mos. 15 ds.
IF LESS than 1 day: how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Ranches,
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Canada,

10. NAME OF FATHER: John C. Simpson Sr.

11. BIRTHPLACE OF FATHER (State or Country): England,

12. MAIDEN NAME OF MOTHER: Elizabeth Horner

13. BIRTHPLACE OF MOTHER (State or Country): England,

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Cora Simpson
(Address) Caldwell Ida #5

15. Filed June 2 - 1921 John A. Meyer - Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 1 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1st 1921 to May 28th 1921, that I last saw him alive on May 28 1921, and that death occurred on the date stated above, at 1 A. M.

The CAUSE OF DEATH* was as follows:
Carcinoma of the stomach

(Duration) Yrs. 4 mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. E. Froom M. D.
June 2 1921 (Address) Boise Ida,

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Canyon Hill	June 2 1921

20. UNDERTAKER: E. V. Buchanan ADDRESS: Caldwell

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED
JUN 11 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Canyon Registration District No. 3

City of Nampa (If outside limits of city or village, write the word "Rural") Registration District No. 2005

(St.)

File No. 34174

Registered No. 56

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John M. Lewis

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	White	Married

6. DATE OF BIRTH: Sept (Month) 12 (Day) 1887 (Year)

7. AGE: 33 Yrs. 8 Mos. 13 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kansas

10. NAME OF FATHER: Thos. B. Lewis

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Florence L. Morgan

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H. D. Smith
(Address) Nampa

15. Filed May 27 1921 John L. Meyer Local Registrar

SUNS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 25 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 20 1921, to May 25 1921, that I last saw h[illegible] alive on May 25 1921, and that death occurred on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis
Miliary Tuberculosis
(Duration) Yrs. 1 mos. 5 ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) Marion L. Hyde M. D.
May 26 1921 (Address) Nampa Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Nampa Cemetery DATE OF BURIAL: May 27 1921

20. UNDERTAKER: CASE FURNITURE CO. ADDRESS: Caldwell

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in full terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED JUN 11 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 3

Primary Registration District No. 2005

File No. 34175

Registered No. 55

County of [illegible]

City of [illegible] No. [illegible] St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs Mary E. Freeman (Barman)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: married (Write the word.)

6. DATE OF BIRTH: Dec 17 1852 (Month) (Day) (Year)

7. AGE: 68 Yrs. 5 Mos. 5 ds.

IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: James Campbell

11. BIRTHPLACE OF FATHER (State or Country): Mo

12. MAIDEN NAME OF MOTHER: Sally Ann Phillips

13. BIRTHPLACE OF MOTHER (State or Country): Ky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) [illegible]

(Address) Caldwell [illegible]

15. Filed May 24 1921 John H Meyer Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 22 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1 1921 to May 20 1921 that I last saw h[illegible] alive on May 20 1921, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Diabetes

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. S. Summers M. D.

May 22 1921 (Address) Caldwell Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill | DATE OF BURIAL: 5-24 1921

20. UNDERTAKER: CASE FURNITURE CO. | ADDRESS: Caldwell

[illegible] CO., PRINTERS & STEREOTYPERS, OMAHA 50057

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34176

Registered No. 54

1. PLACE OF DEATH

County of Canyon Registration District No. 3

City of Caldwell Primary Registration District No. 1005

(If outside limits of city or village, give township.) (St.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
JUN 11 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME Carl Robert Mamberg

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Oct 29 1 (Month) (Day) (Year)

7. AGE: 7 Yrs. ... Mos. ... ds.

IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Wm F. Mamberg

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Agnes Zesch

13. BIRTHPLACE OF MOTHER (State or Country): Texas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm F. Mamberg

(Address) 903 Grant Caldwell

15. Filed May 20 1921 John V. Meyer Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 19 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 3 1921, to May 19 1921, that I last saw him alive on May 19 1921, and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Myocarditis Acute Nephritis

(Duration) Yrs. 1 mos. 3 ds.

Contributory (Secondary) Diphtheria

(Duration) ... yrs. ... mos. 10 ds.

(Signed) M Daley M. D.

5-20 1921 (Address) Caldwell Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill

DATE OF BURIAL: May 20 1921

20. UNDERTAKER: CASE FURNITURE CO.

ADDRESS: Caldwell

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
JUN 11 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 3
Primary Registration District No. 2005
File No. 34177
Registered No. 53

County of Canyon
City of Caldwell (If outside limits, give township) (No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Dorothy Mae S Kindmore

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.):

6. DATE OF BIRTH: May (Month) 13 (Day) 1920 (Year)

7. AGE: Yrs. 9 Mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: B. G. Kindmore

11. BIRTHPLACE OF FATHER (State or Country): Illinois

12. MAIDEN NAME OF MOTHER: Lillian Margetts

13. BIRTHPLACE OF MOTHER (State or Country): Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) B G Kindmore
(Address) Caldwell, # 5

15. Filed May-14-1921 John S. Meyers Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 13 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 10 1920, to May 13 1921 that I last saw her alive on May 13 1921, and that death occurred on the date stated above, at 9 P.M.

The CAUSE OF DEATH* was as follows:

Inanition

(Duration) From birth yrs. mos. ds.

Contributory (Secondary) Pneumonia bronchial

(Duration) From birth yrs. mos. ds.

(Signed) R. G. Young M. D.

5-14-21 (Address) Caldwell

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill. DATE OF BURIAL: 5-15-1921

20. UNDERTAKER: V. Beckham ADDRESS: Caldwell

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED MAY 20 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 3

Primary Registration District No. 2005

File No. 34178

County of Canyon

City of Caldwell (If outside limits of city or village give township) St.)

Registered No. 52

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charles A Hindberg

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
male	White	Married (Write the word.)

6. DATE OF BIRTH: 1 (Month) 2 (Day) 1860 (Year)

7. AGE: 61 Yrs. 3 Mos. 29 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Denmark

10. NAME OF FATHER: Charles Hindberg

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country): Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Chas Hindberg
(Address) Caldwell

15. Filed May 2 1921 John L. Meyer Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 5 (Month) 1 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 9 1921 to May 1 1921 that I last saw h[illegible] alive on April 29 19..., and that death occurred on the date stated above, at 1 P M.
The CAUSE OF DEATH* was as follows:
Carcinoma of stomach
(Duration) not known Yrs. ... mos. ... ds.
Contributory (Secondary)
(Duration) ... yrs. ... mos. ... ds.
(Signed) J H Cole M. D.
5/2 1921 (Address) Caldwell Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill — DATE OF BURIAL: 5-3 1921

20. UNDERTAKER: CASE FURNITURE CO. — ADDRESS: Caldwell

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH

Dr Cole 5

Dr Cole 2

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED
MAY 20 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 3

Primary Registration District No. 2005

(No. ..... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34179

Registered No. 51

1. **PLACE OF DEATH**

County of Canyon

City of Caldwell

If death occurs away from usual residence, give facts called for under special information.

2. **FULL NAME** Mary L. Davis

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

Dudley 5

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. **SEX**: F

4. **COLOR OR RACE**: W.

5. **SINGLE, MARRIED, WIDOWED OR DIVORCED** (Write the word.): Single

6. **DATE OF BIRTH**: Feb (Month) 3 (Day) 1916 (Year)

7. **AGE**: 15 Yrs. 2 Mos. 20 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. **OCCUPATION**

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. **BIRTHPLACE** (State or Country): Oklahoma

10. **NAME OF FATHER**: Wm M. Davis

11. **BIRTHPLACE OF FATHER** (State or Country): Georgia

12. **MAIDEN NAME OF MOTHER**: Mary J. Irwin

13. **BIRTHPLACE OF MOTHER** (State or Country): Georgia

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**

(Informant) H E Davis

(Address) [illegible]

15. Filed April 25 1921 John L. Meyer Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH**: Apr (Month) 23 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 16 1920, to Jan 26 1921, that I last saw h[illegible] alive on Jan 26 1921, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Diabetes Insipidus

(Duration) 4 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) S B Dudley M. D.

19 ..... (Address) Caldwell Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. **PLACE OF BURIAL OR REMOVAL**: Greenleaf Cemetery

DATE OF BURIAL: 4-25 1921

20. **UNDERTAKER**: CASE FURNITURE CO.

ADDRESS: Caldwell

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34180
Registered No. 50

RECEIVED
MAY 20 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Canyon
City of Caldwell
Registration District No. 3
Primary Registration District No. 2005
No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Earl G. Ode

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: May (Month) 17 (Day) 1908 (Year)

7. AGE: 12 Yrs. 11 Mos. 6 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Nevada

10. NAME OF FATHER Sam T. Ode

11. BIRTHPLACE OF FATHER (State or Country) No. Dakota

12. MAIDEN NAME OF MOTHER Isabelle Summers

13. BIRTHPLACE OF MOTHER (State or Country) Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Isabelle Ode
(Address) Parma, Ida.

15. Filed April 25 1921 John F. Meyers Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr. (Month) 23 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 23 1921, to ..... 19....., that I last saw him alive on Apr. 23 1921, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Diabetes Mellitus
..... (Duration) ..... Yrs. about 10 mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas. B. Allen M. D.
4/26 1921 (Address) Parma, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill
DATE OF BURIAL: 4-25-1921

20. UNDERTAKER: CASE FURNITURE CO
ADDRESS: Caldwell

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED MAY 20 BUREAU OF STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34181

Registration District No. 3

Primary Registration District No. 1005

Registered No. 49

1. PLACE OF DEATH

County of Canyon

City of Caldwell (St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Stewart Beatty

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	W	Widower

6. DATE OF BIRTH: Nov. (Month) 20 (Day) 1837 (Year)

7. AGE: 83 Yrs. 5 Mos. 2 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Penn.

10. NAME OF FATHER: Wm W. Beatty

11. BIRTHPLACE OF FATHER (State or Country): Penn.

12. MAIDEN NAME OF MOTHER: Eleanor Stewart

13. BIRTHPLACE OF MOTHER (State or Country): Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) ——
(Address) Caldwell

15. Filed 4-23- 1921 John A. Meyer Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr (Month) 22 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw him alive on Nov 20 1920
and that death occurred on the date stated above, at 1:55 P.M.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
(Duration) ..... Yrs. 1 mos. 1 ds. 5
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds. 5

(Signed) Dr. Dora A. Hemmenth M.D.
4-23 1921 (Address) Caldwell Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill — DATE OF BURIAL: 4-24 1921

20. UNDERTAKER: CASE FURNITURE CO. — ADDRESS: Caldwell

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED
MAY 20 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 1005
File No. 34182
Registered No. 48

1. PLACE OF DEATH
County of Canyon
City of Caldwell (No. St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Donald V. McLeod
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Oct (Month) 28 (Day) 920 (Year)

7. AGE: Yrs. 5 Mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Murdo McLeod

11. BIRTHPLACE OF FATHER (State or Country) Scotland

12. MAIDEN NAME OF MOTHER Sybil D'Emos

13. BIRTHPLACE OF MOTHER (State or Country) [illegible]

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) D. W. Tingle
(Address) Caldwell Ida.

15. Filed April 18 1921 John L. Meyer. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr. (Month) 18 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 17 1921, to Apr 18 1921, that I last saw him alive on Apr 17 1921, and that death occurred on the date stated above, at 6:30 A.M.
The CAUSE OF DEATH* was as follows:
not known
died suddenly
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) G. W. Montgomery M.D.
19..... (Address) Caldwell

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill
DATE OF BURIAL: 4-19 1921

20. UNDERTAKER: CASE FURNITURE CO.
ADDRESS: Caldwell

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED MAY 20 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Canyon

City of Caldwell

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 3

Primary Registration District No. 1005

(No. ..... St.)

File No. 34183

Registered No. 47

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mrs Matilda Price Frost

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widowed

6. DATE OF BIRTH: Jan (Month) 28 (Day) 840 (Year)

7. AGE: 81 Yrs. 2 Mos. 11 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: Joseph Price

11. BIRTHPLACE OF FATHER (State or Country): Penn.

12. MAIDEN NAME OF MOTHER: — —

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs M. A. Roberts

(Address) 1010 Main, Caldwell, Ida

15. Filed Apr 11 1921 John S. Meyers Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr (Month) 9 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 8 1921, to Apr 8 1921, that I last saw h.e.r. alive on Apr 8 1921, and that death occurred on the date stated above, at 9 A M.

The CAUSE OF DEATH* was as follows:

Bronchitis Chronic

.....(Duration) .....Yrs.....mos.....ds.

Contributory (Secondary) .....

.....(Duration) .....yrs.....mos.....ds.

(Signed) T S Frazer M. D.

4/10 1921 (Address) Caldwell Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State .....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill — DATE OF BURIAL: 4-11 1921

20. UNDERTAKER: Case Furniture Co. — ADDRESS: Caldwell, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 117
Primary Registration District No. 2196
File No. 34185
Registered No. 494

RECEIVED MAY 20 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH.
County of Cassia
City of Burley (Ward, ..., St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George A. Farlow

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH. June (Month) 3 (Day) 1845 (Year)

7. AGE: 75 Yrs. 9 Mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ind.

10. NAME OF FATHER: Samuel Farlow

11. BIRTHPLACE OF FATHER (State or Country): N. C.

12. MAIDEN NAME OF MOTHER: Elizabeth Heavnridge

13. BIRTHPLACE OF MOTHER (State or Country): Tenn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Samuel Farlow
(Address) Burley Ida

15. Filed Apr. 19-21 1921 Dr. J. C. Patterson Local Registrar
By ..... Deputy

SYMS - YORK CO., PTRS. & BORS. 24853

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 13 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 26" 1921, to To Apr 13" 1921, that I last saw him alive on Apr. 13 1921, and that death occured on the date stated above, at 8 Ho P. M.

The CAUSE OF DEATH* was as follows:
Cancer of Liver
(Duration) 1 Yrs. 4 mos. ds.
Contributory (Secondary) ✓ (Duration) yrs. mos. ds.

(Signed) P. J. Story M. D.
4-14-1921 (Address) Burley Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Buhl Ida — DATE OF BURIAL: April 14 1921

20. UNDERTAKER: R. W. Wall — ADDRESS: Burley Ida

FORM V. S. No. 5-12 M. 6-15-17.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
AMERICAN—RESERVED FOR BINDING

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34186
Registered No. 301

RECEIVED MAY 20 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Canyon
City of Burley
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 11
Primary Registration District No. 2196
(....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Pauline Criswell

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. July (Month) 8th (Day) 1903 (Year)

7. AGE: 17 Yrs. 7 Mos. 6 ds.
IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Washington

10. NAME OF FATHER: W. R. Criswell

11. BIRTHPLACE OF FATHER (State or Country): Kentucky

12. MAIDEN NAME OF MOTHER: Lutta Atkinson

13. BIRTHPLACE OF MOTHER (State or Country): Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. H. V. Bonner
(Address) Burley Ida.

15. Filed Apr. 2 1921 Dr. J. L. Patterson Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr. (Month) 2nd (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar. 24 1921 to Apr. 2, 1921 that I last saw h.. alive on Apr. 1st 1921 and that death occurred on the date stated above, at 2:00 P.M.

The CAUSE OF DEATH* was as follows:
Diphtheria
(Duration) ..... Yrs. ..... mos. 9 ds.
Contributory (Secondary)
(Duration) ..... Yrs. ..... mos. ..... ds.
(Signed) Dr. J. L. Patterson M. D.
4-2-1921 (Address) Burley Ida.

*State the Disease Causing Death; or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the ,State....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Dayton, Wash. DATE OF BURIAL: Apr. 4 1921

20. UNDERTAKER: L. E. Gallogly ADDRESS: Burley Ida.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 117
Primary Registration District No. 2196
File No. 34187
Registered No. 203

1. PLACE OF DEATH
County of Cassia
City of Burley
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James Murland
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

RECEIVED MAY 20 1921

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.):

6. DATE OF BIRTH: Nov (Month) 18 (Day) 1920 (Year)

7. AGE: ..... Yrs. 4 Mos. ..... ds. 16
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Burley Ida

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Don't Know

12. MAIDEN NAME OF MOTHER: Myrtle Andrews

13. BIRTHPLACE OF MOTHER (State or Country): Montpelier, Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Mrs M. L. Andrews
(Address): Burley Ida

15. Filed 4-2-21 19..... Rev. J. C. Patterson
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April 2 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Streptococcus Septicemia

..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
..... (Duration) Since Birth Yrs. ..... mos. ..... ds.

(Signed) L. A. Cooper, M. D.
..... 19..... (Address) Burley Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Burley Ida. DATE OF BURIAL: April 3 1921.

20. UNDERTAKER: L. A. Draughn ADDRESS

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34188

Registered No. 302

1. **PLACE OF DEATH**

County of Cassia

City of Burley

(No. 101, N. Almo Ave., St.)

Registration District No. 117

Primary Registration District No. 2196

If death occurs away from usual residence, give facts called for under special information.

2. **FULL NAME** Ida B. Boyd.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married.

6. **DATE OF BIRTH**

Feby (Month) 5 (Day) 1862 (Year)

7. **AGE**

59 Yrs. 2 Mos. 18 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. **OCCUPATION**

(a) Trade, profession or particular kind of work: Housewife.

(b) General nature of industry, business or establishment in which employed (or employer):

9. **BIRTHPLACE** (State or Country) Illinois.

10. **NAME OF FATHER** Rondell

11. **BIRTHPLACE OF FATHER** (State or Country) Illinois.

12. **MAIDEN NAME OF MOTHER** Catherine Rondell.

13. **BIRTHPLACE OF MOTHER** (State or Country) Illinois

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**

(Informant) J. M. Boyd

(Address) 101 N. Almo Ave.

15.

Filed 4-24-27 19.... Dr. J. C. Patterson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH**

April (Month) 23 (Day) 1927 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 18 1927, to April 23 1927 that I last saw her alive on April 23 1927 and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Carcinoma of bile ducts and head of Pancreas.

(Duration) 1 Yrs. ..... mos. ..... ds.

Contributory (Secondary) Gallstones

(Duration) 15 yrs. ..... mos. ..... ds.

(Signed) R. V. Bartz M. D.

4/26 1927. (Address) Burley, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. **PLACE OF BURIAL OR REMOVAL** Twin Falls Ida. **DATE OF BURIAL** April 27 1927

20. **UNDERTAKER** J. B. Talley

ADDRESS Burley Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34189

Registered No. 307

1. PLACE OF DEATH.

County of Cassia

City of Burley

(No. ..... St.)

Registration District No. 117

Primary Registration District No. 2196

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Harold Hunter Richins

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: April (Month) 30 (Day) 1916 (Year)

7. AGE: 4 Yrs. 11 Mos. 10 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Wm Alma Richins

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Lois Hunter

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W. A. Richins

(Address) Burley

15. Filed 4-11-21 191 ..... Dr. J. C. Pattison Local Registrar

SYMS - YORK CO., PTRS. & ADRS. 24853

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 10 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 10, 1921, to Apr 10 1921, that I last saw h alive on Apr 10 1921, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Diphtheria

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) F. H. Cutler M. D.

4-10-1921 (Address) Burley Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Burley Ida — DATE OF BURIAL: Apl 11 1921

20. UNDERTAKER: Burwash — ADDRESS: Burley

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-12 M. 6-15-17.

RECEIVED MAY 20 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34191
Registered No. 22

1. PLACE OF DEATH
County of Cassia Registration District No. 11
City of Burley Primary Registration District No. 296
If death occurs away from usual residence, give facts called for under special information. (No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William K. Rice

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Aug (Month) 22 (Day) 1848 (Year)

7. AGE: 72 Yrs. 8 Mos. 5 ds. IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: William K. Rice

11. BIRTHPLACE OF FATHER (State or Country): N. J.

12. MAIDEN NAME OF MOTHER: Lucy M. Gier

13. BIRTHPLACE OF MOTHER (State or Country): Mich

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Roscoe Rice
(Address) Burley Ida.

15. Filed May 12 1921. Dr. J. C. Patterson Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 27 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 10 1921 to April 27 1921
that I last saw him alive on April 27 1921
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Angina Pectoris
(Duration) ..... Yrs. ..... mos. one hour ds.
Contributory (Secondary) Fibrum Tuberculosis
(Duration) ..... Yrs. ..... mos. 28 ds.
(Signed) P. J. Story M. D.
19.... (Address) Burley Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Pleasant View Cemetery — DATE OF BURIAL: Apl 30 1921

20. UNDERTAKER: Rivercatt — ADDRESS: Burley

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Clearwater RECEIVED JUN 10 1921 BUREAU OF VITAL STATISTICS

Registration District No. 90

Primary Registration District No. 7168

City of Orofino (No. ..... St.)

File No. 34192

Registered No. 18

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Leslie Axtell

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Male	White	Single (Write the word.)

6. DATE OF BIRTH Feb (Month) 7 (Day) 1921 (Year)

7. AGE 3 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Orofino, Idaho.

10. NAME OF FATHER Henry Melvile Axtell

11. BIRTHPLACE OF FATHER (State or Country) Iowa

12. MAIDEN NAME OF MOTHER Clyde Coffman

13. BIRTHPLACE OF MOTHER (State or Country) Wash

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
Henry Melvile Axtell (Informant)
Orofino, Idaho. (Address)

15. May 13, 21. Filed ..... 19 .....
J. M. Jacky Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 13 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 4 1921, to May 12 1921, that I last saw her alive on May 12, 1921 and that death occurred on the date stated above, at 7 A.M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Earle W Boswell M. D.

May 13 1921 (Address) Orofino Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Orofino Idaho

DATE OF BURIAL May 13 1921

20. UNDERTAKER C.E. Bobo & Son

ADDRESS Orofino Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

RECEIVED JUN 10 1921 BUREAU OF VITAL STATISTICS

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 90
Primary Registration District No. 2168
File No. 34193
Registered No. 19

1. PLACE OF DEATH

County of Clearwater
City of Orofino (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Annie Tane

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Oct. (Month) 22 (Day) 1851 (Year)

7. AGE: 69 Yrs. 6 Mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Redman

11. BIRTHPLACE OF FATHER (State or Country): - - - - ----------

12. MAIDEN NAME OF MOTHER: ----------

13. BIRTHPLACE OF MOTHER (State or Country): ----------

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Walter Tane
(Address) Orofino Idaho

15. Filed May 16 1921 J. M. Faircloth Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 14 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1919, to May 14 1921, that I last saw h[illegible] alive on May 10 1921, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Arterio-Sclerosis

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Paralysis
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Faircloth M. D.
May 14 1921 (Address) Orofino Idy

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Orofino Idaho
DATE OF BURIAL: May 15 1921

20. UNDERTAKER: Bobo & Son
ADDRESS: Orofino Idah

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34194

Registered No. 20

1. PLACE OF DEATH

RECEIVED JUN 10 1921 BUREAU OF VITAL STATISTICS

Registration District No. 90

Primary Registration District No. 2168

County of Clearwater

City of Orofino (If outside limits, give township) St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Samuel Guy

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH

..... 1864
(Month) (Day) (Year)

7. AGE

56 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Pennsylvania

10. NAME OF FATHER Henry Guy

11. BIRTHPLACE OF FATHER (State or Country) Scotland

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (State or Country) Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Frank P. Fitz

(Address) Pierce, Idaho

15. Filed May 17 1921

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 15 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ✓ 19..., to ✓ 19...

that I last saw h... alive on ✓ 19...,

and that death occurred on the date stated above, at ... M.

The CAUSE OF DEATH* was as follows:

/ Cirrhosis of the arteries.

..... (Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary) .....

..... (Duration) ... yrs. ... mos. ... ds.

(Signed) J C Bullock Coroner M. D.

May 17 1921 (Address) Orofino, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Morris, Pennsylvania	May 23 1921
20. UNDERTAKER	**ADDRESS**
C.E. Bobo & Son	Orofino, Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JUN 10 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 90

County of Clearwater — Primary Registration District No. 266 — File No. 34195

City of Lenora (No. ..... St.) — Registered No. 21

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Dale Elton Rutledge

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.):

6. DATE OF BIRTH: May (Month) 30 (Day) 1920 (Year)

7. AGE: 1 Yrs. 2 Mos. 1 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work:

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Lenora

10. NAME OF FATHER: Steven A Rutledge

11. BIRTHPLACE OF FATHER (State or Country): Wash

12. MAIDEN NAME OF MOTHER: Rena Walker

13. BIRTHPLACE OF MOTHER (State or Country): Wash

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Steven A Rutledge

(Address) Lenora Idaho

15. Filed May 31 1921 — J M Family — Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 30 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1 1921, to May 31 1921, that I last saw him alive on May 31 1921, and that death occurred on the date stated above, at 12:25 P.M.

The CAUSE OF DEATH* was as follows:

Acute Gastro-Enteritis.

(Duration) ..... Yrs. ..... mos. 18 ds.

Contributory (Secondary): Intestinal stasis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J M Family M. D.

5/31/1921 (Address) Orofino Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lenora Idaho — DATE OF BURIAL: May 31 1921

20. UNDERTAKER: Steven Rutledge — ADDRESS: Orofino Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11

RECEIVED
JUN 10 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34196
Registered No. 22

1. PLACE OF DEATH Registration District No. 90
County of Clearwater Primary Registration District No. 2 68
City of Orofino (If outside city limits, give township) St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John M. Holland

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: About (Month) (Day) 1863 (Year)

7. AGE: About 58 yrs. ✓ mos. ✓ ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business or establishment in which employed (or employer): General Farm Work

9. BIRTHPLACE (State or Country): Norway

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Unknown.

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. W. Atteberry
(Address) Orofino, Idaho.

15.
Filed May 11 1921
J. M. Hardy
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May Tenth (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 15th 1905, to May 10th 1921, that I last saw him alive on May 10th 1921 and that death occurred on the date stated above, at 4:50 P. M.

The CAUSE OF DEATH* was as follows:

Septicaemia

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) Insanity

..... (Duration) Unknown yrs. ..... mos. ..... ds.

(Signed) J. Hansen M. D.
5/11/21 (Address) Orofino Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 15 yrs. 9 mos. 26 ds.
In the State 34 About yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? Unknown
Former or usual residence Latah County

19. PLACE OF BURIAL OR REMOVAL: Sanitarium, Cemetery
DATE OF BURIAL: 5/11 1921

20. UNDERTAKER: J. W. Atteberry
ADDRESS: Orofino

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34197

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Clearwater

City of Elk River (If not in incorporated limits, give township.) St.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
JUN 3 1921
BUREAU OF VITAL STATISTICS

Registration District No. 91

Primary Registration District No. 2166

2. FULL NAME Anna Bahn

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. September 17 (Month) (Day) 1863 (Year)

7. AGE: 57 Yrs. 9 Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Norway

10. NAME OF FATHER: Christensen

11. BIRTHPLACE OF FATHER (State or Country): Norway

12. MAIDEN NAME OF MOTHER: X

13. BIRTHPLACE OF MOTHER (State or Country): Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Oscar Bahn

(Address) Elk River Idaho

15.

Filed May 25th, 1921 Mrs. F. P. McCormick Local Registrar

SYMS - YORK CO., LITHS. & ROBS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 25th, 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 25 1921, to ..... 191....., that I last saw h..... alive on ..... 191....., and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Taking Carbolic acid Either accidental or suicidal

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) F. P. McCormick M. D.

..... 19..... (Address) .....

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Park Idaho — DATE OF BURIAL: May 26 1921

20. UNDERTAKER: Morris & Son — ADDRESS: Elk River

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34198

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

RECEIVED JUN 3 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH.

Registration District No. 91

Primary Registration District No. 2168

County of Clear Water

City of Elk River (If not in limits, give township) St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Clara Belle McNeil

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. March (Month) 12 (Day) 1921 (Year)

7. AGE: .....Yrs. 1 Mos. 14 ds.

IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Elk River

10. NAME OF FATHER Albert McNeil

11. BIRTHPLACE OF FATHER (State or Country) Washington

12. MAIDEN NAME OF MOTHER Bertha Johnson

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) F. P. McComas

(Address) Elk River

15.

Filed May 30 1921 Mrs. F. P. McComas Local Registrar

SYMS - YORK CO., PTRS. & STNRS. 24853

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr (Month) 26 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 25 1921, to April 26 1921, that I last saw her alive on April 25 1921 and that death occured on the date stated above, at .....M.

The CAUSE OF DEATH* was as follows:

Intestinal trouble

.....(Duration) .....Yrs. .....mos. .....ds.

Contributory (Secondary) .....

.....(Duration .....yrs. .....mos. .....ds.

(Signed) F. P. McComas M. D.

.....19..... (Address) Elk River Idaho

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL: April 27 1921

20. UNDERTAKER: Morris Bros | ADDRESS: Elk River Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED JUN 13 1921 BUREAU OF VITAL STATISTICS STATE OF IDAHO

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 34
Registration District No. 2020
File No. 34199
Registered No. 6

1. PLACE OF DEATH

County of Elmore
City of Inter Home (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William Elmer Waller

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH: Sep. (Month) 7 (Day) 1892 (Year)

7. AGE: 28 Yrs. 7 Mos. 19 Ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Elba Ohio

10. NAME OF FATHER: Louis Lincoln Waller

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Maria Emily Luke

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chas. F. Waller
(Address) Inter Home Ida

15. Filed 5—1—1921 J. E. Evans Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr. (Month) 26 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 18 1921, to April 26, 1921
that I last saw him alive on April 26 1921
and that death occurred on the date stated above, 8.30 P.M.
The CAUSE OF DEATH* was as follows:
Septicemia

(Duration) ..... Yrs. ..... mos. 10 ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. E. Evans M. D.
6-1-1921 (Address) Inter Home Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mtn. Home — DATE OF BURIAL: 4-29-1921

20. UNDERTAKER: C. W. Donovan — ADDRESS: Mtn. Home

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34200

Registered No. 7

RECEIVED JUN 13 1921 BUREAU OF VITAL STATISTICS

Registration District No. 34

Primary Registration District No. 2020

1. PLACE OF DEATH

County of Elmore

City of Mtn Home (If outside limits, give township) St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Margaret Wall

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.): Widowed

6. DATE OF BIRTH: (Month) (Day) 1837 (Year)

7. AGE: 84 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ireland

10. NAME OF FATHER: Hugh Gillespie

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Boyd

13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. R. Anderson

(Address) Mtn Home Ida

15. Filed 5-12-1921 F. E. Evans Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 11 (Day) 19 21 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 8 19 21, to May 11 19 21, that I last saw h[illegible] alive on May 8 19 21 and that death occurred on the date stated above, at 9.30 P. M.

The CAUSE OF DEATH* was as follows:

Myocarditis arterio-sclerosis.

(Duration) 2 Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) O. S. Hamilton M. D.

5-12-1921 (Address) Mountain Home Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: St Joseph M[illegible] | DATE OF BURIAL 19

20. UNDERTAKER: [illegible] Conover | ADDRESS Mtn Home

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. [redacted] CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 35

County of Elmore Primary Registration District No. 2021

City of King Hill (If not in city give township) St.)

File No. 34201

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William Pendal Mullins

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

JUN 3 1921
BUREAU OF VITAL STATISTICS

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Mail

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): At Home

6. DATE OF BIRTH: Feb. (Month) 19th (Day) 1917 (Year)

7. AGE: 4 yrs. 4 mos. ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business or establishment in which employed (or employer) At Home

9. BIRTHPLACE (State or Country): Idaho Elmo Co.

10. NAME OF FATHER: Oscar L. Mullins

11. BIRTHPLACE OF FATHER (State or Country): Kentucky

12. MAIDEN NAME OF MOTHER: Mary Elizebeth Irwin

13. BIRTHPLACE OF MOTHER (State or Country): Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Oscar L. Mullins
(Address) King Hill Ida

15. Filed May 21 1921 J. W. Davis Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 19 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 19 1921, to May 19 1921 that I last saw him alive on ..... 191 , and that death occurred on the date stated above, at 5: P M.

The CAUSE OF DEATH* was as follows:
Accidental drowning

(Duration) — yrs. — mos. — ds.

Contributory (Secondary)

(Duration) — yrs. — mos. — ds.

(Signed) Irving Ford M. D.
May 19 1921 (Address) Glenns Ferry

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and 2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence, ...

19. PLACE OF BURIAL OR REMOVAL: Glenns Ferry | DATE OF BURIAL: May 21 1921

20. UNDERTAKER: J. W. Buchanan | ADDRESS: Glenns Ferry

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

Form V. S. No. [redacted]

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH ... tion District No. 35

County of Elmore JUN 3 1921 Primary Registration District No. 2021

City of Glenn's Ferry BUREAU OF VITAL STATISTICS No. ..., ... St.)

File No. 34202

Registered No. ...

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Unnamed

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: May (Month) 11th (Day) 1921 (Year)

7. AGE: ... yrs. ... mos. ... ds. IF LESS than 1 day how many 1 hrs. or ... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry business or establishment in which employed (or employer): ...

9. BIRTHPLACE (State or Country): America

10. NAME OF FATHER: Alvi V. Rice

11. BIRTHPLACE OF FATHER (State or Country): America

12. MAIDEN NAME OF MOTHER: Effie King

13. BIRTHPLACE OF MOTHER (State or Country): America

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Alvi V. Rice
(Address) Glenn's Ferry Idaho

15.
Filed May 12th 1921 J. W. Doris Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 11th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 11th 1921, to May 11 1921, that I last saw her alive on May 11th 1921, and that death occurred on the date stated above, at 6:45 P M.

The CAUSE OF DEATH* was as follows:

... (Duration) ... yrs. ... mos. 1 hr ds.
Contributory (Secondary) Premature Birth
... (Duration) ... yrs. ... mos. ... ds.

(Signed) J. W. Doris M. D.
May 12 1921 (Address) J. W. Doris

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and 2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs ... mos ... ds. In the State ... yrs ... mos ... ds.
Where was disease contracted.
If not at place of death?
Former or usual residence ...

19. PLACE OF BURIAL OR REMOVAL: Mountain Home Idaho — DATE OF BURIAL: May 12th 1921

20. UNDERTAKER: Alvi V. Rice — ADDRESS: Glenn's Ferry Idaho

N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 18672

Form V. S. [redacted]

RECEIVED
MAY 24 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 35

County of Elmore Registration District No. 2021

City of Glenns Ferry (No. ....., ... St.)

File No. 34203

Registered No. [redacted]

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital or institution state name instead of street and number

2. FULL NAME Carrie Leeright

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Aug (Month) 25 (Day) 1861 (Year)

7. AGE: 59 yrs. 6 mos. 17 ds. IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business or establishment in which employed (or employer) Housewife

9. BIRTHPLACE (State or Country) Perry Co. Ill.

10. NAME OF FATHER Ed. Pyatt.

11. BIRTHPLACE OF FATHER (State or Country) — Ill

12. MAIDEN NAME OF MOTHER Nina Cerain

13. BIRTHPLACE OF MOTHER (State or Country) Ill Perry Co.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Geo. W. Leeright
(Address) Glenns Ferry Ida

15.
Filed March 16 1921 J. W. Davis
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Mar (Month) 14 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 9th, 1921, to March 14 1921
that I last saw her alive on March 14th, 1921,
and that death occurred on the date stated above, at 3:25 A. M.
The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... yrs. ..... mos. 5 ds.

Contributory (Secondary) Influenza

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. W. Davis M. D.

March 16 1921 (Address) Glenns Ferry Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and 2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Glenns Ferry Idaho — DATE OF BURIAL: March 16 1921

20. UNDERTAKER: Joe Rubsam — ADDRESS: Glenns Ferry Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34204

Registered No. 38

RECEIVED JUN 11 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH.

Registration District No. 2119

County of Franklin

Primary Registration District No. 27

City of Weston (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sybil Kofoed

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. Oct (Month) 1 (Day) 1920 (Year)

7. AGE: Yrs. 7 Mos. 25 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Franklin Co Idaho

10. NAME OF FATHER Geo. H. Kofoed

11. BIRTHPLACE OF FATHER (State or Country) Franklin Co

12. MAIDEN NAME OF MOTHER Rozella Williams

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George H. Kofoed

(Address) Weston Idaho

15. Filed May 31 1921 Dan Griffiths Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 25 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 22 1921, to May 25 1921, that I last saw her alive on May 24 1921, and that death occured on the date stated above, at 11 60 M.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia

(Duration) Yrs. mos. 3 ds.

Contributory (Secondary)

(Duration yrs. mos. ds.

(Signed) Thos B Holden M. D.

19 (Address) Weston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Weston, Ida. DATE OF BURIAL: May 27 1921

20. UNDERTAKER: — ADDRESS: —

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & ADMS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34205
Registered No. 31

RECEIVED JUN 11 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH.
Registration District No. 2119
County of Franklin Primary Registration District No. 27
City of Weston (If not in city give township) St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Myrtle Mary Gunter

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. March (Month) 29 (Day) 1921 (Year)

7. AGE: ....Yrs. ....Mos. 17 ds.
IF LESS than 1 day how many ....hrs. or ....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country) Franklin Co

10. NAME OF FATHER A. C. Gunter

11. BIRTHPLACE OF FATHER (State or Country) N. C.

12. MAIDEN NAME OF MOTHER Mary Elizabeth Rasmussen

13. BIRTHPLACE OF MOTHER (State or Country) Franklin Co

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Lars. Rasmussen
(Address) Weston Idaho

15. Filed May 21 1921 Dan Wells Local Registrar

SYMS - YORK CO., PTRS. & MFRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 15 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 7 1921, to April 15 1921, that I last saw her alive on April 7 1921, and that death occured on the date stated above, at 11 30 A.M.

The CAUSE OF DEATH* was as follows:
Pneumonia

(Duration) ....Yrs. ....mos. 8 ds.

Contributory (Secondary)
(Duration ....yrs. ....mos. ....ds.

(Signed) Thos B Holder M. D.
19.... (Address) Weston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Preston Idaho — DATE OF BURIAL: April 17 1921
20. UNDERTAKER — ADDRESS —

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34206

Registered No. 29

RECEIVED JUN 1 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH.

Registration District No. 2117

Primary Registration District No. 27

County of Franklin

City of Preston (If outside limits, give township.) St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Roy Nelson jr

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
Male	white	single (Write the word.)

6. DATE OF BIRTH.

May (Month) 14 (Day) 1921 (Year)

7. AGE

.....Yrs.....Mos.....ds.

IF LESS than 1 day how many ...hrs. or 40 min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... —

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country) Franklin Co Idaho

10. NAME OF FATHER Roy O Nelson

11. BIRTHPLACE OF FATHER

(State or Country) Franklin Co

12. MAIDEN NAME OF MOTHER Marie Jensen

13. BIRTHPLACE OF MOTHER

(State or Country) Franklin Co

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Roy O Nelson

(Address) Preston Idaho

15.

Filed May 31 1921

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May (Month) 14 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 14 1921, to May 14 1921, that I last saw him alive on May 14 1921 and that death occured on the date stated above, at 6 A. M.

The CAUSE OF DEATH* was as follows:

Premature Birth 5½ months Gestation

.....(Duration) .....Yrs. .....mos. .....ds.

Contributory (Secondary) .....

.....(Duration .....yrs. .....mos. .....ds.

(Signed) Thos B Holder M. D.

.....19..... (Address) Preston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Weston Ida.	May 15 1921
20. UNDERTAKER	ADDRESS
—	

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYNS - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34207

RECEIVED JUN 11 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No.
Primary Registration District No.
County of Franklin
City of Mink Creek (St.)

If death occurs away from usual residence, give facts called for under special information.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Madoline Jeppson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: single (Write the word.)

6. DATE OF BIRTH: May (Month) 14 (Day) 1921 (Year)

7. AGE: ....Yrs. ....Mos. 6 ds.

IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: ✓

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Hyrum W. Jeppson

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Agnes Watson

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15. Filed .... 19....

Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 20 (Day) 19 21 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 14 19 21, to .... 19....,
that I last saw her alive on .... 19....,
and that death occurred on the date stated above, at 7 A. M.
The CAUSE OF DEATH* was as follows:

Died suddenly, cause of death not known.

.... (Duration) .... Yrs. .... mos. .... ds.

Contributory (Secondary)

.... (Duration) .... yrs. .... mos. .... ds.

(Signed) Albert R Curtis M. D.

5/20 19 21. (Address) Preston, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .... yrs. .... mos. .... days. In the State .... yrs. .... mos. .... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Mink Creek	5/21 19 21.
20. UNDERTAKER	ADDRESS
✓	✓

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34208

Registered No. 36

1. PLACE OF DEATH

County of Franklin

City of Washville (St.)

Registration District No. 2119

Primary Registration District No. 27

RECEIVED JUN 14 1921 BUREAU OF VITAL STATISTICS

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Ann Gamble.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F	W	Widowed

6. DATE OF BIRTH: June (Month) 13 (Day) 1842 (Year)

7. AGE: 79 Yrs. 10 Mos. 21 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: ~

(b) General nature of industry, business or establishment in which employed (or employer): ~

9. BIRTHPLACE (State or Country): England.

10. NAME OF FATHER: George Roscoe.

11. BIRTHPLACE OF FATHER (State or Country): England.

12. MAIDEN NAME OF MOTHER: Martha Brittland

13. BIRTHPLACE OF MOTHER (State or Country): England.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) George Gamble

(Address) Preston, Idaho

15. Filed May 31 1921 D. A. R. Cullen Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 4 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 2 1921 to May 4 1921 that I last saw her alive on May 2 1921 and that death occurred on the date stated above, at 9:30 A.M.

The CAUSE OF DEATH* was as follows:

Endarteritis obliterans

(Duration) ..... Yrs. 1 mos. 7 ds.

Contributory (Secondary) C. V. D. [redacted]

(Duration) Assumed yrs. ..... mos. ..... ds.

(Signed) J. H. Cutler Jr. M. D.

5-4 1921 (Address) Preston Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Franklin, Ida. DATE OF BURIAL: May 7 1921

20. UNDERTAKER ~ ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2119
Primary Registration District No. 27
File No. 34209
Registered No. 32

1. PLACE OF DEATH
County of Franklin
City of Mink Creek (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Neff Warren Rasmussen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Feb. (Month) 21 (Day) 1921 (Year)

7. AGE: 0 Yrs. 7 Mos. 22 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Rasmus Rasmussen

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Effie Lillian Larsen

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Rasmus Rasmussen
(Address) Mink Creek Idaho

15. Filed May 31 1921 — Dora R. Cullen, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 13 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Gastro enteritis, acute

(Duration) ..... Yrs. ..... mos. 3 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Curtis Bland M. D.
5/13/1921 (Address) Preston, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mink Creek Idaho — DATE OF BURIAL: May 13 1921

20. UNDERTAKER: None — ADDRESS:

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Caribou

City of ——

(No. ——, —— St.)

Registration District No. 2119

Primary Registration District No. 27

File No. 34210

Registered No. 28

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Araminta E. Packer

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: 7

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH. Dec. (Month) 8 (Day) 1877 (Year)

7. AGE: Yrs. 43 Mos. 4 ds. 9

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Preston, Idaho

10. NAME OF FATHER: Joseph D. Sharp

11. BIRTHPLACE OF FATHER (State or Country): Illinois

12. MAIDEN NAME OF MOTHER: Rebecca J. Higley

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) A. T. Sharp

(Address) Preston, Idaho

15. Filed May 31, 1921 Dan Cutler Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 17 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 14 1921, to April 15 1921, that I last saw her alive on April 15 1921, and that death occured on the date stated above, at 5:00 P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... Yrs. ..... mos. 10 ds.

Contributory (Secondary) Premature delivery

(Duration ..... yrs. ..... mos. 2 ds.

(Signed) Russell Tigert M. D.

4/19/1921. (Address) Soda Springs Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Preston Ida — DATE OF BURIAL: Apr. 21 1921

20. UNDERTAKER: W. A. Gridmore — ADDRESS: Preston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & ENGS. 24658

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JUN 11 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 2119

County of Franklin

Primary Registration District No. 27

File No. 34211

City of Fairview (No. ....., ... St.)

Registered No. 30

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elsie Peterson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: 3 (Month) 13 (Day) 1921 (Year)

7. AGE: Yrs. ..... Mos. 1 Ds. 28

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: X

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Logan Utah

10. NAME OF FATHER: John Peterson

11. BIRTHPLACE OF FATHER (State or Country): Richmond Utah

12. MAIDEN NAME OF MOTHER: Edith Jane Cottle

13. BIRTHPLACE OF MOTHER (State or Country): Richmond Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm Cottle

(Address) Fairview Idaho

15. Filed May 31 1921 Dr A R Cuddy Local Registrar

SYMS-YORK CO. PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 5 (Month) 9 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5-2 1921, to 5-9 1921 that I last saw h[illegible] alive on 5-2 1921 and that death occurred on the date stated above, at 6 P M.

The CAUSE OF DEATH* was as follows:

Died in convulsions

Dr. was not present.

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Mother in insane home

(Duration) ..... yrs. 2 mos. ..... ds.

(Signed) Dr A R Cuddy M. D.

5-10 1921 (Address) Preston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Richmond Utah

DATE OF BURIAL: May 11 1921

20. UNDERTAKER: none

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34212
Registered No. 95

RECEIVED
JUN 11 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Franklin Registration District No. 2119

City of Preston (No. , St.) Primary Registration District No. 27

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Clark Hubbard Salisbury

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	W	

6. DATE OF BIRTH: May (Month) 14 (Day) 1921 (Year)

7. AGE: — Yrs. — Mos. — ds. IF LESS than 1 day how many 12 hrs. or — min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business or establishment in which employed (or employer) —

9. BIRTHPLACE (State or Country) Preston Idaho

10. NAME OF FATHER Norman D Salisbury

11. BIRTHPLACE OF FATHER (State or Country) Baker Oregon

12. MAIDEN NAME OF MOTHER Eliza Hubbard

13. BIRTHPLACE OF MOTHER (State or Country) Willard Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Norman D Salisbury

(Address) Preston Ida

15. Filed May 31 1921 Dr A Cullen Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 14 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 14 — 1921, to May 14 1921 that I last saw h. alive on Never 19—, and that death occurred on the date stated above, at —M. The CAUSE OF DEATH* was as follows: Child dead when I arrived. Blue baby.

(Duration) — Yrs. — mos. 1/2 ds.

Contributory (Secondary) —

(Duration) — yrs. — mos. — ds.

(Signed) G W States M. D.

May 14 1921 (Address) Preston Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death — yrs. — mos. — days. In the State — yrs. — mos. — days

Where was disease contracted if not at place of death? —

Former or usual residence —

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Preston Ida	May 15 1921
20. UNDERTAKER W A Skidmore	ADDRESS Preston Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34213

Registered No. 34

1. PLACE OF DEATH

County of Franklin — Registration District No. 219

City of Glendale — Primary Registration District No. 27

(St.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED JUN 11 1921 BUREAU OF VITAL STATISTICS

2. FULL NAME Eldra Vinay Owen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F	W.	

6. DATE OF BIRTH: May (Month) 5 (Day) 1921 (Year)

7. AGE: ___ Yrs. ___ Mos. ___ ds. IF LESS than 1 day how many ___ hrs. or 30 min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Glendale Ida

10. NAME OF FATHER Ernest Owen

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER Matilda L. Peterson

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ernest Owen

(Address) Preston Ida.

15. Filed May 31 1921

Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 5 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 5 1921, to May 5 1921, that I last saw h[illegible] alive on May 5 1921, and that death occurred on the date stated above, at 5a M.

The CAUSE OF DEATH* was as follows:

Premature birth.

(Duration) — Yrs. — mos. — ds.

Contributory (Secondary) —

(Duration) ___ yrs. ___ mos. ___ ds.

(Signed) G W Slater M. D.

May 5 1921 (Address) Preston Ida

*State the Disease Causing Death; or in deaths from Violent Causes state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ___ yrs. ___ mos. ___ days. In the State ___ yrs. ___ mos. ___ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Preston Idaho	May 6 1921

20. UNDERTAKER	ADDRESS
W. A. Hartmore	Preston Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34214

Registered No. 33

1. PLACE OF DEATH

County of Franklin

City of Preston (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED JUN 11 1927 BUREAU OF VITAL STATISTICS

Registration District No. 27

Primary Registration District No. 27 2119

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Nathaniel Howard Eames

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M.	W.	

6. DATE OF BIRTH: Dec (Month) 14 (Day) 1920 (Year)

7. AGE: Yrs. 4 Mos. 20 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business or establishment in which employed (or employer) —

9. BIRTHPLACE (State or Country) Preston Idaho

10. NAME OF FATHER Nathaniel H Eames

11. BIRTHPLACE OF FATHER (State or Country) Preston Idaho

12. MAIDEN NAME OF MOTHER Ruby Teagle

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A H Eames
(Address) Preston Idaho

15. Filed May 31 19 27 D. A. Ruleo Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 4 (Day) 1927 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 14 1927, to May 4 1927, that I last saw h.. alive on May 3 1927, and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Meningitis (Streptococcus Hemolyticus

(Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary) Acute double otitis media

(Duration) ..... yrs. ..... mos. 20 ds.

(Signed) A. R. Cutler M. D.

19..... (Address) Preston Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Preston Idaho	May 5 1927
20. UNDERTAKER	**ADDRESS**
W. A. Skidmore	Preston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34215
Registered No.

1. PLACE OF DEATH
County of Bannock
City of Pocatello (If outside limits, give township.) St.)
Registration District No. 99
Primary Registration District No. 2177

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
JUN 3 1921
BUREAU OF VITAL STATISTICS

James Bullock Mason

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: June 15 (Month) (Day) 1843 (Year)

7. AGE: 78 Yrs. 11 Mos. 13 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Domestic
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: Thomas Bullock

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Henriette Rushton

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) James T. B. Mason
(Address)

15.
Filed May 10 1921 W. B. Wren Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr 28 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from at Mt Home to 19..., that I last saw h... alive on 19..., and that death occurred on the date stated above, at ...M.
The CAUSE OF DEATH* was as follows:

Senility

(Duration) ...Yrs...mos...ds.
Contributory (Secondary)
(Duration) ...yrs...mos...ds.

(Signed) W. B. Wren M.D. M. D.
19... (Address) Mt Home Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ...yrs...mos...days. In the State ...yrs...mos...days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Parke | DATE OF BURIAL: May 2 1921

20. UNDERTAKER: None | ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
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FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34216

Registered No.

1. PLACE OF DEATH

County of Fremont

City of St. Anthony

Registration District No. 9

Primary Registration District No. 2 1 7

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED JUN 3 1921 BUREAU OF VITAL STATISTICS

2. FULL NAME Opal Spillman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Infant. (Write the word.)

6. DATE OF BIRTH: Feb (Month) 27th-21. (Day) 1 (Year)

7. AGE: ..... Yrs. ..... Mos. I ds. I2 IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): St. Anthony, Ida.

10. NAME OF FATHER: William Spillman

11. BIRTHPLACE OF FATHER (State or Country): London , England

12. MAIDEN NAME OF MOTHER: Carrie S. Eggertz.

13. BIRTHPLACE OF MOTHER: Utah. (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm Spillman

(Address) Sugar #1 Box 30

15. Filed May 10 1921 W B Burt Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April 10th-2I. 19..... (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 27th-2I. 19..... to April 10th-2I 19....., that I last saw h..... alive on April 5th-2I. 19....., and that death occurred on the date stated above, at 3 A.M.

The CAUSE OF DEATH* was as follows:

Congential Cardiac Valvular disease

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. Frank Watkins M. D.

(Address) St. Anthony, Ida.

19 April 11th-2I.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL 19.....

20. UNDERTAKER | ADDRESS

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 3427

Registered No.

RECEIVED JUN 3 1921 BUREAU OF VITAL STATISTICS

Registration District No. 9 1

Primary Registration District No. 177

1. PLACE OF DEATH

County of Fremont

City of St anthony (Ward) (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Daniel H. Brown

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	white	single

6. DATE OF BIRTH

Dec 1 (Month) 1860 (Day) (Year)

7. AGE

60 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Rancheman

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) utah

10. NAME OF FATHER Daniel G. Brown

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER anna Brown

13. BIRTHPLACE OF MOTHER (State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W H Brown

(Address) Salina Utah

15.

Filed May 10 1921 W Brown Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

4 (Month) 16 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3-24 1921, to 4-16- 1921, that I last saw him alive on 3-16- 1921, and that death occurred on the date stated above, at 6 a M.

The CAUSE OF DEATH* was as follows:

Anastasia

(Duration) Yrs. 2 mos. - ds.

Contributory (Secondary) mitral insufficiency

(Duration) yrs. mos. ds.

(Signed) Jno R Gray M. D.

4/18 1921 (Address) St anthony Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
rigby	4/18/1921

20. UNDERTAKER	ADDRESS
Edison Taylor	St anthony Ida

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34218
Registered No.

RECEIVED JUN 9 1921 BUREAU OF VITAL STATISTICS

Registration District No.
Primary Registration District No. 6

1. PLACE OF DEATH
County of Gem
City of Emmett (No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Henry Arp

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): married

6. DATE OF BIRTH: What age (Month) (Day) 1 (Year)

7. AGE: Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retail Lumber
(b) General nature of industry, business or establishment in which employed (or employer): manager

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: Joachin Arp.

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Katherine Hilbert

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Ben Arp.
(Address): Monroe, Wash

15. Filed May 2 1921 J. L. Reynolds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr (Month) 28 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 24 1921 to Apr 28 1921 that I last saw him alive on Apr 28 1921, and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:
~~Chr~~ Uraemia due to
Chronic nephritis
(Duration) several Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) R. H. Cummings M. D.
Apr 30 1921 (Address) Emmett Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Emmett Idaho — DATE OF BURIAL: 4/30 1921

20. UNDERTAKER: E. D. Buckmeun — ADDRESS: Emmett Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34219
Registered No.

RECEIVED
JUN 9 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
Registration District No.
Primary Registration District No. 6
County of Gem
City of Emmett (No. St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Archie J. Biglin
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: not known (Month) (Day) (Year)

7. AGE: 75 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER: Martin Biglin

11. BIRTHPLACE OF FATHER (State or Country): Ireland ~~Maryland~~

12. MAIDEN NAME OF MOTHER: unknown

13. BIRTHPLACE OF MOTHER (State or Country): "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wm H Burns
(Address) Emmett Idaho

15. Filed 5/18/ 1921
J. A. Reynolds
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 12 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 12 1921, to one visit 19, that I last saw h— alive on May 12 1921, and that death occurred on the date stated above, at 11 P M.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) several Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. A. Reynolds M. D.

5/18 1921 (Address) Emmett Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Bramwell, Idaho
DATE OF BURIAL: 5/13 1921

20. UNDERTAKER: C. D. Bucknum
ADDRESS: Emmett Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JUN 9 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34220
Registered No.

1. PLACE OF DEATH
County of Gem
Registration District No.
Primary Registration District No.
City of Emmett (Ward, St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James Jones
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	white	Widower

6. DATE OF BIRTH: Aug (Month) 27 (Day) 1847 (Year)

7. AGE: 73 Yrs. 8 Mos. 13 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Indiana

10. NAME OF FATHER: unknown

11. BIRTHPLACE OF FATHER (State or Country): "

12. MAIDEN NAME OF MOTHER: "

13. BIRTHPLACE OF MOTHER (State or Country): "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) James M Jones
(Address) Emmett Idaho

15. Filed 5/18 1921 J. L. Reynolds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 10 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 8 1921, to May 10 1921, that I last saw h[illegible] alive on May 10 1921, and that death occurred on the date stated above, at M.
The CAUSE OF DEATH* was as follows:

Apoplexia

(Duration) Yrs. mos. 3 ds.
Contributory (Secondary) Arterio Sclerosis
(Duration) Several yrs. mos. ds.
(Signed) J. L. Reynolds M. D.
5/18 1921 (Address) Emmett

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Emmett Idaho — DATE OF BURIAL: 5/12 1921

20. UNDERTAKER: O. D. Buckner — ADDRESS: Emmett Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

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FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34221

RECEIVED JUN 9 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
Registration District No. 6
Primary Registration District No.
County of Ada
City of Emmett (Ward, St.)
Registered No.
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elizabeth Ritchie Meek
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: widow (Write the word.)

6. DATE OF BIRTH: March (Month) 15 (Day) 1842 (Year)

7. AGE: 79 Yrs. 2 Mos. 1 ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: James Aitken

11. BIRTHPLACE OF FATHER (State or Country): Scotland

12. MAIDEN NAME OF MOTHER: Fanny Ritchie

13. BIRTHPLACE OF MOTHER (State or Country): Not Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Elsie B. Varns
(Address) Emmett Idaho

15. Filed 5/18 1921
J. L. Reynolds
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 16 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 15 1921, to May 16 1921, that I last saw her alive on May 16 1921, and that death occurred on the date stated above, at 4 P M.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary): Chronic Heart Disease

(Duration) Several yrs. ... mos. ... ds.

(Signed) J. L. Reynolds M. D.

5/18 1921 (Address) Emmett

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Marissa Ill — DATE OF BURIAL ... 19...

20. UNDERTAKER: C. D. Buckner — ADDRESS: Emmett Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-18

BUREAU OF VITAL STATISTICS
JUN 14 1921
RECEIVED

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34223

Registration District No. 49
Primary Registration District No. 4428
Registered No. .....

1. PLACE OF DEATH.
County of Idaho
City of Kamiah
No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Susie Reuben Corbett

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: Indian
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow
6. DATE OF BIRTH. About (Month) 1 (Day) 1841 (Year)
7. AGE: About 80 Yrs. ..... Mos. ..... Ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): Idaho
10. NAME OF FATHER: Chief Joseph
11. BIRTHPLACE OF FATHER (State or Country): Idaho
12. MAIDEN NAME OF MOTHER: Not Known
13. BIRTHPLACE OF MOTHER (State or Country): " "
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Albert Davis
(Address) Kamiah Ida
15. Filed 5/23 1921 C J Johnson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 21 (Day) 1921 (Year)
17. I HEREBY CERTIFY, That I attended deceased from 5-11 1921, to 5-22 1921, that I last saw h.. alive on 5-21 1921, and that death occured on the date stated above, at 9:00 M.
The CAUSE OF DEATH* was as follows:
Senile Debility
..... (Duration) ..... Yrs. ..... mos. 1 ds.
Contributory (Secondary) .....
..... (Duration ..... yrs. ..... mos. ..... ds.
(Signed) C Taylor M. D.
5-23 1921 (Address) Kamiah

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Ind Cem No 1 Kamiah — DATE OF BURIAL: 5/24 1921
20. UNDERTAKER: C J Johnson — ADDRESS: Kamiah Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

BYRD - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-18

BUREAU OF VITAL STATISTICS
RECEIVED
JUN 14 1921

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34224
Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
Registration District No. 49
Primary Registration District No. 2458
County of Lewis
City of ..... (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Melvin Hamilton

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY,

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE:

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Dec (Month) 26 (Day) 1861 (Year)

7. AGE: 59 Yrs. 4 Mos. 21 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... farmer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Iowa

10. NAME OF FATHER Wm E. Hamilton

11. BIRTHPLACE OF FATHER (State or Country) Ohio Penn

12. MAIDEN NAME OF MOTHER Ellen Clark

13. BIRTHPLACE OF MOTHER (State or Country) Del

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) W. H. Hamilton
(Address) Lewiston Idaho

15. Filed 5/14 1921 J. H. Thuson Local Registrar

SYMS - YORK CO., PTRS. & STRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
May (Month) 12 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 13th 1921, to alone 191..., that I last saw him alive on May 12 1921, and that death occured on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:
Acute appendicitis
.....
.....
.....(Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary)
.....(Duration ..... yrs. ..... mos. ..... ds.

(Signed) C. F. Benson M. D.
5-14-1921 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Dodd Cem Rameck Ida — DATE OF BURIAL: 5/14 1921

20. UNDERTAKER: C. F. Johnson — ADDRESS: Rameck Ida

FORM V. S. No. 5-25 M. 1-16-[illegible]

RECEIVED JUN 9 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 103

County of Idaho Registration District No. 2181

City of Mt Idaho (No. ..... St.)

File No. 34225

Registered No. 10

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William Stanley Jr Williams

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Oct. (Month) 15-4 (Day) 1837 (Year)

7. AGE: 83 Yrs. 6 Mos. 19 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Madisonville Tenesee

10. NAME OF FATHER: William Williamas

11. BIRTHPLACE OF FATHER (State or Country): 7 1

12. MAIDEN NAME OF MOTHER: 2 1

13. BIRTHPLACE OF MOTHER (State or Country): 2 1

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm. T. Williams

(Address) Grangeville, Ida.

15. Filed June 1 1921 G. S. Stockton Local Registrar

SYMS - YORK CO., PTRS. & STRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 3 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 21 1921 to May 3 1921 that I last saw h[illegible] alive on May 1 1921 and that death occured on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(Duration) Several Yrs. ____ mos. ____ ds.

Contributory (Secondary) Valvular lesion of heart

(Duration) Several yrs. ____ mos. ____ ds.

(Signed) G. S. Stockton M. D.

5/4 1921 (Address) Grangeville Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mt Idaho — DATE OF BURIAL: May 4 1921

20. UNDERTAKER: E B Hancock — ADDRESS: Grangeville

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 103
Primary Registration District No. 1001
File No. 34226
Registered No. 11

RECEIVED JUN 9 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Idaho
City of Grangeville (or Township.....) (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary E Rossiter

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married.

6. DATE OF BIRTH: July (Month) 17 (Day) 1869 (Year)

7. AGE: 51 Yrs. 9 Mos. 14 ds.
IF LESS than 1 day how many..... hrs. or.....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Oregon.

10. NAME OF FATHER: Eli Mason.

11. BIRTHPLACE OF FATHER (State or Country): ?

12. MAIDEN NAME OF MOTHER: ?

13. BIRTHPLACE OF MOTHER (State or Country): ?

14. THE ABOVE IS TRUE TO THE BEST ~~OF MY~~ KNOWLEDGE
(Informant) Mrs Rossiter
(Address) Grangeville

15. Filed June 1 1921 G. S. Stockton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 10 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 10 1921, to May 11 1921 that I last saw h.er alive on May 11 1921, and that death occurred on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:
accidental Gun shot wound thro' the lungs

(Duration) ..... Yrs..... mos. 24 hrs.

Contributory (Secondary)
(Duration) ..... yrs..... mos..... ds.

(Signed) G. S. Stockton M. D.
5/12 1921 (Address) Grangeville Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Prairie View — DATE OF BURIAL: May 12 1921

20. UNDERTAKER: A. L. Mauzy — ADDRESS: Grangeville

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED JUN 9 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 103

Primary Registration District No. 1001

File No. 34227

Registered No. 12

County of Idaho

City of Grangeville (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Albert Koch

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Unknown (Month) (Day) 1854 (Year)

7. AGE: 67 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Cook

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: —

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) E S Hancock

(Address) Grangeville

15. Filed June 1 1921 G S Stockton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 26 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 24 1921, to May 25 1921, that I last saw him alive on May 25 1921, and that death occured on the date stated above, at 11 A. M.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) P B Chipman M. D.

6/1 1921 (Address) Grangeville Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Prairie View — DATE OF BURIAL: May 25 1921

20. UNDERTAKER: E S Hancock — ADDRESS: Grangeville

SYMS - YORK CO., PTRS. & BORS. 24653

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34228

Registered No. 13

RECEIVED JUN 9 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH.

Registration District No. 103

Primary Registration District No. 1001

County of Idaho

City of Grangeville (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Percy Mark Glanville

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Oct. (Month) 3 (Day) 1874 (Year)

7. AGE: 46 Yrs. 8 Mos. 18 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Druggist

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Michigan

10. NAME OF FATHER: Wm Glanville

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Elizabeth Cleveland

13. BIRTHPLACE OF MOTHER (State or Country): Canada.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mabel Sonnerdy

(Address) Grangeville, Ida

15. Filed June 1 1921 G S Stockton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 21 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 21 1921, to May 21 1921, that I last saw h[im] alive on May 21 1921 and that death occured on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Accidentally drowned during flood.

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G S Stockton M. D.

5/24 1921 (Address) Grangeville Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Prairie View

DATE OF BURIAL: May 24 1921

20. UNDERTAKER: A J Maugg

ADDRESS: Grangeville

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & ENGS. 24658

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

34229 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 105
County of Idaho Primary Registration District No. 2183 File No. 7
City of Grencher (or Township) ....., ... St.) Registered No. .....
If death occurs away from usual residence, give facts called for under special information.
2. FULL NAME Gertrude Stolz
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

RECEIVED JUN 4 BUREAU OF VITAL STATISTICS

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH: Oct (Month) 16 (Day) 1899 (Year)
7. AGE: 21 yrs. 6 mos. 16 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewifery
(b) General nature of industry business, or dstablishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): Idaho
10. NAME OF FATHER: E T Stolz
11. BIRTHPLACE OF FATHER (State or Country): [illegible]
12. MAIDEN NAME OF MOTHER: Mary Verhaar
13. BIRTHPLACE OF MOTHER (State or Country): Minn
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Francis G. Nuttall
(Address) Green creek Idaho
15.
Filed May 2 1921 H H Mann Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 2 (Day) 1921 (Year)
17. I HEREBY CERTIFY, That I attended deceased from April 20 1921, to May 2 1921, that I last saw her alive on May 1 1921 and that death occurred on the date stated above, at 8:00 P.M.
The CAUSE OF DEATH* was as follows:
Ptomaine poisoning
(Duration) ..... yrs. ..... mos. 8 ds.
Contributory (Secondary) None
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Wesley F. Orr M. D.
5/2 1921 (Address) Cottonwood Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Greencreek — DATE OF BURIAL: 5-4 1921
20. UNDERTAKER: H H Mann — ADDRESS: Cottonwood Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Jefferson

City of Rigby (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 98

Primary Registration District No. 2176

RECEIVED
MAY 20 1921
BUREAU OF VITAL STATISTICS

File No. 34232

Registered No. 24

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F	Mexican	Dufont

6. DATE OF BIRTH: Apr 21 (Month) (Day) 1921 (Year)

7. AGE: ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many 4 hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Dufont
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ida.

10. NAME OF FATHER: Jose Calderon

11. BIRTHPLACE OF FATHER (State or Country): Mexico

12. MAIDEN NAME OF MOTHER: Margarita Calderon

13. BIRTHPLACE OF MOTHER (State or Country): Mexico

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Eufracia Garcia
(Address) Rigby

15. Filed 5/10 1921 Ray W. Fisher Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr 21 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to Apr 21 1921 that I last saw h.er alive on Apr 21 1921 and that death occurred on the date stated above, at 6 M.

The CAUSE OF DEATH* was as follows:

Premature delivery

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. A Anderson M. D.

Apr 22 1921 (Address) Rigby, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Rigby	4-23 1921
20. UNDERTAKER	ADDRESS
Funds	Rigby

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
MAY 20 1921
BUREAU OF VITAL STATISTICS

PLACE OF DEATH.

Registration District No. 98

County of Jefferson — Primary Registration District No. 2176

City of Ririe (St.)

File No. 34233

Registered No. 25

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Henry Sayer.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

SEX: M.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

DATE OF BIRTH. Apr. (Month) 24 (Day) 1866 (Year)

AGE: 54 Yrs. 3 Mos. 16 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

OCCUPATION

Trade, profession or particular kind of work: Farmer.

General nature of industry, business, or establishment in which employed (or employer):

BIRTHPLACE (State or Country): Utah.

NAME OF FATHER: Thomas Sayer

BIRTHPLACE OF FATHER (State or Country): England.

MAIDEN NAME OF MOTHER: Elizabeth Jolley

BIRTHPLACE OF MOTHER (State or Country): England.

I HEREBY CERTIFY THAT THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. J. H. Sayer.

(Address) Ririe, Idaho.

Filed Jan 10th 1921 Ray V. Fisher Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan 8 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 8th 1921, to Jan 8th 1921, that I last saw him alive on Jan 8th 1921, and that death occured on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:

Poisoning (accidental)
Phenol.

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Sam T. Price M. D.

Jan 9 1921 (Address) Ririe, Idaho

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rigby, Idaho. DATE OF BURIAL: Jan 13th 1921

20. UNDERTAKER: C. E. Dimmock ADDRESS: Idaho Falls, Idaho.

- WEIK CO., PTRS. & ROBS. 24653

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34234
Registered No. 26

1. PLACE OF DEATH

Registration District No. 98
Primary Registration District No. 2176

County of Jefferson
City of Ririe (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED MAY 20 1921 BUREAU OF VITAL STATISTICS

2. FULL NAME Heber A. Morgan

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Infant

6. DATE OF BIRTH: Mar 10 1921 (Month) (Day) (Year)

7. AGE: ..... Yrs. ..... Mos. 10 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ida

10. NAME OF FATHER: Joseph C. Morgan

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Malissa Bassett

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Joseph C. Morgan
(Address) Rigby Ida

15. Filed 5/10 1921 Ray H. Fisher Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar 20 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 10 1921, to Mar 20 1921 that I last saw h.. alive on Mar 18 1921 and that death occurred on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:

Congenital malformation

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) Sam F. Price M. D.

3/21 1921 (Address) Ririe, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Poplar Ida — DATE OF BURIAL: 3/21 1921

20. UNDERTAKER — ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED MAY 30 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 98
Primary Registration District No. 2176
File No. 34238
Registered No. 30

1. PLACE OF DEATH
County of Jefferson
City of Rigby (No. St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Percival A Caldwell
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: married (Write the word.)

6. DATE OF BIRTH: Dec 26 1891 (Month) (Day) (Year)

7. AGE: 29 Yrs. 4 Mos. 6 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer): A

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Alvin S. Caldwell

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Ada Harper

13. BIRTHPLACE OF MOTHER (State or Country): Eng.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Alvin S. Caldwell
(Address) Rigby, Ida.

15. Filed 5/10 1921 Ray H Fisher Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 2 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 24 1921 to May 2 1921
that I last saw h.im alive on May 2 1921
and that death occurred on the date stated above, at 12 M.
The CAUSE OF DEATH* was as follows:

Cerebral Abscess

(Duration) Yrs. mos. 5 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) H. A. Anderson M. D.
5/3 1921 (Address) Rigby, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rigby — DATE OF BURIAL: 5-7 1921

20. UNDERTAKER: W. L. Young — ADDRESS: Rigby

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED MAY 27 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3424 1

1. PLACE OF DEATH
County of Jerome
City of Hagerman (No. ....., ... St.)
Registration District No. .....
Primary Registration District No. .....
Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charles Adams Reynolds Jr.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: single (Write the word.)

6. DATE OF BIRTH: December (Month) 29 (Day) 19 (Year)

7. AGE: ..... Yrs. / Mos. 27 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Colorado

10. NAME OF FATHER: Chas Adams Reynolds

11. BIRTHPLACE OF FATHER (State or Country): Ky.

12. MAIDEN NAME OF MOTHER: Hiela Thomas

13. BIRTHPLACE OF MOTHER (State or Country): Ky.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Charles Reynolds.
(Address) Hagerman Ida.

15.
Filed ..... 19 .....
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 24 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 20 1921, to Feb 24 1921, that I last saw him alive on Feb 24 1921, and that death occurred on the date stated above, at 11 30 A M.

The CAUSE OF DEATH* was as follows:
Bronchs pneumonia

(Duration) ..... Yrs. ..... mos. 4 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E L Berry M. D.
Feb 24 1921 (Address) Hagerman Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Odd Fellows Cemetery Hagerman Ida
DATE OF BURIAL: Feb 25 1921

20. UNDERTAKER: H. Eggers, Com
ADDRESS: Hagerman Ida

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
MAY 27 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34242
Registered No.

1. PLACE OF DEATH
County of Jerome
City of Hazelton (No. , St.)
Registration District No.
Primary Registration District No.
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME David Rosenoff
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: German-Russian
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Sept (Month) 25 (Day) 1910 (Year)

7. AGE: 10 Yrs. 7 Mos. 14 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Russia

10. NAME OF FATHER: Jochab Rosenoff

11. BIRTHPLACE OF FATHER (State or Country): Russia

12. MAIDEN NAME OF MOTHER: Anna Fink

13. BIRTHPLACE OF MOTHER (State or Country): Russia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant)
(Address) Joseph Petersen Hazelton Ida

15. Filed May 26 1921 E. E. Berry M. D. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 9 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at 5 0 M.
The CAUSE OF DEATH* was as follows:
Accidental Drowning
(Disclosed on this one until after death E.E.B.)
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) E. E. Berry M. D.
5/10 1921 (Address) Hazelton

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Hazelton Idaho
DATE OF BURIAL: May 11 1921

20. UNDERTAKER: Ayers
ADDRESS: Hazelton Ida
Chinman Cemetery Cem.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
MAY 27 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH — Registration District No. 23
County of Jerome — Primary Registration District No. 1017-2017
City of Hazelton (No. ....., ... St.) — File No. 34243
Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Rosa Rosenoff

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: Russian
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Nov 4 1905 (Month) (Day) (Year)

7. AGE: 5 Yrs. 6 Mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Montana

10. NAME OF FATHER: Jacob Rosenoff

11. BIRTHPLACE OF FATHER (State or Country): Russia

12. MAIDEN NAME OF MOTHER: Anna Fink

13. BIRTHPLACE OF MOTHER (State or Country): Russia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) .....
(Address) Jacob Rosenoff Hazelton Ida

15. Filed May 10 1921 E. D. Piper Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 9 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..., to ..... 19...,
that I last saw h..... alive on ..... 19...,
and that death occurred on the date stated above, at 5 P.M.
The CAUSE OF DEATH* was as follows:
Accidental Drowning
(I did not see this case until after death E. D. P.)
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) E. D. Parry M. D.
5-10 1921 (Address) Hazelton Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Hazelton Idaho — DATE OF BURIAL: May 11 1921

20. ~~UNDERTAKER~~ H. Eyers — ADDRESS: Hazelton Ida
Shimmon Cemetery Assn.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34244
Registered No.

1. PLACE OF DEATH

Registration District No. 23
Primary Registration District No. 1017-2017

County of Jerome
City of Jerome (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
MAY 27 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME Lela LEE

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Infant (Write the word.)

6. DATE OF BIRTH: Apr 12 (Month) (Day) 1921 (Year)

7. AGE: ..... Yrs. ..... Mos. 12 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Jerome

10. NAME OF FATHER: Harry LEE

11. BIRTHPLACE OF FATHER (State or Country): Wyoming

12. MAIDEN NAME OF MOTHER: Hazel White

13. BIRTHPLACE OF MOTHER (State or Country): Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Hazel White
(Address) Jerome Idaho

15.
Filed ..... 19 .....
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr (Month) 24 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 12 1921, to Apr 24 1921, that I last saw h.. alive on Apr 24 1921, and that death occurred on the date stated above, at 2 P. M.
The CAUSE OF DEATH* was as follows:

Premature Birth.

..... (Duration) ..... Yrs. ..... mos. 12 ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E. D. Silver M. D.
5/26 1921 (Address) Jerome

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Jerome Cemetary	Apr 25 1921
20. UNDERTAKER	ADDRESS
Harry Lee (Father)	Jerome Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34245

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

RECEIVED MAY 24 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH.

Registration District No. 23

County of Jerome

Primary Registration District No. 1017-2017

City of Jerome (If outside city limits or village, write TOWNSHIP.) St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Christine Coats

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. May (Month) 5 (Day) 1857 (Year)

7. AGE: 70 Yrs. 11 Mos. 6 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Stockman
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mo

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) .....

15. Filed 4/13 1921 E. D. Piper M.D. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 11 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 1920, to Apr 10 1921, that I last saw him alive on Apr. 10 1921, and that death occured on the date stated above, at 1 P. M.

The CAUSE OF DEATH* was as follows:

Arterio sclerosis

(Duration) Chronic Yrs. ..... mos. ..... ds.

Contributory (Secondary) Apoplexy

(Duration 1 yrs. — mos. ..... ds.

(Signed) E. D. Piper M. D.

4/13 1921 (Address) Jerome

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain Home — DATE OF BURIAL: 191

20. UNDERTAKER: D. W. Brunsman — ADDRESS: Jerome

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BKBS. 24658

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED MAY 27 1924 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34246
Registered No. .....

1. PLACE OF DEATH.
Registration District No. 23
Primary Registration District No. 1012-2017
County of Jerome
City of Jerome (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Nellie Florence Thomas

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH. Sept. (Month) 16 (Day) 1916 (Year)
7. AGE: 4 Yrs. 4 Mos. 7 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work... Child
(b) General nature of industry, business, or establishment in which employed (or employer).....
9. BIRTHPLACE (State or Country) Pittsburg, Pa.
10. NAME OF FATHER Clarence S. Thomas
11. BIRTHPLACE OF FATHER (State or Country) Pittsburg Pa.
12. MAIDEN NAME OF MOTHER Emma D Steiner
13. BIRTHPLACE OF MOTHER (State or Country) Pittsburg Pa.
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Chas. F. Zeller
(Address) Jerome, Ida.
15. Filed Feb 4 1924 E. D. Pyle M. D. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan. (Month) 23 (Day) 1921 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Jan 23 1921, to Jan 23 1921, that I last saw her alive on Jan 23 1921, and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Fracture of Vertex & base of skull due to being thrown from buggy in Runaway (Duration) ..... Yrs. 5 mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Chas F. Zeller M. D.
1/23 1921 (Address) Jerome, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Jerome cemetery — DATE OF BURIAL: 1-24-1921
20. UNDERTAKER: D. R. Herrsond — ADDRESS: Jerome

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34247

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

RECEIVED
MAY 27 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH.

County of Jerome Registration District No. 23

City of Jerome Primary Registration District No. 1017-2017

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs Alice Ellen Allan

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: 7

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. April (Month) ..... (Day) 1861 (Year)

7. AGE: 61 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... at Home
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Canada

10. NAME OF FATHER John Ryder Ridgeway

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER Betsy Brownman

13. BIRTHPLACE OF MOTHER (State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) John P Ridgeway
(Address) .....

15. Filed May 4 1921 E. D. Pyle M.D. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 4 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 14 1921, to May 4 1921, that I last saw h alive on May 4 1921, and that death occured on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

La Grippe

.....(Duration) ..... Yrs. ..... mos. 19 ds.

Contributory (Secondary) Chronic Myocarditis

.....(Duration 10 yrs. ..... mos. ..... ds.

(Signed) E. D. Pyle M. D.

5/4 1921 (Address) Jerome

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Chicago Ill. DATE OF BURIAL Removal May 6 1921

20. UNDERTAKER: D. A. L Henson ADDRESS Jerome

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., FTRS. & BORS. 24654

FORM V. S. No. 5-25 M. 1-[illegible]

RECEIVED
MAY 27 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34249
Registered No. .....

1. PLACE OF DEATH. Registration District No. 23
County of Jerome Primary Registration District No. 1017-2017
City of Jerome (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Richard Alexander Burks.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	W	Married

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE ..... 1 ..... Yrs. ..... 8 ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Jerome, Ida

10. NAME OF FATHER Richard A Burks

11. BIRTHPLACE OF FATHER (State or Country) Virginia

12. MAIDEN NAME OF MOTHER Leona Shepard

13. BIRTHPLACE OF MOTHER (State or Country) Wash

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) C. F. Zeller
(Address) Jerome, Idaho

15. Filed Jan 27 1921 E. D. Pyper Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan. 26 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 26 1921, to Jan. 26 1921, that I last saw h[illegible] alive on Jan 26 1921, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Status Lymphaticus
Enlarged Pituitary Gland
.....(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
.....(Duration ..... yrs. ..... mos. ..... ds.
(Signed) C. F. Zeller M. D.
19..... (Address) Jerome, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Jerome Cemetery	Jan 28 1921
20. UNDERTAKER	ADDRESS
L. A. Sheridan	Jerome

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

DISINTERMENT PERMIT

STATE OF IDAHO
DEPARTMENT OF PUBLIC HEALTH
BOISE, IDAHO

APPLICATION HAVING BEEN MADE for the disinterment of the body of Richard A. Burks Jr

now lying buried in Jerome Cemetery, in the City or Town of Jerome

County of Jerome State of Idaho, who died on the 26 day of January, 1921, Aged 1 years 8 months 12 days, the cause of death being _____ and not directly or indirectly by diphtheria; (membranous croup); scarlet fever; smallpox; leprosy; asiatic cholera; typhus fever; or yellow fever as shown by the certificate of death of said deceased, given by

Dr A.R.Zeller attending physician

THIS IS TO CERTIFY that permission is hereby given for such disinterment and removal by Private private or railway conveyance

to Jerome Cemetery in the City or Town of Jerome County of Jerome

State of Idaho to take effect upon the approval by the local board of health of the City, Town, or County of Jerome it being understood and provided that nothing herein shall be deemed as contravening or in anywise modifying or releasing the Regulations of the Department of Public Health governing the Transportation of Corpses or the requirements for a Transportation permit, and all Transportation Companies and Common Carriers will be governed accordingly; and provided further, that where the disinterment is for the purpose of reinterment in another part of the same cemetery, or in a contiguous cemetery, the removal shall not be made by any public conveyance. The disinterment and removal must be done under the personal supervision of a licensed Embalmer in good standing. If the remains are to be removed from the cemetery they (including the disinterred casket), must be enclosed in a new metallic lined outer case before removal.

Given under my hand and Seal of the Department of Public Health at Boise, Idaho,

permit issued to: this 21st day of Sept, A.D. 19 21.

W. W. Benson
by Director ~~Registrar~~ Vital Statistics

The foregoing application for disinterment and removal is hereby approved by the local Board of Health of the City, Town or County of Jerome State of Idaho, this 21 day of Sept 19 21.

Health officer

Form DPH-48019

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED MAY 3 BUREAU OF STATISTICS

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 126
County of Kootenai Subdivision, Registration District No. 2204
City of Harrison (No. ..... St.)
File No. 34251
Registered No. 52

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charlie C. Lehman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH. Sept (Month) 9 (Day) 1876 (Year)

7. AGE 44 Yrs. 7 Mos. 20 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Farmer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Camden Ohio

10. NAME OF FATHER Benjamin Lehman

11. BIRTHPLACE OF FATHER (State or Country) Pa

12. MAIDEN NAME OF MOTHER Emma Cook

13. BIRTHPLACE OF MOTHER (State or Country) Camden Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Chas Lehmann
(Address) Harrison, Idaho.

15. Filed May 1 1921 J. M. Kinney Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 28 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 12 1921, to April 28 1921, that I last saw him alive on April 29 1921, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Pneumonia
.....(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
.....(Duration ..... yrs. ..... mos. ..... ds.
(Signed) J. M. Kinney M. D.
4-28-1921 (Address) Harrison Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Harrison — DATE OF BURIAL May 1 1921

20. UNDERTAKER Kitchen — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34252

Registered No. 79

1. PLACE OF DEATH. Registration District No. 126

County of Kootenai Primary Registration District No. 2204

City of Harrison (If not in incorporated limits, give township.) St.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
MAY 20 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME Muriel Madson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. June (Month) 29 (Day) 1903 (Year)

7. AGE: 17 Yrs. 9 Mos. 23 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer)...

9. BIRTHPLACE (State or Country) Wis

10. NAME OF FATHER Nelson Madson

11. BIRTHPLACE OF FATHER (State or Country) Denmark

12. MAIDEN NAME OF MOTHER Lillian Benjamin

13. BIRTHPLACE OF MOTHER (State or Country) Minn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Madsen
(Address)

15. Filed May 1 1921 J M Timmons Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 22 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 1 1921, to April 22 1921, that I last saw her alive on April 22 1921, and that death occured on the date stated above, at 9 P M.

The CAUSE OF DEATH* was as follows:
Endocarditis

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary)

(Duration ... yrs. ... mos. ... ds.

(Signed) J M Timmons M. D.

4-23 1921 (Address) Harrison Idee

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL ..... 191...

20. UNDERTAKER | ADDRESS
M Ketchum

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

34253

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 9

Registered No. 78

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

RECEIVED
MAY 20 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH.

Registration District No. 126

County of Kootenai

Subdistrict Registration District No. 2204

City of Black Lake (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Thos B Stillman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH. June 17 1834 (Month) (Day) (Year)

7. AGE: 87 Yrs. 2 Mos. 25 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Miner

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): New London, Conn.

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) F E Dwan

(Address) Harrison Ida.

15. Filed May 1 1921

J H Tenney
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April 12 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 9 1921, to April 12 1921, that I last saw h..... alive on ..... 191..., and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Senility

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Endocarditis

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) J H Tenney M. D.

4-15-1921 (Address) Harrison Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL ..... 191...

20. UNDERTAKER M Ketchum | ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STNRS. 24658

RECEIVED
MAY 20 1921
BUREAU OF VITAL STATISTICS

Washington State Board of Health

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

34254
Record No.

Registered No.

PLACE OF DEATH

County of Spokane,

City or Town of precinct of Blanchard

Registration Dist No. 153 No.

(If death occurred in a hospital or institution, give its NAME instead of street and number)

2. FULL NAME Isaac Saud Fitzjohn,

(a) Residence No. St.,
(Usual place of abode)

(b) If non-resident, give city or town, and state

(c) How long in Registration Dist. yrs. mos. ds.; how long in U. S. if of foreign birth yrs. mos. ds.

Personal and Statistical Particulars

3. Sex: Male
4. Color or Race: White
5. Single, Married, Widowed or Divorced (Write the word): Married

5. (a) If married, widowed, or divorced:
Husband of
or
Wife of

6. Date of birth: X
(Month) (Day) (Year)

7. Age: 69 yrs. mos. ds. If less than one day: hrs. or min.

8. Occupation of deceased:
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): X
(c) Name of employer: self

9. Birthplace (City or town)
(State or Country): England

PARENTS

10. Name of Father: X
11. Birthplace of Father (City or town) (State or Country): X
12. Maiden name of Mother: X
13. Birthplace of Mother (City or town) (State or Country): X

14. Informant: Jesse W. Strange,
Address: Blanchard, Idaho.

15. Filed 4/24, 1921 Lois Hendricks
Registrar.

Medical Certificate of Death

16. Date of death: Apr 21, 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 29, 1921, to Apr 21, 1921
that I last saw him alive on Apr 20, 1921
and that death occurred on the date stated above, at 11 P m.
(State the disease causing death, or, in deaths from violent causes, state: (1) Means and nature of injury; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL).
The CAUSE OF DEATH was as follows:

READ DETAILS ON OTHER SIDE

(Primary) Lobar Pneumonia
(See 1 and 3 other side) double

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY ~
(Secondary)
(See 2 other side)

(Duration) yrs. mos. ds.

18. Where was disease contracted if not at the place of death? Blanchard ~

(a) Did an operation precede death? no Date of

(b) Was there an autopsy? no

(c) What test confirmed diagnosis? ~

(Signed) Earle D Propst M. D.

4-23, 1921 Address Spirit Lake Idaho

19. Place of Burial, Cremation or Removal: Blanchard
Date of Burial: 4/22, 1921

20. Undertaker: Wm Stevens
Address: Newport Wn

I HEREBY CERTIFY, upon honor, That I have made the effort but was unable to secure answers to questions
(Insert numbers of unanswered questions)
(Signature of Undertaker)

RECEIVED
MAY 20 1921
BUREAU OF VITAL STATISTICS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1—30M—3-20

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34255

RECEIVED
MAY 28 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Kootenai
City of Spirit Lake (No. ..... St.)
Registration District No. 41
Primary Registration District No. .....
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Frances Maxine Roberts
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem.
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Sing.
6. DATE OF BIRTH: Dec. 9th (Month) (Day) 1920 (Year)
7. AGE: — Yrs. — Mos. 30 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): Spirit Lake, Idaho
10. NAME OF FATHER: Roland Roberts
11. BIRTHPLACE OF FATHER (State or Country): Wales, England
12. MAIDEN NAME OF MOTHER: Ina Frances Rooks
13. BIRTHPLACE OF MOTHER (State or Country): Mo.
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Roland Roberts
(Address) Spirit Lake, Ida.
15. Filed 1/10 1920 Chas. Hamrick Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: January 8th (Month) (Day) 1921 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Jan. 8 1921, to Jan. 8 1921
that I last saw h— alive on Jan. 8 1921,
and that death occurred on the date stated above, at 9:00 A.M.
The CAUSE OF DEATH* was as follows:
Broncho-Pneumonia
(Duration) ..... Yrs. ..... mos. 3 ds.
Contributory (Secondary) Congestion of Lungs
(Duration) ..... yrs. ..... mos. 3 0 ds.
(Signed) Frank Vern M. D.
1/8 1921 (Address) Rathdrum, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Athol Idaho — DATE OF BURIAL: 1/10 1920
20. UNDERTAKER: C. W. Stevens — ADDRESS: Rathdrum

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JUN 9 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 30
Primary Registration District No. 8051
(No. ..... St.)

File No. 34258
Registered No. 923

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Koot

City of Post Falls R.F.D.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME No Name McClean

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: May (Month) 6 (Day) 1921 (Year)

7. AGE: ..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many 5 hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Post Falls R.F.D.

10. NAME OF FATHER: Milton McClean

11. BIRTHPLACE OF FATHER (State or Country): North Carolina

12. MAIDEN NAME OF MOTHER: Elnora Norris

13. BIRTHPLACE OF MOTHER (State or Country): N. Carolina

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Milton McClean
(Address) Post Falls

15. Filed June 4 1921 D D Brennan Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 7 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 6 1921, to ..... 19....., that I last saw h..... alive on May 6 1921, and that death occurred on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Prematurity

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D D Brennan M. D.

6/7 1921 (Address) Coda

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? —

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Pleasant View Cem

DATE OF BURIAL: May 7 1921

20. UNDERTAKER: None

ADDRESS —

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

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FORM V. S. No. 5-12 M. 6-15-17.

RECEIVED
JUN 9 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34259
Registered No. 924

1. PLACE OF DEATH
County of Kootenai
City of Post Falls Ida
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 80
Registration District No. 1051
(No. 1 Post Falls Ida St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME August - Wendt

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. ~~SINGLE~~, ~~MARRIED~~, WIDOWED OR ~~DIVORCED~~. (Write the word.): Widowed

6. DATE OF BIRTH. ..... 1..... (Month) (Day) (Year)

7. AGE: 55 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many .... hrs. or .....min.?'

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: Wendt

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) William Wendt
(Address) Post Falls Ida

15. Filed June 4 1921. D.D. Brenna Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 9 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 9 1921 to May 9th 1921 that I last saw h— alive on May 9th 1921 and that death occurred on the date stated above, at 2 A. M.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs

4 (Duration) 4 Yrs. — mos. — ds.

Contributory (Secondary) .....

..... (Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) F. L. McCauley M. D.

5/9 1921 (Address) Post Falls, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs.....mos....days. In the ,State....yrs....mos.....days

Where was disease contracted if not at place of death? Don't know

Former or usual residence Kellogg, Idaho

19. PLACE OF BURIAL OR REMOVAL: Kellogg Ida — DATE OF BURIAL: May 10 1921.

20. UNDERTAKER: R B Mooney — ADDRESS: Coeur d'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34260
Registered No. 925

RECEIVED
JUN 9 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
Registration District No. 30
Primary Registration District No. 1051
County of Kootenai
City of Coeur d'Alene (No. 340 Forest Ave. St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Henry Fogler

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Sept (Month) 30 (Day) 1884 (Year)

7. AGE: 38 Yrs. 8 Mos. 14 ds.
IF LESS than 1 day: how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Landscape Gardener
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Albert Fogler

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Henry Fogler
(Address) Coeur d'Alene Ida

15. Filed June 4 1921 D D Drennan Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 14 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....
and that death occurred on the date stated above, at 7 A M.
The CAUSE OF DEATH* was as follows: Rifle shot thru Heart
Suicide
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) R B Mooney Coroner M. D.
5/16 1921 (Address) Coeur d'Alene Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State 2 yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetery
DATE OF BURIAL: 5/17 1921
20. UNDERTAKER: R B Mooney
ADDRESS: Coeur d'Alene

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Kootenai

City of Coeur d'Alene (If outside limits, give township) St.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED JUN 9 1921 BUREAU OF VITAL STATISTICS

Registration District No. 30

Primary Registration District No. 1051

File No. 34261

Registered No. 926

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John C. Rhodes

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: married (Write the word)

6. DATE OF BIRTH: October 20. 1871 (Month) (Day) (Year)

7. AGE: 49 Yrs. 6 Mos. 26 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Miner

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mo

10. NAME OF FATHER: Thomas Rhodes

11. BIRTHPLACE OF FATHER (State or Country): Mo

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Annie Rhodes

(Address) Hayden Lake, Ida.

15. Filed June 7 1921 D. D. Drennan Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 16. 21 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 9 1921 to May 16. 1921 that I last saw h.... alive on May 12. 1921, and that death occurred on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) about 6 Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Frank Verzi M. D.

5/17 1921 (Address) Kellogg, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State 2 yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetery — DATE OF BURIAL: May 17 1921

20. UNDERTAKER: O. P. Mooney — ADDRESS: Coeur d'Alene

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JUN 9 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34262
Registered No. 927

1. PLACE OF DEATH
County of Kootenai Registration District No. 30
City of Coeur d'Alene Primary Registration District No. 1051
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME J. Fred Raines
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Sept (Month) 30 (Day) 1883 (Year)

7. AGE: 38 Yrs. — Mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Merchant
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kansas.

10. NAME OF FATHER: Chas. W. Raines.

11. BIRTHPLACE OF FATHER (State or Country): Dont Know

12. MAIDEN NAME OF MOTHER: Phebe Shinneston

13. BIRTHPLACE OF MOTHER (State or Country): Dont Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. J. F. Raines
(Address) Coeur d'Alene Idg

15. Filed June 4 1921 D.D. Drennan Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 23 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 9, 1921, to ..... 19.....
that I last saw h..... alive on May 23 1921
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
General Septicaemia
Sacred Heart Hospt.
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Son Leg
Ulcer (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) J. M. Graber M. D.
6/2 1921 (Address) Spokane Wash

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Moores Funeral Chapel — DATE OF BURIAL: 5/25/1921
20. UNDERTAKER: Moores — ADDRESS: CdA

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JUN 9 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 30
Primary Registration District No. 1051
File No. 34263
Registered No. 928

1. PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene (No. Wolf Lodge St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME David Meyers
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widower

6. DATE OF BIRTH: March (Month) 4 (Day) 1850 (Year)

7. AGE: 69 Yrs. 2 Mos. 16 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Penn

10. NAME OF FATHER: Philipp Meyers

11. BIRTHPLACE OF FATHER (State or Country): Penn

12. MAIDEN NAME OF MOTHER: Emma Keppen

13. BIRTHPLACE OF MOTHER (State or Country): Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Meyers
(Address) Coeur d'Alene, Ida.

15. Filed June 7 1921 DD Reuna Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 24 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 19 1921 to May 24 1921 that I last saw h.im alive on May 19 1921, and that death occurred on the date stated above, at 3.4 M.
The CAUSE OF DEATH* was as follows:
Nephritis (Chronic
(Duration) 3 Yrs. — mos. — ds.
Contributory (Secondary)
(Duration) — yrs. — mos. — ds.
(Signed) W. H. Haedecke M. D.
May 25 1921 (Address) Coeur d'Alene Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State 15 yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetery — DATE OF BURIAL: May 26 1921
20. UNDERTAKER: J B Mooney — ADDRESS: Coeur d'Alene

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 30
Primary Registration District No. 1051
File No. 34264
Registered No. 929

RECEIVED JUN 9 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene (If outside limits, give township.) 7-Fifth St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Robt-J. Rozes
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: single (Write the word.)

6. DATE OF BIRTH: May (Month) 28 (Day) 1921 (Year)

7. AGE: ....Yrs....Mos....ds.
IF LESS than 1 day how many 2 hrs. or ....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country)

10. NAME OF FATHER: Theadore Rozes

11. BIRTHPLACE OF FATHER (State or Country): Wis

12. MAIDEN NAME OF MOTHER: Ida May Germain

13. BIRTHPLACE OF MOTHER (State or Country): Ont.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Theadore Rozes
(Address) 923-7th St

15. Filed June 4 1921 D D Drenna Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 28 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 28 1921, to May 28 1921, that I last saw h. alive on May 28 1921, and that death occurred on the date stated above, at 9:30 A.M.

The CAUSE OF DEATH* was as follows: Premature birth

....(Duration) ....Yrs....mos....ds.

Contributory (Secondary)

....(Duration) ....yrs....mos....ds.

(Signed) Kate Wagner, M.D.
5/28 1921 (Address) Dr. Mrs. K. Kinkel Coeur d'Alene Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: St. Thomas, Cem. Cd'Alene — DATE OF BURIAL: 5-30 1921

20. UNDERTAKER: C Cassedy — ADDRESS: Cd'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34265

Registered No. 930

RECEIVED
JUN 9 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 30

Primary Registration District No. 1051

County of Kootenai

City of ... (or Village of Lodge ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Martha Larson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.): Widow

6. DATE OF BIRTH: Feb (Month) 8 (Day) 1841 (Year)

7. AGE: 78 Yrs. 2 Mos. 22 ds.

IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business or establishment in which employed (or employer): ...

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER: Andrew Nickberg

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: [illegible]

13. BIRTHPLACE OF MOTHER (State or Country): [illegible]

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A. N. Larson

(Address) Coeur d'Alene Idaho R.F.D.

15. Filed June 4 1921 D D Dreman, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 30 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 20 1921, to May 30 1921, that I last saw h[illegible] alive on May 28 1921, and that death occurred on the date stated above, at 2 P M.

The CAUSE OF DEATH* was as follows:

Paralysis

(Duration) [illegible] Yrs. [illegible] mos. 10 ds.

Contributory (Secondary) ...

(Duration) [illegible] yrs. [illegible] mos. [illegible] ds.

(Signed) W H Hoeden M. D.

6/1 1921 (Address) Coeur d'Alene Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State 15 yrs. ... mos. ... days

Where was disease contracted if not at place of death? ...

Former or usual residence ...

19. PLACE OF BURIAL OR REMOVAL: Bishop Hill. Ill. DATE OF BURIAL: June 2 1921

20. UNDERTAKER: R B Mooney ADDRESS: Coeur d'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JUN 1 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Latah — Registration District No. 62

City of Genesee — Primary Registration District No. 214 — St.)

File No. 34266

Registered No. 3

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Arnold Theo. LeRoy Kidwell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: May (Month) 17 (Day) 21 (Year)

7. AGE: — Yrs. — Mos. 2 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Genesee

10. NAME OF FATHER: Fred Kidwell

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Melvina Cox

13. BIRTHPLACE OF MOTHER (State or Country): Minn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Fred Kidwell

(Address) Genesee Idaho

15. Filed May 2, 1921 — W. F. Eden, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 5 (Month) – 20 (Day) – 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5-18- 1921 to 5-20- 1921 that I last saw him alive on 5-20- 1921 and that death occurred on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

Epileptic convulsion due to bichloride poisoning.

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. Ponsar M. D.

5-21 1921 (Address) Genesee Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Genesee Idaho — DATE OF BURIAL: May 24 1921

20. UNDERTAKER: F. E. Lambert — ADDRESS: Genesee

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Latah — Registration District No. 64

City of near Troy — Primary Registration District No. 2144 — St.)

File No. 34267

Registered No.

RECEIVED
JUN 3 1921
BUREAU OF VITAL STATISTICS

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Axel Victor Gyolander

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): ~~Widower~~ Widowed

6. DATE OF BIRTH: February 9 (Month) (Day) 1845 (Year)

7. AGE: 76 Yrs. 3 Mos. 22 ~~24~~ ds.

IF LESS than 1 day: how many..... hrs. or.....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Sweden.

10. NAME OF FATHER: Carl gustave Gyolander

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Mary Andersson

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A. V. Gyolander

(Address) R. F. D. Troy Latah Co Ida

15. Filed May 31 1921 — Grace M. Pickard, Local Registrar — Dept

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 30 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1, 1921, to May 30 1921, that I last saw him alive on May 18 1921, and that death occurred on the date stated above, at 10 M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) 2 Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. B. Blanchard M. D.

May 30 1921 (Address) Troy Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Burnt Ridge — DATE OF BURIAL: May 31 1921

20. UNDERTAKER: John J. Pickard — ADDRESS: Troy Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

RECEIVED
JUN 3 1921
BUREAU OF VITAL STATISTICS

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Latah
City of Troy
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 64
Primary Registration District No. 2144
(No. ... St.)
File No. 34268
Registered No.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Fritz Olof Wilford Hedberg

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Oct 5 1906 (Month) (Day) (Year)

7. AGE: 14 yrs. 9 mos. ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) School boy

9. BIRTHPLACE (State or Country): Troy Idaho

10. NAME OF FATHER: John Hedberg

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Ulma Pauleson

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Herman Paulson
(Address) Troy, Idaho

15.
Filed May 12 1921 J. E. Pickerd Local Registrar
By L. M. P. Dept.

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 11 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 24 1921, to May 11 1921, that I last saw him alive on May 11 1921 and that death occurred on the date stated above, at 1:45 P.M.

The CAUSE OF DEATH* was as follows:
Pneumonia

(Duration) yrs. mos. 17 ds.
Contributory (Secondary) Influenza
(Duration) yrs. mos. 16 ds.

(Signed) B. Blodgett M. D.
5/12 1921 (Address) Troy Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Dry Creek
DATE OF BURIAL: May 13 1921

20. UNDERTAKER: J. E. Pickerd
ADDRESS: Troy

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 64
Primary Registration District No. 2144
File No. 34269
Registered No.

1. PLACE OF DEATH

County of Latah
City of Troy (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
JUN 3 1921
BUREAU OF VITAL STATISTICS

NAME Joseph E Pickerd

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH: Dec (Month) 7 (Day) 1855 (Year)

7. AGE: 62 Yrs. 5 Mos. 3 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: undertaker
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Penn

10. NAME OF FATHER: John Pickerd

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Rosanah Hamilton

13. BIRTHPLACE OF MOTHER (State or Country): Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Mayme L Pickerd
(Address): Troy Idaho

15. Filed 5/12 1921 Lucy Mae Pickerd Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 12 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 8 1921, to May 12 1921, that I last saw him alive on May 12 1921, and that death occurred on the date stated above, at 6 P M.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(Duration) ..... Yrs. ..... mos. 4 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J Rhoades M. D.

5 12 1921 (Address) Troy Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Palouse Wash	May 15 1921
20. UNDERTAKER: E Anderson	ADDRESS: Clarkston Wash

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

34270

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
JUN 9 1921
BUREAU OF VITAL STATISTICS

Registration District No. 66
Primary Registration District No. 2146

File No. 3

Registered No. .....

1. PLACE OF DEATH.

County of Latah

City of Bovill (Ward) St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Dorothy Donner

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Feb (Month) 16 (Day) 1918 (Year)

7. AGE: 3 Yrs. 2 Mos. 26 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): none

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: Lee H. Donner

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Rose L. Tongue

13. BIRTHPLACE OF MOTHER (State or Country): Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. Lee H. Donner.
(Address) Bovill Idaho

15. Filed May 14 1921 Mrs F.C. Gibson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 12 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 11 1921, to May 12 1921, that I last saw her alive on May 11 1921, and that death occured on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:

Shock following Measles

Burns

(Duration) Yrs. mos. 1 ds.

Contributory (Secondary) Burns by hot water

(Duration) yrs. mos. ds.

(Signed) F.C. Gibson M. D.

5/12 1921 (Address) Bovill Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days In the State ..... yrs ..... mos ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Bovill Idaho — DATE OF BURIAL: May 15 1921

20. UNDERTAKER: Father — ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 24654

FORM V. S. No. 5-A—25 M. 1-19.

34271

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Latah — Registration District No. 66

City of Bovill — Registration District No. 2176 — Bovill Hospital (St.)

File No. 4

Registered No.

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give ITS NAME instead of street and number.

2. FULL NAME Lars J. Kaaen

JUN 5 BUREAU OF VITAL STATISTICS

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Male	White	Married (Write the word.)

6. DATE OF BIRTH: November (Month) 16 (Day) 1849 (Year)

7. AGE: 71 Yrs. 6 Mos. 6 ds. — IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Norway

10. NAME OF FATHER: John Larson

11. BIRTHPLACE OF FATHER (State or Country): Norway

12. MAIDEN NAME OF MOTHER: Ellen Enderson

13. BIRTHPLACE OF MOTHER (State or Country): Norway.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Kaaen
(Address) Park Idaho

15. Filed May 25 1921 — Mrs F.C. Gibson, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 23 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 22 1921, to May 23 1921, that I last saw him alive on May 23 1921, and that death occurred on the date stated above, at 3 P. M.
The CAUSE OF DEATH* was as follows:

Paralytic Illeus
Paralytic Ileus
(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary)
(Duration) ... yrs. ... mos. ... ds.

(Signed) F.C. Gibson M. D.
5/28/1921 (Address) Bovill Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. 2 days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Spokane Wn.	... 19 ...
20. UNDERTAKER: Glen Price	ADDRESS: Moscow, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34272

Registered No. 27

1. PLACE OF DEATH

County of Latah RECEIVED Registration District No. 61

City of Moscow JUN 9 1921 Primary Registration District No. 1011

If death occurs away from usual residence, give facts called for under special information.

BUREAU OF VITAL STATISTICS

No. ..... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Charles Frederick Butterfield

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH: May (Month) 16 (Day) 1921 (Year)

7. AGE: ..... Yrs. ..... Mos. 2 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: Norton J. Butterfield

11. BIRTHPLACE OF FATHER (State or Country): Wisconsin

12. MAIDEN NAME OF MOTHER: Leone Hamilton

13. BIRTHPLACE OF MOTHER (State or Country): Washington

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C. C. Butterfield

(Address) 606 E. Fourth St. Moscow Idaho

15. Filed 5/18 1921 M Hawitters Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 18th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 16 1921, to May 18 1921, that I last saw h.wm alive on May 18 1921, and that death occurred on the date stated above, at 9:20a M.

The CAUSE OF DEATH* was as follows:

Convulsions

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) I do not know

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas. L. Gitman M. D.

5/18 1921 (Address) Moscow Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.) The Entire

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Moscow | DATE OF BURIAL: 5/19 1921

20. UNDERTAKER: Eden Dale | ADDRESS: Moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED JUN 9 1921 BUREAU OF VITAL STATISTICS

Registration District No. 61
Primary Registration District No. 1011
File No. 34273
Registered No. 26

1. PLACE OF DEATH
County of Latah
City of Moscow (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George W. Tanner

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widower (write the word.)

6. DATE OF BIRTH: April 21 1830 (Month) (Day) (Year)

7. AGE: 91 Yrs. ..... Mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Virginia

10. NAME OF FATHER: — Tanner

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: ?

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Geo Tanner
(Address) Moscow

15. Filed May 18 1921 W H Hawthorne Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 17th 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feby 28 1921 to May 17 1921 that I last saw h[im] alive on May 9 1921 and that death occurred on the date stated above, at 3:00 P.M.

The CAUSE OF DEATH* was as follows:

Bronchial Asthma

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas. L. Gritman M. D.
5/18 1921 (Address) Moscow, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Moscow | DATE OF BURIAL: 5/18 1921

20. UNDERTAKER: [illegible] | ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED
JUN 9 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Latah
City of Moscow (No. ..... St.)
Registration District No. 61
Primary Registration District No. 1011
File No. 34274
Registered No. 25

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jarvis R Harris

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH: April 7 1847 (Month) (Day) (Year)

7. AGE: 74 Yrs. 1 Mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): 2

10. NAME OF FATHER: ,

11. BIRTHPLACE OF FATHER (State or Country): ,

12. MAIDEN NAME OF MOTHER: ,

13. BIRTHPLACE OF MOTHER (State or Country): ,

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) .....
(Address) .....

15. Filed May 16 1921 M Hawthorne Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 15 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1 1921 to May 15 1921 that I last saw him alive on May 15 1921 and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:
Lobar Pneumonia

(Duration) ..... Yrs. ..... mos. 15 ds.
Contributory (Secondary) Influenza
(Duration) ..... yrs. 3 mos. ..... ds.

(Signed) J. W. McNamar M. D.
5/16 1921 (Address) Moscow

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Moscow | DATE OF BURIAL: 5/17 1921

20. UNDERTAKER: Ellis Funeral Home | ADDRESS: Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34275
Registered No. 24

RECEIVED
JUN 9 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Latah
City of Moscow (Ward) St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 61
Primary Registration District No. 1011

2. FULL NAME George Clark

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single
6. DATE OF BIRTH: April (Month) 7 (Day) 1906 (Year)
7. AGE: 15 Yrs. 1 Mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry, business or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Idaho
10. NAME OF FATHER: George Clark
11. BIRTHPLACE OF FATHER (State or Country): Indiana
12. MAIDEN NAME OF MOTHER: Florence D Brooks
13. BIRTHPLACE OF MOTHER (State or Country): Penn
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Geo Clark
(Address): Avon Idaho
15. Filed May 12 1921 W H Smithers Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 12 (Day) 1921 (Year)
17. I HEREBY CERTIFY, That I attended deceased from May 7th 1921, to May 12 1921, that I last saw h.... alive on May 12 1921, and that death occurred on the date stated above, at 7:30 P.M.
The CAUSE OF DEATH* was as follows:
Obstruction of the bowel
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Intussusception
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Chas. L. Gatewood M. D.
5/14 1921 (Address) Moscow

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Avon Idaho
DATE OF BURIAL: 5/15 1921
20. UNDERTAKER: Avon Grain
ADDRESS: Moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED JUN 9 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Latah — Registration District No. 61
City of Moscow (Ward) ..... (St.) — Registration District No. 1011
File No. 34276
Registered No. 23

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George H. P. O'Donnell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married
6. DATE OF BIRTH: July (Month) 13 (Day) 1864 (Year)
7. AGE: 56 Yrs. 9 Mos. 25 ds. — IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer): Owner
9. BIRTHPLACE (State or Country): Ireland
10. NAME OF FATHER: Chas O'Donnell
11. BIRTHPLACE OF FATHER (State or Country): Ireland
12. MAIDEN NAME OF MOTHER: Margaret Smith
13. BIRTHPLACE OF MOTHER (State or Country): England
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Wm G. O. Donnell
(Address): Moscow
15. Filed May 9 1921 — W. H. Barithers, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 8th (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 25 1921, to May 8 1921, that I last saw him alive on May 8 - 1921, and that death occurred on the date stated above, at 12:40 M.

The CAUSE OF DEATH* was as follows:

Spinal Sclerosis

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas. L. Fortman M. D.

5/9 1921 (Address) Moscow Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. 6 days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Moscow — DATE OF BURIAL: 5/10 1921

20. UNDERTAKER: Glen Price — ADDRESS: Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

RECEIVED
JUN 9 1921
BUREAU OF VITAL STATISTICS

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Latah — Registration District No. 61
City of Moscow — Primary Registration District No. 1011
(Ward) (St.)
File No. 34277
Registered No. 22

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Otto J. Stone

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M.	W	Single

6. DATE OF BIRTH: April (Month) 16 (Day) 1903 (Year)

7. AGE: 18 Yrs. Mos. 21 ds. — IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Truck Driver
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Chas H. Stone

11. BIRTHPLACE OF FATHER (State or Country): Ill.

12. MAIDEN NAME OF MOTHER: Anna Zimmerman

13. BIRTHPLACE OF MOTHER (State or Country): Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Chas H. Stone
(Address): Moscow Ida

15. Filed May 7 1921 — H. Hawthorne, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 7 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ... 19... to ... 19...
that I last saw h... alive on ... 19...,
and that death occurred on the date stated above, at 7:30 A.M.
The CAUSE OF DEATH* was as follows:

Crushed between two auto trucks. Accidental.

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) Glen Price Coroner M. D.
5/7 1921 (Address) Moscow

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Moscow	5/8 1921
20. UNDERTAKER	ADDRESS
Glen Price	Moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34278
Registered No. 21

RECEIVED
JUN 9 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Latah
City of Moscow
(No. St.)
Registration District No. 61
Primary Registration District No. 1011
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mariah Ann Courtwright
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Widowed

6. DATE OF BIRTH: April 10 1843 (Month) (Day) (Year)

7. AGE: 78 Yrs. 24 Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER: John Stiles

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: ?

13. BIRTHPLACE OF MOTHER (State or Country): ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant)
(Address)

15. Filed May 5 1921 W. H. Carruthers
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 4 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 2 1921, to May 4 1921
that I last saw her alive on May 3 1921
and that death occurred on the date stated above, at 5-30 P.M.
The CAUSE OF DEATH* was as follows: Acute Endocarditis

(Duration) Yrs. mos. ds.
Contributory (Secondary): Pulmonary Tuberculosis
(Duration) yrs. mos. ds.
(Signed) J. N. Clark M. D.
5/5 1921 (Address) Moscow

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Moscow
DATE OF BURIAL: May 7 1921

20. UNDERTAKER: Glen Rice
ADDRESS: Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JUN 4 1921 BUREAU OF VITAL STATISTICS

34279

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2147
Primary Registration District No. 67
File No. 3
Registered No. 35

1. PLACE OF DEATH
County of Latah
City of Deary R1 (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Wilson W. Lemar
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): single

6. DATE OF BIRTH: Nov. 25 (Month) (Day) 1859 (Year)

7. AGE: 61 Yrs. 7 Mos. 6 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Day laborer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ky.

10. NAME OF FATHER: Reson Lemar

11. BIRTHPLACE OF FATHER (State or Country): Ky.

12. MAIDEN NAME OF MOTHER: Sarah Hogue

13. BIRTHPLACE OF MOTHER (State or Country): Ky.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) F. E. McGraw
(Address) Deary Ida.

15. Filed 6/1 1921 P. E. Faust Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 31 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5/30 1921 to 5-31 1921 that I last saw h.im alive on 5/30 1921 and that death occurred on the date stated above, at 9 A. M.
The CAUSE OF DEATH*·was as follows: Chronic Valvular Heart Disease
(Duration) ? Yrs. ..... mos. ..... ds.
Contributory (Secondary) Nephritis
(Duration) ? yrs. ..... mos. ..... ds.
(Signed) P. E. Faust M. D.
6/1 1921 (Address) Deary

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Wild Rose Cem. DATE OF BURIAL: 6/1 1921

20. UNDERTAKER: ✓ ADDRESS: ✓

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34280
Registered No. 9

1. PLACE OF DEATH.
County of Lincoln
City of Shoshone (No. ..... St.)
Registration District No. 16
Primary Registration District No. 1016

RECEIVED
JUN 11 1921
BUREAU OF VITAL STATISTICS

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Virginia Anderson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. May 7 1858
(Month) (Day) (Year)

7. AGE: 63 Yrs. 00 Mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: Young Calvin

11. BIRTHPLACE OF FATHER (State or Country): Kentucky

12. MAIDEN NAME OF MOTHER: Sara Garner

13. BIRTHPLACE OF MOTHER (State or Country): Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Rufus Anderson
(Address) Shoshone

15. Filed June 4 1921
J. L. Fuller
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 3 1921
(Month) (Day) 191 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..... to ..... 191....., that I last saw h..... alive on ..... 191....., and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

No M. D. in attendance
accidental drowning
(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Shoshone — DATE OF BURIAL: 6-4 1921

20. UNDERTAKER: O. J. Brennan — ADDRESS: Shoshone

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMONDS YORK CO., PTRS. & STRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 16
Primary Registration District No. 1016
File No. 34281
Registered No. 9

1. PLACE OF DEATH.
County of Lincoln
City of Shoshone (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

RECEIVED
JUN 11 1921
BUREAU OF VITAL STATISTICS

2. USUAL RESIDENCE. Charles W Wernicke

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. January (Month) 13 (Day), 1847 (Year)

7. AGE: 74 Yrs. 4 Mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Tin Smith
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: Carl Wernicke

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Don't Know Perhaps Germany

13. BIRTHPLACE OF MOTHER (State or Country): Don't know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Charles Wernicke
(Address) Shoshone Idaho

15. Filed May 16 1921
J. L. Fuller Local Registrar

SYMS - YORK CO., SYMS & SONS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 15 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 6 1921, to May 15 1921, that I last saw h[illegible] alive on May 15 1921, and that death occured on the date stated above, at 5-30 P.M.

The CAUSE OF DEATH* was as follows:
Cerebral apoplexy.

..... (Duration) ..... Yrs. ..... mos. 9 ds.
Contributory (Secondary) Senility
..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. L. Fuller M. D.
May 16 1921 (Address) Shoshone Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Shoshone — DATE OF BURIAL: 5-17 1921

20. UNDERTAKER: O. J. Brennan — ADDRESS: Shoshone

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
JUN 17 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34282
Registered No.

1. PLACE OF DEATH
Registration District No. 17
Primary Registration District No. 2200
County of Lincoln
City of Richfield (No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lillian Dorcas Anderson
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: May 29th 1880 (Month) (Day) (Year)

7. AGE: 41 Yrs. Mos. 2 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Grantsville Utah

10. NAME OF FATHER: Sharoni Durfee

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Jane Merritt

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Della Durfee
(Address) Richfield Idaho

15. Filed June 2 1921 P E Bartlett Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 31 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 31 1921 to May 31 1921 that I last saw her alive on May 31 1921 and that death occurred on the date stated above, at 2 P M.

The CAUSE OF DEATH* was as follows:
Chronic Interstitial Brights

(Duration) 15 Yrs. 5 mos. 6 ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) O E Bloom M. D.
June 1921 (Address) Richfield Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Shorhour — DATE OF BURIAL: June 3 1921

20. UNDERTAKER: O J Brinson — ADDRESS:

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34283
Registered No.

1. PLACE OF DEATH.
County of Madison
City of Thornton
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No.
(No. ..., ... St.)

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Frederick W Furth

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	W	Married

6. DATE OF BIRTH
Oct (Month) 9 (Day) 1882 (Year)

7. AGE
39 yrs. 7 mos. 14 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Utah

10. NAME OF FATHER William Burton Furth

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER Elizabeth Kndal

13. BIRTHPLACE OF MOTHER (State or Country) Utah ~~Brayton~~

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Clara Furth Kramer
(Address) Thornton

15.
Filed 5/2 1921 G G Estes Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
May (Month) 23 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occurred on the date stated above, at 6 P M.

The CAUSE OF DEATH* was as follows:
Pneumonia - Gas
Shot Wound

..... (Duration) ... yrs. ... mos. ... ds.

Contributory (Secondary)
..... (Duration) ... yrs. ... mos. ... ds.

(Signed) J Rysorg - Coroner
5/24 1921 (Address) Ryley Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Winlock Utah — DATE OF BURIAL: 5/26 1921

20. UNDERTAKER: J Rysorg — ADDRESS: Ryley

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SVMS - YORK CO., PTRS. & BDRS. 49760

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. Independence 1 100
Primary Registration District No. 1 2178
File No. 34284
Registered No.

1. PLACE OF DEATH
County of Madison
City of Rexburg
(No. 210 N. C St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Rean Williams
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Male	White	Single (Write the word.)

6. DATE OF BIRTH
May (Month) 22 (Day) 1921 (Year)

7. AGE
.... Yrs. .... Mos. 1 ds.
IF LESS than 1 day how many 5½ hrs. or 36 min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business or establishment in which employed (or employer) none

9. BIRTHPLACE (State or Country) Rexburg Madison Co Idaho

10. NAME OF FATHER John Howard Williams

11. BIRTHPLACE OF FATHER (State or Country) Santa Rosa Sonoma Co California U.S.

12. MAIDEN NAME OF MOTHER Lillie Caroline J.R. Pedersen

13. BIRTHPLACE OF MOTHER (State or Country) ~~Wanganui~~ Woodville Wanganui New Zeland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H H Williams
(Address) Rexburg Idaho R F D # 1 Box

15. Filed 5 23 1921
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
5 (Month) 22-21 (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5-22-1921, to 5-22-21 19...., that I last saw h.. M.. alive on 5-22-21 19...., and that death occurred on the date stated above, at 4 55P M.

The CAUSE OF DEATH* was as follows:
Premature birth
child not viable

.... (Duration) .... Yrs. .... mos. 1 ds.

Contributory (Secondary) ....
.... (Duration) .... yrs. .... mos. .... ds.

5/22 1921 (Signed) Lorin F. Peck M. D.
(Address) Rexburg, I.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .... yrs. .... mos. .... days. In the State .... yrs. .... mos. .... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Burton Cemetery	5-24th 1921
20. UNDERTAKER	ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH 100

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Madison

City of Rexburg

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 1 Independence

Primary Registration District No. 1 44 2178

(No. ..... St.)

File No. 34285

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lea Williams

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: May (Month) 22 (Day) 1921 (Year)

7. AGE: ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or 40 min.? 5

8. OCCUPATION

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business or establishment in which employed (or employer): none

9. BIRTHPLACE (State or Country): Rexburg Madison Idaho

10. NAME OF FATHER: John Howard Williams

11. BIRTHPLACE OF FATHER (State or Country): Santa Rosa Sonoma Co California U S A

12. MAIDEN NAME OF MOTHER: Lillie Caroline J R Petersen

13. BIRTHPLACE OF MOTHER (State or Country): Woodville Wayapuni New Zeland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J H Williams 133

(Address) Rexburg Idaho R F D No 1 Box 84

15. Filed 5/23 1921 G E Esplin Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 5-22-21 19.....
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5-22- 1921, to 5-22- 1921 that I last saw her alive on 5-22- 1921, and that death occurred on the date stated above, at 4 25 P.M.

The CAUSE OF DEATH* was as follows: Premature Birth
child not viable

(Duration) ..... Yrs. ..... mos. 1 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Louie L Riel M. D.

5/ 2 1921 (Address) Rexburg

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Burton Cemetary	5-24 1921
20. UNDERTAKER	ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 100

Primary Registration District No. 2178

File No. 34286

County of Madison

City of Plano (No. ....., ... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Thomas Reed White

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. December (Month) 5 (Day) 1859 (Year)

7. AGE: 61 Yrs. 5 Mos. 9 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Thomas White

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Clarissa Reed

13. BIRTHPLACE OF MOTHER (State or Country): U. S. A.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John R. White

(Address) Plano Idaho

15. Filed May 16 1921 G. L. Espe Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 14 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 1921, to May 14 1921, that I last saw him alive on May 14 1921, and that death occured on the date stated above, at 7a M.

The CAUSE OF DEATH* was as follows: Asthma

(Duration) ..... Yrs. ..... mos. 4 ds.

Contributory (Secondary) Chronic Intoxication Nephritis

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. Nelson M. D.

19 (Address) Rexburg, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Plano	May 19 1921
20. UNDERTAKER	ADDRESS
David R. Young	Rexburg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYNS - YORK CO., PTRS. & BDRS. 24654

FORM V. S. No. 5-12 M. 6-15-17.

7

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34287
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Kootenai
City of Lyons
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 100
Primary Registration District No. 2178
(No. ....., ... St.)

2. FULL NAME Louisa J. Butler

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: widow (Write the word.)

6. DATE OF BIRTH: March 11 1849 (Month) (Day) (Year)

7. AGE: 72 Yrs. 2 Mos. 3 ds. IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: Josiah Young

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Elizabeth E. Kendy

13. BIRTHPLACE OF MOTHER (State or Country): France

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Sara Butler
(Address) Thornton

15. Filed 5-15-21 G. H. Estes Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 14 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1 1920 to May 14 1921
that I last saw her alive on April 6 1921
and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows: Carcinoma Uteri

(Duration) 1 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) J. Pearson M. D.

19.... (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs....mos....days. In the State....yrs....mos....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Austin — DATE OF BURIAL: 5/17/1921

20. UNDERTAKER: J. Young — ADDRESS: Payne

should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34288
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

Registration District No. 100
Primary Registration District No. 2178

1. PLACE OF DEATH
County of Madison
City of Rigby
If death occurs away from usual residence, give facts called for under special information.

(No. ....., ... St.)

2. FULL NAME Frank Green

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem.
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Jan (Month) 27 (Day) 1899 (Year)

7. AGE: 27 Yrs. 3 Mos. 20 ds.
IF LESS than 1 day how many .... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Richard Smalley

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: M. Davis

13. BIRTHPLACE OF MOTHER (State or Country): Wales

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Richard Smalley
(Address) Rigby Idaho

15. Filed 5/13 1921
G G Teske
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 12 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 12 1921 to May 12 1921
that I last saw her alive on May 12 1921
and that death occurred on the date stated above, at 8 40 M.

The CAUSE OF DEATH* was as follows:
Hemorrhage & Shock
.....
.....
.....
(Duration) ..... Yrs. ..... mos. 4 hrs ds.

Contributory (Secondary) Placenta Previa
(Duration) ..... Yrs. 4 mos. 14 ds.

(Signed) Farley Nelson M. D.
5-13 1921 (Address) Rigby Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the ,State....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Lewisville — DATE OF BURIAL: 5/15 1921

20. UNDERTAKER: Gregory — ADDRESS: Rigby

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-25 M. 1-16-18

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 100
Primary Registration District No. 2178
File No. 34289
Registered No. .....

1. PLACE OF DEATH.

County of Madison
City of Independence (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Catherine Flamm

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed
6. DATE OF BIRTH. ..... (Month) ..... (Day) 1844 (Year)
7. AGE: 77 Yrs. ..... Mos. ..... ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
   (a) Trade, profession or particular kind of work: None
   (b) General nature of industry, business, or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): Canada
10. NAME OF FATHER: David Bowen
11. BIRTHPLACE OF FATHER (State or Country): Canada
12. MAIDEN NAME OF MOTHER: Meagher
13. BIRTHPLACE OF MOTHER (State or Country): Canada
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
    (Informant) C. H. Flamm
    (Address) Rupburg Idaho R.F.D. 1
15. Filed 5/17 1921 G. G. Estes Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 10 (Day) 1921 (Year)
17. I HEREBY CERTIFY, That I attended deceased from 4-2 1920, to May 10 1921, that I last saw h[er] alive on May 5 1921, and that death occured on the date stated above, at 6 P. M.
    The CAUSE OF DEATH* was as follows:
    Mitral regurg
    Liver Complication
    .....(Duration) ..... Yrs. ..... mos. ..... ds.
    Contributory (Secondary) .....
    .....(Duration ..... Yrs. ..... mos. ..... ds.
    (Signed) G. G. Estes M. D.
    ..... 19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
    At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
    Where was disease contracted if not at place of death?.....
    Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rupburg, Idaho — DATE OF BURIAL: May 12 1921
20. UNDERTAKER: John M. Richards — ADDRESS: Rupburg, Ida.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 100

Primary Registration District No. 2178

File No. 34290

County of Madison

City of Rexburg Ida (No. ....., ... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Elizabeth Hansen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Widowed

6. DATE OF BIRTH: October 28 1868 (Month) (Day) (Year)

7. AGE: 52 yrs. 6 mos. 10 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: William F Rigby

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Ann Yeates

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Louis Hansen
(Address) Rexburg

15. Filed 5/9 1921 G L Eske Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 8 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 15-1921 191.., to May 8-1921 191.., that I last saw her alive on May 8-1921 191.., and that death occurred on the date stated above, at 9:30 P M.

The CAUSE OF DEATH* was as follows:
Diabetes Mellitus

(Duration) 2 yrs. — mos. — ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Louis H. Rich M. D.
5/9 1921 (Address) Rexburg

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rexburg | DATE OF BURIAL: ..... 191..

20. UNDERTAKER: John Phillips with Rexburg Furniture Co | ADDRESS: Rexburg

Instructions: Print plainly in ink. Do not use pencil. Be sure to answer all questions. Use extra sheet if necessary. Do not abbreviate. Write out fully and spell correctly. Give exact place of death, especially if in a city. If in a hospital or institution, give its name instead of street and number. If death occurred in a moving conveyance, state the place where dead body was first removed therefrom. The information required concerning the deceased person must be given by the person best qualified to furnish it. Every question must be answered, or the certificate will be returned. Before signing, be sure that you have stated the CAUSE OF DEATH in accordance with the instructions on back of certificate. Statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-18

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 100
Primary Registration District No. 2178
File No. 34292
Registered No. ____

1. PLACE OF DEATH.
County of Madison
City of Hibbard
(No. ____, ____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Isabella Ricks

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. February 22 1912 (Month) (Day) (Year)

7. AGE: 9 Yrs. 2 Mos. 13 ds.
IF LESS than 1 day how many ____ hrs. or ____ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): ____

9. BIRTHPLACE (State or Country): Hibbard Idaho

10. NAME OF FATHER: Orson Ricks

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Margaret A. Archibald

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Orson Ricks
(Address) Rigburg R2 Box 2

15. Filed 5/6 1921 G.L. Eskelson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 5 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ____ 191__, to ____ 191__, that I last saw h____ alive on ____ 191__, and that death occured on the date stated above, at 12:40 P.M.

The CAUSE OF DEATH* was as follows:
Mitral regurgitation
Broncho pneumonia
(Duration) ____ Yrs. ____ mos. ____ da.

Contributory (Secondary) ____
(Duration) ____ yrs. ____ mos. ____ da.

(Signed) G.L. Eskelson M. D.
19__ (Address) ____

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days
Where was disease contracted if not at place of death? ____
Former or usual residence ____

19. PLACE OF BURIAL OR REMOVAL: Rigburg, Idaho — DATE OF BURIAL: May 7 1921

20. UNDERTAKER: Jno. W. Richards — ADDRESS: Rigburg, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOOKS. 24654

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34293

Registered No. 19

RECEIVED
JUN 11 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 19

Primary Registration District No. 2013

County of Minidoka

City of Rupert (Village, Town or City) St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs Celestia Artimesia Davis

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Widow

6. DATE OF BIRTH: Jan. 14 (Month) (Day) 1847 (Year)

7. AGE: 74 Yrs. 2 Mos. 17 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Missouri

10. NAME OF FATHER Harry Green

11. BIRTHPLACE OF FATHER (State or Country) Vermont

12. MAIDEN NAME OF MOTHER Jane Ann Rich

13. BIRTHPLACE OF MOTHER (State or Country) Ohio.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Roberts.

(Address) .....

15. Filed 4—11 1921 E. F. Elmore Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April 4 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1 1921 to April 4 1921

That I last saw h— alive on April 4 1921

and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E. E. Loomis M. D.

4-10 1921 (Address) Rupert Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Apr 7 DATE OF BURIAL 1921

20. UNDERTAKER Calvin Keller ADDRESS Rupert Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED JUN 1 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH.

Registration District No. 19

Primary Registration District No. 2015

File No. 34294

Registered No. 20

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH.

County of Blaine

City of Rupert (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elizabeth H. Ratliff

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Fem

4. COLOR OR RACE White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word) Widowed

6. DATE OF BIRTH. Dec (Month) 21 (Day) 1847 (Year)

7. AGE 74 Yrs. 4 Mos. 8 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... House Wife

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Iowa

10. NAME OF FATHER Archibald Hendricks

11. BIRTHPLACE OF FATHER (State or Country) Indiana

12. MAIDEN NAME OF MOTHER Mary Paul

13. BIRTHPLACE OF MOTHER (State or Country) Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs L. Angle

(Address) South Dakota

15.

Filed May 10 1921

E. O. Elmore
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 29 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 25" 1921, to April 29 1921, that I last saw her alive on Apr 29 1921, and that death occured on the date stated above, at 1000 P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar

(Duration) ..... Yrs. ..... mos. 7 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Leland Stagner M. D.

5-7 1921 (Address) Rupert, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Deels Cemetery — **DATE OF BURIAL** May 1 1921

20. UNDERTAKER W. G. Goodman — **ADDRESS** Rupert

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34295

Registered No. 21

1. PLACE OF DEATH.

Registration District No. 19

Primary Registration District No. 2015

County of Minidoka

City of Minn (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED JUN 3 1921 BUREAU OF VITAL STATISTICS

2. FULL NAME Elva ~~Elton~~ Leavitt

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. April (Month) 26 (Day) 1921 (Year)

7. AGE ..... Yrs. 2 Mos. 1 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Children
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Louis Leavitt

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Bessie Urry

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Louis Leavitt
(Address) Minidoka

15. Filed June 3 1921 E. O. Glenn Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24858

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 28 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4-26 1921, to 4-28 1921, that I last saw h~~im~~ alive on 4-26 1921 and that death occured on the date stated above, at 10 A. M.

The CAUSE OF DEATH* was as follows: Premature Birth. Weakness.

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

5-31 1921 (Address) Rupert

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL ..... 191...

20. UNDERTAKER | ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of I[illegible]
BOARD OF H[illegible]
Bureau of Vital [illegible]
File No. 34293
Registered No. 24

1. PLACE OF DEATH.
County of Minidoka
City of Paul (No. 1921 St.)
Registration District No. 19
Primary Registration District No. 2013
If death occurs away from usual residence, give facts called for under special information.

RECEIVED
JUN 1 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME Colin D MacRae

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married
6. DATE OF BIRTH. May (Month) 21 (Day) 1896 (Year)
7. AGE: 24 Yrs. 10 Mos. 23 ds. IF LESS than 1 day how many ....hrs. or ....min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Colo
10. NAME OF FATHER: Colin MacRae
11. BIRTHPLACE OF FATHER (State or Country): Scotland
12. MAIDEN NAME OF MOTHER: Mary J. Rutherford
13. BIRTHPLACE OF MOTHER (State or Country): New York
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Colin MacRae
(Address) Paul Ida
15. Filed June 3 1921 E T Dehnow Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 13 (Day) 1921 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Apr. 11 1921, to Apr. 13 1921, that I last saw h[illegible] alive on Apr. 13 1921 and that death occured on the date stated above, at 4 P M.
The CAUSE OF DEATH* was as follows:
Diphtheria
(Duration) Yrs. mos. 10 da.
Contributory (Secondary)
(Duration) Yrs. mos. da.
(Signed) E. Kenneth M. D.
4/14 1921 (Address) Burley Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, [illegible], Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rupert Ida — DATE OF BURIAL: Apl 15 1921
20. UNDERTAKER: Newcott — ADDRESS: Burley Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PTRS. & BOKS. 24658

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34299
Registered No. 23

RECEIVED JUN 17 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 19
Primary Registration District No. 2015

County of Minidoka

City of Heyburn (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Alice Jane Davis

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F.	White	married

6. DATE OF BIRTH: January 8th (Month) (Day) 1893 (Year)

7. AGE: 28 Yrs. 3 Mos. 4 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Utah

10. NAME OF FATHER Thomas Davis

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER Mitilda M. Douglas

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Thomas Davis

(Address) Malad Idaho

15. Filed 6 8 1921 E. O. Elmore Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 5 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ~~19~~ ..... to ~~19~~ .....

that I last saw h~~e~~r alive on ~~19~~ .....

and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of Heart

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F. H. Cutler M. D.

19 ..... (Address) Burley Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Malad Idaho	May 6 1921
20. UNDERTAKER Chris Keller	ADDRESS Rupert Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13 CERTIFICATE O[illegible]

RECEIVED JUN 11 1921 BUREAU OF VITAL STATISTICS

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No.
County of Minidoka Primary Registration District No. 2015
City of Rural (If outside city limits, write Rural.) St.)
File No. 34300
Registered No. 26

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Joseph Warren Staker

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. March (Month) 5 (Day) 1918 (Year)

7. AGE: 3 Yrs. 1 Mos. [illegible] ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Joseph E. Staker

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Louise Greenwell

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant): J E Staker
(Address):

15. Filed May 25 1921 [signature] Local Registrar

SYMS - YORK CO., PTRS. & STRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 4 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 3 1921, to April 4 1921, that I last saw h[illegible] alive on April 4 1921, and that death occured on the date stated above, at 1 P. M.

The CAUSE OF DEATH* was as follows:
Diphtheria Laryngitis

(Duration) Yrs. mos. 1 ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed) [signature] M. D.
19 (Address) Burley Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rupert Idaho — DATE OF BURIAL: Apl 7 1921

20. UNDERTAKER: R. W. Watt — ADDRESS: Burley Ida

FORM V. S. 1.

CERTIFICATE OF DEATH

BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34301
Registered No. 2

1. PLACE OF DEATH
County of Minidoka
City of Rupert
If death occurs away from usual residence, give facts called for under special information.

RECEIVED JUN 17 1921 BUREAU OF VITAL STATISTICS

Registration District No. M
Primary Registration District No. 2015
(No. ..... St.)
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Rose Robinson Blackhurst

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (the word.)
6. DATE OF BIRTH: Oct (Month) 25 (Day) 1873 (Year)
7. AGE: 48 Yrs. 6 Mos. — ds. IF LESS than 1 day how many .... hrs. or .....min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
9. BIRTHPLACE (State or Country): Utah
10. NAME OF FATHER: Lewis Robinson
11. BIRTHPLACE OF FATHER (State or Country): Ill
12. MAIDEN NAME OF MOTHER: Louisa R Gheen
13. BIRTHPLACE OF MOTHER (State or Country): Ind
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R. L. Blackhurst
(Address) Rupert Ida
15. Filed May 23 1921 E. O. Spence Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 24 (Day) 1921 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Jan. 1 1921 to Apr. 24 1921
that I last saw her alive on Apr. 24 1921
and that death occurred on the date stated above, at 2 P. M.
The CAUSE OF DEATH* was as follows:
Chronic Arthritis
(Duration) 2 Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... Yrs. ..... mos. ..... ds.
(Signed) J. C. Patterson M. D.
4-25 1921 (Address) Burley Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Pleasant View Cemetery — DATE OF BURIAL: Apl. 27. 1921
20. UNDERTAKER: R W Watt — ADDRESS: Burley Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 34304
Registered No. 645

1. PLACE OF DEATH

County of Nez Perce
City of Lewiston (St.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
JUN 13 1921
BUREAU OF VITAL STATISTICS

Grace E Love

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Widower

6. DATE OF BIRTH: June (Month) 29 (Day) 1841 (Year)

7. AGE: 79 Yrs. 10 Mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Vt.

10. NAME OF FATHER: Jno. Love

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER: Emerson

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ed Mermod
(Address)

15. Filed Jun 8 1921
Susan E Bruce
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 2 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1910, to May 2 1921, that I last saw him alive on April 30 1921, and that death occurred on the date stated above, at 5 A.M.

The CAUSE OF DEATH* was as follows:
Valvular heart trouble
(Duration) 10 Yrs. mos. ds.
Contributory (Secondary) Unknown
(Duration) yrs. mos. ds.

(Signed) J B Morris M. D.
May 1921 (Address) Lewiston

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston Idaho
DATE OF BURIAL: May 6 1921

20. UNDERTAKER: Vasoan W. Co
ADDRESS: Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
JUN 15 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Nez Perce — Registration District No. 96
City of Lewiston — Primary Registration District No. 1009 — Mules Hospital St.)
File No. 34305
Registered No. 646

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ila Loen Lucke Rial

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Oct (Month) 17 (Day) 1896 (Year)

7. AGE: 24 Yrs. 6 Mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Neb.

10. NAME OF FATHER: Dan Lucke

11. BIRTHPLACE OF FATHER (State or Country): [illegible]

12. MAIDEN NAME OF MOTHER: Dollie Davis

13. BIRTHPLACE OF MOTHER (State or Country): Neb.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) .....
(Address) P.W. Rial

15. Filed May 8 1921 — Susan E. Bruce, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 2 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 10 1921, to May 2 1921, that I last saw h[illegible] alive on May 2 1921, and that death occurred on the date stated above, at 3a.M.

The CAUSE OF DEATH* was as follows:
General Peritonitis
+ Septicaemia.
(Duration) ..... Yrs. 1 mos. ..... ds.
Contributory (Secondary) Self. induced abortion.
(Duration) ..... yrs. 1 mos. ..... ds.

(Signed) Edgar L White M. D.
May 2 1921 (Address) Lewiston Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Lewiston Ida — DATE OF BURIAL: May 3 1921

20. UNDERTAKER: Vassar & Co — ADDRESS: Lewiston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 34306
Registered No. 647

1. PLACE OF DEATH

County of Nez Perce

City of Lewiston (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
JUN 13 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME Murray

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	white	Single

6. DATE OF BIRTH: May (Month) 7 (Day) 1921 (Year)

7. AGE: ..... Yrs. ..... Mos. S.B. ds.

IF LESS than 1 day how many ..... hrs. or 10 min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Chas Murray

11. BIRTHPLACE OF FATHER (State or Country): Pa.

12. MAIDEN NAME OF MOTHER: Mary Eaton

13. BIRTHPLACE OF MOTHER (State or Country): Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chas Murray
(Address) Lewiston

15. Filed June 8 1921 Susan E. Bruce Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 7 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 7 1921, to May 7 1921, that I last saw h.. alive on May 7 1921, and that death occurred on the date stated above, at 11:57 A.M.

The CAUSE OF DEATH* was as follows:
Premature birth
7 months gestation

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Elmer G Braddock M. D.

May 7 1921 (Address) Lewiston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Normal Hill Lewiston	5/7 1921
20. UNDERTAKER	ADDRESS
VAUGHAN UNDERTAKING CO.	

E. M. Brower

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

alley.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34307
Registered No. 648

1. PLACE OF DEATH

Registration District No. 96
Primary Registration District No. 1009
County of Nez Perce
City of Lewiston (No. 627 Prospect Ave St.)

JUN 13 1921
BUREAU OF VITAL STATISTICS

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Alice M. McCormack

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Married

6. DATE OF BIRTH: July (Month) 14 (Day) 1865 (Year)

7. AGE: 55 Yrs. 9 Mos. 25 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Canada

10. NAME OF FATHER: Vernon

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Ann Vernon Tucker

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. [illegible]
(Address) 627 Prospect Ave Lewiston

15. Filed June 8 19..... Susan E. Bruce Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 9 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1917 19..... to May 9 1921
that I last saw her alive on May 5 1921
and that death occurred on the date stated above, at 6 A.M.
The CAUSE OF DEATH* was as follows:
Aortic Regurgitation

.....(Duration) 4 Yrs. ..... mos. ..... ds.
Contributory (Secondary)
.....(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John H Alley M. D.
5-10 1921 (Address) Lewiston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Normal Hill Cemetery — DATE OF BURIAL: 5/12 1921

20. UNDERTAKER: Vassar Und Co. — ADDRESS: Lewiston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34308
Registered No. 649

RECEIVED
JUN 13 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 96
Primary Registration District No. 1009

County of Nez Perce
City of Lewiston (or Village or Township) St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME C. Hardin Livingston

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word.)
Male	White	Married

6. DATE OF BIRTH: Oct (Month) 13 (Day) 1883 (Year)

7. AGE: 37 Yrs. 6 Mos. 28 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farming
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: W. C. Livingston

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Jennie Ball

13. BIRTHPLACE OF MOTHER (State or Country): Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs C H Livingston
(Address)

15. Filed June 8 1921 Susan E Bruce Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 10th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1 1920 to May 11 1921 that I last saw h. alive on May 11 1921 and that death occurred on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

Gunshot wound of cranium
Decompression Operation
May 11 1921

(Duration) Yrs. 6 mos. ds.

Contributory (Secondary) Pachymeningetis

(Duration) yrs. 6 mos. ds.

(Signed) E G Broadock M. D.

May 13 1921 (Address) Lewiston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Lorimor Iowa	19

20. UNDERTAKER: [illegible] UNDERTAKING CO. ADDRESS: Lewiston Ida

Walter Grandfield. Earl Brown.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED JUN 13 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34309
Registered No. 650

Registration District No. 96
Primary Registration District No. 1009

1. PLACE OF DEATH
County of Nez Perce
City of Lewiston (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Marion E. Shepler

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Dec (Month) 13 (Day) 1861 (Year)

7. AGE: 59 Yrs. 5 Mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mo.

10. NAME OF FATHER: Peter Shepler

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Rachel Bicker

13. BIRTHPLACE OF MOTHER (State or Country): Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs M E Shepler
(Address) Lewiston Ida

15. Filed June 8 1921 Susan E Bruce Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 13 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 4, 1921, to May 12, 1921, that I last saw h.. alive on May 12, 1921, and that death occurred on the date stated above, at 5 a. M.
The CAUSE OF DEATH* was as follows:
Simple Apoplexy
(Duration) ..... Yrs. ..... mos. 8 ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) E E Inman M. D.
5/13 1921 (Address) Lewiston Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston Ida — DATE OF BURIAL: 5/15 1921

20. UNDERTAKER — ADDRESS: Lewiston Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

White

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34310

Registration District No. 95

Primary Registration District No. 1009

Registered No. 551

1. PLACE OF DEATH

County of Nez Perce

City of Lewiston (No. ..... Lewiston Orchards St.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED JUN 13 1921 BUREAU OF VITAL STATISTICS

2. FULL NAME Betty Jo Rolfe

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Jan (Month) 21 (Day) 1921 (Year)

7. AGE: Yrs. 3 Mos. 27 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: T. E. Rolfe

11. BIRTHPLACE OF FATHER (State or Country): Calif

12. MAIDEN NAME OF MOTHER: Erma Jackson

13. BIRTHPLACE OF MOTHER (State or Country): Wash

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) T. E. Rolfe

(Address) Lewiston Orchards

15.

Filed June 8 1921 Noan E. Burns Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 18 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 14 1921, to May 18 1921 that I last saw h.. alive on May 18 1921, and that death occurred on the date stated above, at 4:30 P. M.

The CAUSE OF DEATH* was as follows:

Strangulation from Whooping Cough.

(Duration) ..... Yrs. ..... mos. 15 ds.

Contributory (Secondary) Same

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Edgar L. White M. D.

May 18 1921 (Address) Lewiston Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Lewiston Ida

DATE OF BURIAL: 5/20 1921

20. UNDERTAKER: VASSAR UNDERTAKING

ADDRESS: Lewiston Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34311
Registered No. 65-2

1. PLACE OF DEATH

County of Nez Perce — Registration District No. 96

City of Lewiston — Primary Registration District No. 1009

(No. St.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED JUN 10 1921 BUREAU OF VITAL STATISTICS

2. FULL NAME Mary Jane Rapp

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widowed

6. DATE OF BIRTH: May (Month) 11 (Day) 1849 (Year)

7. AGE: 72 Yrs. — Mos. 7 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): N Y

10. NAME OF FATHER: Owen McLaughlin

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Mary Murray

13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs J. M. Brown

(Address) Moorhead, Minn.

15. Filed June 8 1921 Susan E. Bruce Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 18th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 2nd 1921, to May 18 1921, that I last saw h.er alive on May 18th 1921, and that death occurred on the date stated above, at 1:30 M.

The CAUSE OF DEATH* was as follows:

Facial Erysipelas

(Duration) ..... Yrs. ..... mos. 3d ds.

Contributory (Secondary) Gall Stones

(Duration) 1 yrs. ..... mos. ..... ds.

(Signed) O. C. Epperson M. D.

19..... (Address) Lewiston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Blue Earth Minn

DATE OF BURIAL ..... 19.....

20. UNDERTAKER

ADDRESS Lewiston Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED JUN 15 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 34312
Registered No. 65-3

1. PLACE OF DEATH
County of Nez Perce
City of Lewiston (St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Robert Dallas Blair
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Sept (Month) 19 (Day) 1844 (Year)

7. AGE: 76 Yrs. 8 Mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Compositor
(b) General nature of industry, business or establishment in which employed (or employer): Job Printing

9. BIRTHPLACE (State or Country): Pennsylvania

10. NAME OF FATHER: Alexander Blair

11. BIRTHPLACE OF FATHER (State or Country): Scotland

12. MAIDEN NAME OF MOTHER: Sarah Martin

13. BIRTHPLACE OF MOTHER (State or Country): Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Fred T. Thompson
(Address) Lewiston Idaho

15. Filed June 8 1921 Susan E. Bruce Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 24 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 15 1921, to May 24 1921, that I last saw h~~im~~ alive on May 24 1921 and that death occurred on the date stated above, at 8 A.M.
The CAUSE OF DEATH* was as follows:
Mitral insufficiency

(Duration) Yrs. 1 mos. 6 ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) Elmer E Brodrick M. D.
May 24 1921 (Address) Lewiston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Normal Hill Cemetery — DATE OF BURIAL: 5/26 1921

20. UNDERTAKER: VASSAR UNDERTAKING CO. — ADDRESS: Lewiston Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED
JUN 10 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Nez Perce — Registration District No. 96
City of Lewiston (St.) — Primary Registration District No. 1009
File No. 34313
Registered No. 654

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Thomas M. Tabor

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Nov (Month) 9 (Day) 1878 (Year)

7. AGE: 42 Yrs. 6 Mos. 12 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Taxi owner Business
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mo.

10. NAME OF FATHER: Mathew Tabor

11. BIRTHPLACE OF FATHER (State or Country): Minn.

12. MAIDEN NAME OF MOTHER: Elizabeth Brown

13. BIRTHPLACE OF MOTHER (State or Country): Texas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Mrs Thomas M Tabor
(Address):

15. Filed June 8 1921 — Susan E. Bruce, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 25th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 25 1921 to May 25 1921 that I last saw h[e] alive on May 25 1921 and that death occurred on the date stated above, at 8:30 P.M.

The CAUSE OF DEATH* was as follows:
Angina Pectoris

(Duration) ..... Yrs. ..... mos. 1 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Elmer G Broadbent M. D.
May 26 1921 (Address) Lewiston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Normal Hill Cemetery — DATE OF BURIAL: 5/28 1921

20. UNDERTAKER: VASSAR UNDERTAKING CO. — ADDRESS: Lewiston Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34314
Registered No. 655

1. PLACE OF DEATH

County of Lewis — Registration District No. 96

City of Clarkston — Primary Registration District No. 1909

(If outside limits, give township) — (St. Joseph Hospital)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED JUN 12 1921 BUREAU OF VITAL STATISTICS

2. FULL NAME Patrick Doyle

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widowed.

6. DATE OF BIRTH: January (Month) 3 (Day) 1837 (Year)

7. AGE: 84 Yrs. 4 Mos. 27 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Mason

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ontario Canada

10. NAME OF FATHER: Garret Doyle

11. BIRTHPLACE OF FATHER (State or Country): County Wexford Ireland

12. MAIDEN NAME OF MOTHER: Catherine Ward

13. BIRTHPLACE OF MOTHER (State or Country): County Wexford Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E Bowen

(Address) Clarkston Wash

15. Filed June 8 1921 — Susan E Bruce, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 27 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 26 1921, to May 27 1921, that I last saw h.im alive on May 27 1921, and that death occurred on the date stated above, at 12 noon M.

The CAUSE OF DEATH* was as follows:

Chronic Cirrhosis of Liver

(Duration) several years Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Paul W Johnson M. D.

5/28 1921 (Address) Clarkston Wash

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. 1 days. In the State ..... yrs. ..... mos. 1 days

Where was disease contracted if not at place of death? at residence Clarkston Wash

Former or usual residence Clarkston Wash

19. PLACE OF BURIAL OR REMOVAL: Clarkston Wash — DATE OF BURIAL: 5/28 1921

20. UNDERTAKER: H P Merchant — ADDRESS: Clarkston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED
JUN 13 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 34315
Registered No. 656

1. PLACE OF DEATH

County of Nez Perce
City of Lewiston (No. 105 Main St. St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Pauline Willander

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	white	Married

6. DATE OF BIRTH June (Month) 14 (Day) 1873 (Year)

7. AGE 47 Yrs. 11 Mos. 17 ds.

IF LESS than 1 day how many..... hrs. or.....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Norway

10. NAME OF FATHER H. Hammerstad

11. BIRTHPLACE OF FATHER (State or Country) Norway

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER (State or Country) Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Chas Willander

(Address) Lewiston Idaho 1805 Main

15. Filed June 8 1921 Susan E. Bruce Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH ~~June~~ May (Month) 29 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....

that I last saw h..... alive on ..... 19.....

and that death occurred on the date stated above, at .....M.

The CAUSE OF DEATH* was as follows:

Suffocation under fallen sacked wheat—
Accidental

(Duration) .....Yrs.....mos.....ds.

Contributory (Secondary)

(Duration) .....yrs.....mos.....ds.

(Signed) W B Williamson Coroner

19..... (Address) Lewiston, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Normal Hill Cemetery — **DATE OF BURIAL** 6/2 1921

20. UNDERTAKER Vassar Undertaking — **ADDRESS** Lewiston, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

RECEIVED
JUN 13 1921
BUREAU OF VITAL STATISTICS

Registration District No. 96
Primary Registration District No. 1009
File No. 34316
Registered No. 65-7

County of Nezperce
City of Lewiston (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Robert Sliver

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	

6. DATE OF BIRTH: May (Month) 29 (Day) 1921 (Year)

7. AGE: ——— Yrs. ——— Mos. ——— ds. IF LESS than 1 day how many 6 hrs. or ——— min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ———
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Lewiston Ida.

10. NAME OF FATHER D. A. Sliver

11. BIRTHPLACE OF FATHER (State or Country) Marin N. C.

12. MAIDEN NAME OF MOTHER Dora Robritson

13. BIRTHPLACE OF MOTHER (State or Country) Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) D A Sliver
(Address) Austin Nash

15. Filed June 8 1921 Susan E. Bruce Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 29 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 24 1921, to May 27 1921 that I last saw h..... alive on ..... 19..... and that death occurred on the date stated above, at 2.30 a.m.

The CAUSE OF DEATH* was as follows:
Premature infant about 1 mo. (Placenta Praevia)

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. D. Clark M. D.
May 29 1921 (Address) Genesee Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence Asotin Wash Lewiston

19. PLACE OF BURIAL OR REMOVAL: Clarkston Wash. DATE OF BURIAL: 5/30 1921

20. UNDERTAKER: A. P. Merchant ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

RECEIVED
JUN 15 1921
BUREAU OF VITAL STATISTICS

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 34319
Registered No. 660

1. PLACE OF DEATH
County of Nez Perce
City of Lewiston (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Frank Julius Stevens
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Feb (Month) 8 (Day) 1863 (Year)

7. AGE: 58 Yrs. 3 Mos. 22 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Restaurant Prop.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Peter Stevens

11. BIRTHPLACE OF FATHER (State or Country): Me.

12. MAIDEN NAME OF MOTHER: Brink

13. BIRTHPLACE OF MOTHER (State or Country): ——

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs F. J. Stevens
(Address) Lewiston Idaho

15. Filed June 8 1921 — Susan E Bruce, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 30 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 10 1921 to May 30 1921 that I last saw h[illegible] alive on May 30 1921 and that death occurred on the date stated above, at 9 P. M.
The CAUSE OF DEATH* was as follows:
Broncho Pneumonia
(Duration) ..... Yrs. ..... mos. 2 ds.
Contributory (Secondary) Chronic Valvular heart disease
(Duration) 1 yrs. ..... mos. ..... ds.
(Signed) W. A. Clark M. D.
May 30 1921 (Address) Lewiston Idaho

State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? Lewiston Idaho
Former or usual residence Nez Perce Idaho

19. PLACE OF BURIAL OR REMOVAL: Normal Hill Cemetery — DATE OF BURIAL: 6/1 1921

20. UNDERTAKER: VASSAR UNDERTAKING CO. — ADDRESS: Lewiston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 128

Primary Registration District No.

File No. 34321

Registered No.

County of Nez Perce

City of Near Culdesac (Ward, Village or Town) (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Andrew Moody

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Red

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Oct (Month) 18 (Day) 1871 (Year)

7. AGE: 50 Yrs. Mos 6 ds. 16

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Francis Moody

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Rebecca Wapeki

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Nellie Ahtee
(Address) Ferdinand Idaho.

15. Filed May 19 21 George Lapwai
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 3 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 16th 1921, to May 2nd 1921, that I last saw him alive on May 2nd 1921, and that death occurred on the date stated above, at 6:30 A.M.

The CAUSE OF DEATH* was as follows:

Diabetes

(Duration) 4 Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) George Gaisnard M. D.

May 1921 (Address) Culdesac Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Ferdinand Ida. DATE OF BURIAL: May 5 1921

20. UNDERTAKER: Wann ADDRESS: Lapwai Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 128

Primary Registration District No. Culdesac

File No. 34324

Registered No.

1. PLACE OF DEATH

County of Nez Perce

City of Near Culdesac (If outside city limits, give township) Vicinity St.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
MAY 20 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME Kenneth Allen Martimore

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: March (Month) 31 (Day) 1850 (Year)

7. AGE: 64 Yrs. 11 Mos. 11 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: William Mortimore

11. BIRTHPLACE OF FATHER (State or Country): Illinois

12. MAIDEN NAME OF MOTHER: Kathrine Rhodes

13. BIRTHPLACE OF MOTHER (State or Country): Pennsylvania

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Watt Martimore

(Address) Pasco Washington

15. Filed March 19 21 George Gaimard Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 11 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 16 1921 to March 11 1921 that I last saw him alive on March 10 1921, and that death occurred on the date stated above, at 5:00 A.M.

The CAUSE OF DEATH* was as follows: Cancer of Cheek

(Duration) 3 0 Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) George Gaimard M. D.

March 19 21 (Address) Culdesac Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Culdesac Idaho

DATE OF BURIAL: March 19 21

20. UNDERTAKER: Nasburg

ADDRESS Lewiston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

34325

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 92
Primary Registration District No. 2170

File No. 5
Registered No. 21

1. PLACE OF DEATH.

County of Nez Perce
City of Gifford (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

RECEIVED
JUN 4 1921
BUREAU OF VITAL STATISTICS

2. USUAL RESIDENCE. Martina Fredrickson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. Aug (Month) 17 (Day) 184[illegible] (Year)

7. AGE: 72 Yrs. 9 Mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Denmark

10. NAME OF FATHER: Lars Andreson

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: Marie —

13. BIRTHPLACE OF MOTHER (State or Country): Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) C. R. Fredericksen
(Address)

15. Filed 5 – 23 1921 E. E. Watts Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 5 (Month) 22 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 7 1918, to 5 – 22 1921, that I last saw h[illegible] alive on May 22 1921, and that death occured on the date stated above, at 9 P M.

The CAUSE OF DEATH* was as follows:
Valvular insufficiency

(Duration) 3 Yrs. — mos. — ds.
Contributory (Secondary) Anasarca
(Duration 1 yrs. 3 mos. — ds.

(Signed) E. E. Watts M. D.
5-22-1921 (Address) Gifford Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Clarkston Wash. DATE OF BURIAL: 5-25 1921

20. UNDERTAKER: H. R. Merchant ADDRESS: Clarkston Wash

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24658

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34326

Registered No. 629

1. PLACE OF DEATH

County of Nezperce Registration District No. 96

City of Lewiston (No. ..... St.) Primary Registration District No. 1009

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

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MAY 20 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME Sarah E. Wilmarth

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Feb (Month) 21 (Day) 1877 (Year)

7. AGE: 44 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Oregon Old Rock

10. NAME OF FATHER John H. Keeney

11. BIRTHPLACE OF FATHER (State or Country) Del

12. MAIDEN NAME OF MOTHER Martha Stoops

13. BIRTHPLACE OF MOTHER (State or Country) Del.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15. Filed Ap 4 1921 Susan E. Bruce Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 20 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....

that I last saw h..... alive on ..... about 19.....,

and that death occurred on the date stated above, at 7 1/2 A.M.

The CAUSE OF DEATH* was as follows:

Shot-Gun Wound
Homicide

.....(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

.....(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W B Williamson Coroner M. D.

.....19..... (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Lewiston Ida.	May 2 1921
20. UNDERTAKER	ADDRESS
Varnar Undr. Co	Lewiston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

White

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34327

Registered No. 630

RECEIVED MAY 20 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 96

Primary Registration District No. 1009

County of Nez Perce

City of Lewiston, (or Village of....., or Township of....., St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Dorothy Huntley

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): married

6. DATE OF BIRTH: April (Month) March 15 (Day) 1892 (Year)

7. AGE: 28 Yrs. 11 Mos. 17 ds.

IF LESS than 1 day how many..... hrs. or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: Halvor Halvorson

11. BIRTHPLACE OF FATHER (State or Country): Norway

12. MAIDEN NAME OF MOTHER: Jacobins

13. BIRTHPLACE OF MOTHER (State or Country): Denmark.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jess Huntley.

(Address).....

15. Filed May 4 1921 Susan E Bruce Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 2 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 5 1921, to April 2 1921, that I last saw h.. alive on April 2 1921, and that death occurred on the date stated above, at 6 A M.

The CAUSE OF DEATH* was as follows:

Chronic Valvular heart disease.

(Duration) 2 Yrs. mos. ds.

Contributory (Secondary) Chronic Interstitial Nephritis.

(Duration) yrs. mos. ds.

(Signed) Edgar L White M. D.

19..... (Address) Lewiston Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Genesee Ida. DATE OF BURIAL: 4/4 1921

20. UNDERTAKER: [illegible] Undertaking Co ADDRESS Lewiston Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

RECEIVED MAY 20 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34328
Registered No. 631

1. PLACE OF DEATH

Registration District No. 96
Primary Registration District No. 1009
County of Nez Perce
City of Lewiston (No. White Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William Rowland.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: White

5. SINGLE, ~~MARRIED, WIDOWED OR DIVORCED~~ (Write the word.)

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1 (Year)

7. AGE: 70 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Shop Keeper.
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): N. C.

10. NAME OF FATHER: Unknown.

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Roy Cauley
(Address) Lewiston Ida.

15. Filed Apr 4 1921 — Susan E Bruce, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 8 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 8 1921, to April 8 1921, that I last saw h~~im~~ alive on April 8 1921, and that death occurred on the date stated above, at 8 A. M.

The CAUSE OF DEATH* was as follows:
Cancer of Throat.
.....
.....
(Duration) ..... Yrs. 8 mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) Edgar L White M. D.
19..... (Address) Lewiston Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Lewiston Ida — DATE OF BURIAL: April 9 1921

20. UNDERTAKER: Hassan U. C. — ADDRESS: Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34329

Registered No. 632

1. PLACE OF DEATH

County of Nez Perce

City of Lewiston

If death occurs away from usual residence, give facts called for under special information.

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MAY 20 1921
BUREAU OF VITAL STATISTICS

Registration District No. 96

Primary Registration District No. 1009

(If not in hospital, give street address or location. If in hospital or institution, give its name instead of street address.) Miles Hospital St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Jas Givens

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: July (Month) 25 (Day) 1890 (Year)

7. AGE: 30 Yrs. 8 Mos. 17 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Stock buyer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Okla.

10. NAME OF FATHER: Johnas Givens

11. BIRTHPLACE OF FATHER (State or Country): Mo.

12. MAIDEN NAME OF MOTHER: Rachel Jackson

13. BIRTHPLACE OF MOTHER (State or Country): Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Roy Givens

(Address)

15. Filed May 4 1921 Susan E Bruce Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 12 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 8 1921 to April 12 1921 that I last saw him alive on April 12 1921 and that death occurred on the date stated above, at 2:30 P. M.

The CAUSE OF DEATH* was as follows:

Acute dylitation of Heart and Stomach + Shock.

(Duration) Yrs. mos. 1 ds.

Contributory (Secondary) Shock + Fracture of upper third Rt. femur

(Duration) yrs. mos. 4 ds.

(Signed) E L White M. D.

4-12 1921 (Address) Lewiston Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston Ida | DATE OF BURIAL: 4/14 1921

20. UNDERTAKER: Vassar Mtd Co | ADDRESS: Lewiston Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19:

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 96

Primary Registration District No. 1009

File No. 34330

Registered No. 633

County of Nez Perce

City of Lewiston (St.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
MAY 20 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME Jefferson Cornett

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1 (Year)

7. AGE: 40 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day, how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Engineer.
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): —

10. NAME OF FATHER: —

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Roy C Parley
(Address) .....

15. Filed May 4 1921 Susan E Bruce, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 13 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 7 1921, to April 13 1921, that I last saw him alive on April 13 1921, and that death occurred on the date stated above, at 12 30 P.M.

The CAUSE OF DEATH* was as follows:

Burns from gasoline

(Duration) ..... Yrs. ..... mos. 6 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J R Morris M. D.

19..... (Address) Lewiston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Spokane Wash — DATE OF BURIAL: ..... 19.....

20. UNDERTAKER: Varsar Undertaking Co — ADDRESS: Lewiston Id

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Nez Perce — Registration District No. 96

City of Lewiston — Primary Registration District No. 1009

(No. St.)

File No. 34331

Registered No. 634

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George W. Hansell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

RECEIVED MAY 20 1921 BUREAU OF VITAL STATISTICS

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH: Feb (Month) 14 (Day) 1921 (Year)

7. AGE: 0 Yrs. 2 Mos. = ds. IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Oregon

10. NAME OF FATHER: Blain W. Hansell

11. BIRTHPLACE OF FATHER (State or Country): Oregon

12. MAIDEN NAME OF MOTHER: Myrtle Holmes

13. BIRTHPLACE OF MOTHER (State or Country): Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) B.W. Hansell

(Address) Lewiston, Ida.

15. Filed May 4 1921 — Noam E. Bruce, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr (Month) 14th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 4th 1921, to Apr 14 1921, that I last saw h. alive on ~ 19..., and that death occurred on the date stated above, at ... M.

The CAUSE OF DEATH* was as follows:

Heart failure

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary): Patent Foramen ovale

(Duration) ... yrs. 4 mos. ... ds.

(Signed) O E Terrell M. D.

19... (Address) Terrell Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Athena Oregon — DATE OF BURIAL: Apr 19 21

20. UNDERTAKER: Vassa Und' Co — ADDRESS: Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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FORM V. S. No. 5-25 M. 1-19.

RECEIVED MAY 20 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34332

Registered No. 635

1. PLACE OF DEATH

Registration District No. 96

Primary Registration District No. 1009

County of Nez Perce

City of Lewiston (or Village, or Township, or Precinct) St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Marie Neumann

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.): Widow

6. DATE OF BIRTH: Dec 26 1841 (Month) (Day) (Year)

7. AGE: 79 Yrs. 3 Mos. 22 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: Dillman

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Henry A. Neumann
(Address)

15. Filed May 4 1921 Susan E. Bruce Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April 18 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Intestinal Nephritis
(Duration) 2 Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) John N Alley M. D.
19..... (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston Idaho — DATE OF BURIAL: 4/19 1921

20. UNDERTAKER: Vassar Undertaking — ADDRESS: Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 34333
Registered No. 686

1. PLACE OF DEATH

County of Nez Perce
City of Lewiston (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED MAY 20 1921 BUREAU OF VITAL STATISTICS

2. FULL NAME Myrtle L Jenks

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6. DATE OF BIRTH: May (Month) 29 (Day) 1877 (Year)

7. AGE: 43 Yrs. 10 Mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kansas

10. NAME OF FATHER: W B. Stone

11. BIRTHPLACE OF FATHER (State or Country): Penn.

12. MAIDEN NAME OF MOTHER: Myers

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ebenezer Jenks.
(Address)

15. Filed May 4 1921 Wm E Bruce Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 19th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 10 1920, to Apr 19 1921, that I last saw h.. alive on Apr 18 1921 and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Diabetis Coma
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Diabetes Mellitus
(Duration) + yrs. ..... mos. ..... ds.

(Signed) O B Epsaman M. D.
19..... (Address) Lewiston Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston, Idaho
DATE OF BURIAL: Apr 22 1921

20. UNDERTAKER: Vasser Bud Co.
ADDRESS: Lewiston Id

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED MAY 20 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 34334
Registered No. 637

1. PLACE OF DEATH

County of Nez Perce
City of Lewiston (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Frank B Robinson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH ..... 1 .....
(Month) (Day) (Year)

7. AGE 60 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) New York.

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (State or Country) "

12. MAIDEN NAME OF MOTHER "

13. BIRTHPLACE OF MOTHER (State or Country) "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Em Brown
(Address) Lewiston Ida

15. Filed May 4 1921 Susan E Bruce
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 24 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw him alive on ..... 19.....
and that death occurred on the date stated above, at about 4 A.M.
The CAUSE OF DEATH* was as follows:
Heart Failure
.....
.....
.....(Duration) .....Yrs.....mos.....ds.
Contributory (Secondary) .....
.....(Duration) .....yrs.....mos.....ds.
(Signed) W B Williamson Coroner M. D.
.....19..... (Address) Lewiston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Lewiston Ida | DATE OF BURIAL 4/27 1921

20. UNDERTAKER Vassar Undertaking Co. | ADDRESS Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED MAY 20 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 96
Primary Registration District No. 1009
File No. 34335
Registered No. 638

County of Nez Perce
City of Lewiston (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME A. B. Nordyke

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Jan (Month) 11 (Day) 1854 (Year)

7. AGE: 57 Yrs. 3 Mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Jesse Nordyke

11. BIRTHPLACE OF FATHER (State or Country): U.S.

12. MAIDEN NAME OF MOTHER: Lavina Helm

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Eva Bruce
(Address) Lewiston Ida

15. Filed May 4 1921 Susan E. Bruce
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 24 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 22 1921, to April 24 1921, that I last saw him alive on April 24 1921, and that death occurred on the date stated above, at 2 30 P.M.

The CAUSE OF DEATH* was as follows:
(Arterio sclerosis)
Angina Pectoris

(Duration) Yrs. mos. 3 ds.
Contributory (Secondary) Arterio sclerosis
(Duration) 3 yrs. mos. ds.

(Signed) E. L. White M. D.
Apr. 25 1921 (Address) Lewiston Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston Ida
DATE OF BURIAL: 4/26 1921

20. UNDERTAKER: VARNAH UNDERTAKING CO.
ADDRESS: Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34336

Registered No. 639

RECEIVED MAY 20 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Nez Perce Registration District No. 96

City of Lewiston Primary Registration District No. 1009

(If not in hospital or institution, give No. ..... St.) St. Joes Hospital

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Anny Carter

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: Indian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: (Write the word) ~~Married~~

6. DATE OF BIRTH: Unknown (Month) ~ (Day) 1 (Year)

7. AGE: 80 Yrs. — Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Wa Pi Ti Sonni

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Pe tu ti Lumpy

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E B Warren
(Address) Lewiston, Idaho

15. Filed Apr 27 to May 4th 21 Susan E Bruce Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 26th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 19 1921 to Apr 26 1921 that I last saw h[illegible] alive on Apr 20 1921, and that death occurred on the date stated above, at [illegible] M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas N Miller M. D.

May 5 1921 (Address) Lewiston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? Lapwai

Former or usual residence Lapwai

19. PLACE OF BURIAL OR REMOVAL: Lapwai, Idaho — DATE OF BURIAL: April 27 1921

20. UNDERTAKER: [illegible] UNDERTAKING CO. — ADDRESS: Lewiston Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

34337 Braddock.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED MAY 20 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 96

Primary Registration District No. 1009

File No. 34337

County of Nez Perce

City of Lewiston (No. ..... St.)

Registered No. 640

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Thos J. Maynard

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Sept (Month) 29 (Day) 1855 (Year)

7. AGE: 65 Yrs. 7 Mos. ... ds.

IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ill= Iowa

10. NAME OF FATHER: Nathan Maynard

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Elizabeth Messinger

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15. Filed May 4 1921 Susan E Bruce Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 29 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 15 1921 to April 29 1921 that I last saw h.... alive on April 28 1921, and that death occurred on the date stated above, at 3a M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Prostate Gland

(Duration) 2 Yrs. ... mos. ... ds.

Contributory (Secondary) .....

(Duration) ... yrs. ... mos. ... ds.

(Signed) E S Braddock M. D.

4-29 1921 (Address) Lewiston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Clarkston Wn

DATE OF BURIAL: 5/31 1921

20. UNDERTAKER: Brassas Mod Co.

ADDRESS: Lewiston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 96

County of Nez Perce

Primary Registration District No. 1009

City of Lewiston (No. ..... St.)

File No. 34338

Registered No. 641

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lolitha Isabella Hart

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

RECEIVED MAR 20 1921 BUREAU OF VITAL STATISTICS STATE OF IDAHO

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6. DATE OF BIRTH: Jan (Month) 14 (Day) 1883 (Year)

7. AGE: 38 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Wash

10. NAME OF FATHER: John Bushel

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Mahulah Galloway

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Ida Arbiter

(Address) Anatone

15. Filed May 4 1921 Susan E Bruce Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr (Month) 30 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....

that I last saw h..... alive on ..... 19.....

and that death occurred on the date stated above, at about 7:15 A. M.

The CAUSE OF DEATH* was as follows:

Shot-Gun wound

Homicide

.....(Duration) .....Yrs.....mos.....ds.

Contributory (Secondary) .....

.....(Duration) .....yrs.....mos.....ds.

(Signed) W B Williamson Coroner M. D.

.....19..... (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State .....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Lewiston Idaho

DATE OF BURIAL: May 2 1921

20. UNDERTAKER: Pasoar Undertaking Co.

ADDRESS: Washington

FORM V. S. No. 5-25 M. 1-19.

RECEIVED MAY 20 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 96

County of Nez Perce — Primary Registration District No. 1009

File No. 34339

City of Lewiston (No. ....., ... St.)

Registered No. 642

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Joe Hoop

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Widower

6. DATE OF BIRTH ..... 1 .....
(Month) (Day) (Year)

7. AGE 44 about Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Boatman

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE
(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER
(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15. Filed Apr 4 1921 Susan E. Bruce
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 20 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at about 7:45 A.M.

The CAUSE OF DEATH* was as follows:

Gun Shot Wound
Suicide

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. S. Williamson Coroner M. D.

..... 19..... (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Asotin Wash	Mar. 2 1921

20. UNDERTAKER	ADDRESS
Vassar & Co	Lewiston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34341

Registered No. 15

Registration District No. 26

Primary Registration District No. 2069

RECEIVED JUN 4 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Oneida

City of Malad (If outside limits, give township) (No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Rachael Prethero

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word.): Widow

6. DATE OF BIRTH: March (Month) 21 (Day) 1849 (Year)

7. AGE: 72 Yrs. 1 Mos. 20 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wales

10. NAME OF FATHER: Evan Davis

11. BIRTHPLACE OF FATHER (State or Country): Wales

12. MAIDEN NAME OF MOTHER: Ann Williams

13. BIRTHPLACE OF MOTHER (State or Country): Wales

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Arthur J. Meyer
(Address) Malad City Idaho

15. Filed June 4 1921 — R. T. Maher M.D. Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 12 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 5 1921, to May 12 1921, that I last saw h. alive on May 12 1921 and that death occurred on the date stated above, at 8:10 A.M.
The CAUSE OF DEATH* was as follows:

apoplexy

(Duration) ..... Yrs. ..... mos. 7 ds.

Contributory (Secondary) high blood pressure aortic reg.

(Duration) 5 yrs. ..... mos. ..... ds.

(Signed) R. T. Maher M. D.

May 4 1921 (Address) Malad, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Malad Idaho — DATE OF BURIAL: May 15 1921

20. UNDERTAKER: J. Guy Benson — ADDRESS: Malad Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

RECEIVED JUN 4 1921 BUREAU OF VITAL STATISTICS

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34342

Registered No. 16

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH. Registration District No. 26

County of Oneida Primary Registration District No. 2069

City of Malad (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Alvah M. Smith

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word)
Male	White	Married

6. DATE OF BIRTH: July (Month) 11 (Day) 1865 (Year)

7. AGE: 55 yrs. 10 mos. 5 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) Farmer & Carpenter

9. BIRTHPLACE (State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Zora Smith
(Address) Malad Idaho

15.
Filed June 4 1921 R T Mauer M D
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 16 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1921, to May 16 1921, that I last saw h. him alive on May 16 1921, and that death occurred on the date stated above, at 5a M.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis
(chronic type)
(Duration) 5 yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) R. T. Mauer M. D.
May 17 1921 (Address) Malad, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Pleasantview	May 18 1921

20. UNDERTAKER	ADDRESS
J. Jay Benson	Malad Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Oneida RECEIVED JUN 4 1921 BUREAU OF VITAL STATISTICS

Registration District No. 26

Primary Registration District No. 2069

File No. 34343

City of ..... St.)

Registered No. 17

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Nola Elizabeth Ashton

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: July (Month) 23 (Day) 1920 (Year)

7. AGE: Yrs. 9 Mos. 22 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business or establishment in which employed (or employer) Child

9. BIRTHPLACE (State or Country) Oneida Co Idaho

10. NAME OF FATHER Wm Ashton.

11. BIRTHPLACE OF FATHER (State or Country) Woodruff Idaho

12. MAIDEN NAME OF MOTHER Elizabeth Allen

13. BIRTHPLACE OF MOTHER (State or Country) Portage Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) William Ashton

(Address) .....

15. Filed June 4 1921

R J Mauer M.D
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May (Month) 15 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 15 1921, to May 16 1921, that I last saw her alive on May 15 1921, and that death occurred on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Catarrhal fever

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J F Clinton M. D.

June 3 1921 (Address) Malad

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Portage, Utah

DATE OF BURIAL: May 21 1921

20. UNDERTAKER: Woodland

ADDRESS: Malad

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED JUN 4 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH — Registration District No. 26
County of Owyhee — Primary Registration District No. 2069
City of Malad (or) ..... St.) — File No. 34344
If death occurs away from usual residence, give facts called for under special information. — Registered No. 18
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Edna Thomas

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Married

6. DATE OF BIRTH — May 24 1921 (Month) (Day) (Year)

7. AGE ..... yrs. ..... mos. ..... ds. — IF LESS than 1 day how many ..2.. hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... Child .....
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Guy O Thomas

11. BIRTHPLACE OF FATHER (State or Country) Malad Idaho

12. MAIDEN NAME OF MOTHER Edna Howe

13. BIRTHPLACE OF MOTHER (State or Country) Tremonton Ut

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Guy O. Thomas
(Address) .....

15. Filed June 4 1921 — R. W. Warren Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH — May 26 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 24, to May 26 1921, that I last saw h[illegible] alive on May 25 1921 and that death occurred on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Premature Birth

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) L. E. Hilton M. D.

19..... (Address) Malad

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Malad	May 27 1921

20. UNDERTAKER — ADDRESS
Woodland Furniture Co Malad

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

GYMS - YORK CO., PTGS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

RECEIVED JUN 4 1921 BUREAU OF VITAL STATISTICS

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 26
County of Oneida Primary Registration District No. 2069
City of Downs (If outside limits of city or village, give township.) St.)
File No. 34345
Registered No. 19
If death occurs away from usual residence, give facts called for under special information. If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Baby Schwartz

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	white	Child

6. DATE OF BIRTH May 26 1921 (Month) (Day) (Year)

7. AGE ....yrs....mos....ds. IF LESS than 1 day how many ...2... hrs. or .....mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ....child....
(b) General nature of industry business, or dstablishment in which employed (or employer) ....

9. BIRTHPLACE (State or Country) Downs Idaho.

10. NAME OF FATHER J. B. Schwartz

11. BIRTHPLACE OF FATHER (State or Country) Switzerland

12. MAIDEN NAME OF MOTHER Freda Fellow

13. BIRTHPLACE OF MOTHER (State or Country) Switzerland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R. T. Mauer M.D
(Address) Malad Idaho

15. Filed June 4 1921 R. T. Mauer M.D Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH May 26 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 26 1921, to May 26 1921, that I last saw him alive on May 26 1921 and that death occurred on the date stated above, at 12 30 M.

The CAUSE OF DEATH* was as follows:
Premature birth

....(Duration)....yrs....mos....ds.

Contributory (Secondary)

....(Duration)....yrs....mos....ds.

(Signed) R. T. Mauer M. D.
May 26 1921 (Address) Malad Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death....yrs....mos....days. In the State....yrs....mos....days.
Where was disease contracted if not at place of death?....
Former or usual residence....

19. PLACE OF BURIAL OR REMOVAL Downs | DATE OF BURIAL May 29 1921

20. UNDERTAKER Woodland Furniture Co | ADDRESS Malad

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & SDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34346

Registered No. 20

1. PLACE OF DEATH.

Registration District No. 26

County of Oneida

Primary Registration District No. 2069

City of Stone, ... St.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED JUN 4 1921 BUREAU OF VITAL STATISTICS

2. FULL NAME Joseph Lloyd Stud

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Dec. (Month) 31 (Day) 1920 (Year)

7. AGE: ..... Yrs. 1 Mos. 2 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: child

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Stone Idaho

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country): Farmington Utah

12. MAIDEN NAME OF MOTHER: Charlotte Bamford

13. BIRTHPLACE OF MOTHER (State or Country): Ogden Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph Lloyd

(Address) Stone Idaho

15. Filed June 4 1921 R W Mauer M.D. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 18 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 15 1921, to Feb 15 1921, that I last saw h[illegible] alive on Feb 15 1921 and that death occured on the date stated above, at 11:30 P. M.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) ..... Yrs. ..... mos. 3 ds.

Contributory (Secondary) .....

(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) C. Sandleigh M.D. M. D.

19..... (Address) Snowville Utah

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. 1 mos. 21 days. In the State..... yrs. 1 mos. 21 days

Where was disease contracted if not at place of death? .....

Former or usual residence Stone Idaho

19. PLACE OF BURIAL OR REMOVAL: Snowville Utah — DATE OF BURIAL: Feb 22 1921

20. UNDERTAKER: Jos. Larkin — ADDRESS: Snowville Ut

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

STERN - YORK CO., PTRS. & BOOKS. 24653

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Owyhee
City of Silver
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 43
Primary Registration District No. 2120
(No. ..... St.)

File No. 34347
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Jack Thomas

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH
May (Month) 12 (Day) 1851 (Year)

7. AGE
69 yrs. 11 mos. 28 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Inmate County Hospital
(b) General nature of industry business, or dstablishment in which employed (or employer)

9. BIRTHPLACE (State or Country) England.

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (State or Country) Unknown.

12. MAIDEN NAME OF MOTHER Unknown.

13. BIRTHPLACE OF MOTHER (State or Country) Unknown.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Lynda Knight
(Address) Silver City Idaho.

15.
Filed May 15th 1911 Asher A. Pickett Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
May (Month) 10th (Day) 1911 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 20th 1911, that I last saw h..... alive on ..... 191..., and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

..... 19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Silver City Cemetary	May 10th 1911
20. UNDERTAKER John. Grete.	ADDRESS Silver City

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO. STRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JUN 9 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 5
Primary Registration District No. 2009
File No. 34348
Registered No. 3

1. PLACE OF DEATH
County of Payette
City of New Plymouth (If outside limits of city or village, write the name of township.) St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs. Mary Davis Ahlborn.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Dec. (Month) 2 (Day) 1881 (Year)

7. AGE: 39 Yrs. 4 Mos. 1 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa.

10. NAME OF FATHER: Irwin Davis

11. BIRTHPLACE OF FATHER (State or Country): Minn.

12. MAIDEN NAME OF MOTHER: Adelia Lloyd.

13. BIRTHPLACE OF MOTHER (State or Country): Iowa.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. F. Ahlborn
(Address) New Plymouth, Ida.

15. Filed 5-1- 1921 Wm. T. Dysdale Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 1 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from one or two years off and on 19..... to 4-22 1921
that I last saw h.er alive on 4-22- 1921
and that death occurred on the date stated above, at 3 0 9 M.
The CAUSE OF DEATH* was as follows:
Cancer of Breast
(Duration) 2 Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Wm T Dysdale M. D.
5-1- 1921 (Address) New Plymouth Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Payette Idaho — DATE OF BURIAL: May 2 1921

20. UNDERTAKER: Glenn C Landon — ADDRESS: Payette Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

DISINTERMENT PERMIT

STATE OF IDAHO
DEPARTMENT OF PUBLIC HEALTH
BOISE, IDAHO

APPLICATION HAVING BEEN MADE for the disinterment of the body of Murrell Davis Ahlborn

now lying buried in Falk Cemetery, in the City or Town of New Plymouth

County of Payette State of Idaho, who died on the 1st day of May, 1921, Aged 39 years 10 months

29 days, the cause of death being Cancer of breast and not directly or indirectly by diphtheria;(membranous croup);scarlet fever;smallpox;leprosy;asiatic cholera;typhus fever; or yellow fever as shown by the certificate of death of said deceased, given by

Dr. William Drysdale attending physician

THIS IS TO CERTIFY that permission is hereby given for such disinterment and removal by private
private or railway conveyance

to Park View Cemetery in the City or Town of New Plymouth County of Payette

State of Idaho to take effect upon the approval by the local board of health of the City, Town, or County of

Payette it being understood and provided that nothing herein shall be deemed as contravening or in anywise modifying or releasing the Regulations of the Department of Public Health governing the Transportation of Corpses or the requirements for a Transportation permit, and all Transportation Companies and Common Carriers will be governed accordingly; and provided further, that where the disinterment is for the purpose of reinterment in another part of the same cemetery, or in a contiguous cemetery, the removal shall not be made by any public conveyance. The disinterment and removal must be done under the personal supervision of a licensed Embalmer in good standing. If the remains are to be removed from the cemetery they (including the disinterred casket), must be enclosed in a new metallic lined outer case before removal.

Given under my hand and Seal of the Department of Public Health at Boise, Idaho,

permit issued to:

this 24th day of January, A.D. 1951.

W. W. Bowen

Director, Division of Vital Statistics

The foregoing application for disinterment and removal is hereby approved by the local Board of Health of the City,

Town or County of Payette State of Idaho, this 22 day of January 1951.

[illegible]

Health Officer

Form DPH-48019

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34349
Registered No. 18

RECEIVED
JUN 3 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene (St.)
Registration District No. 4
Primary Registration District No. 1008
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Leoline S Fulton
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Mar (Month) 4 (Day) 1862 (Year)

7. AGE: 59 Yrs. 2 Mos. 20 ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Spinster
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ill.

10. NAME OF FATHER: Geo W. Fulton

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Eliza Woodcock

13. BIRTHPLACE OF MOTHER (State or Country): Mass

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Chas I Fulton
(Address): Coeur d'Alene

15. Filed: May 26 1921. J O Woodward Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 24 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1921, to May 1921, that I last saw h alive on May 24 1921 and that death occurred on the date stated above, at 8 15 P.M.
The CAUSE OF DEATH* was as follows:

Cancer of stomach
(Duration) 1? Yrs. ? mos. ? ds.
Contributory (Secondary)
(Duration) ... yrs. ... mos. ... ds.

(Signed) J L McDonald M. D.
5-26-21 (Address) Coeur d'Alene

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Marysville Kans. DATE OF BURIAL: May 27 1921
20. UNDERTAKER: J R Nidan ADDRESS: Coeur d'Alene Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34350

Registered No. 19

1. PLACE OF DEATH

County of Kootenai

City of Fayette (If outside limits, give township) St.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED JUN 9 1921 BUREAU OF VITAL STATISTICS

Registration District No. 4

Primary Registration District No. 1008

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Harvey Boyd.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widowed

6. DATE OF BIRTH: May (Month) 19 (Day) 1858 (Year)

7. AGE: 63 Yrs. 1 Mos. 18 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): North Carolina

10. NAME OF FATHER: James Patterson

11. BIRTHPLACE OF FATHER (State or Country): North Carolina

12. MAIDEN NAME OF MOTHER: Not Known.

13. BIRTHPLACE OF MOTHER (State or Country): North Carolina

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A. O. Green

(Address) Fayette

15. Filed May 19 1921 J. C. Woodward Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 7 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 1921 to May 7 1921 that I last saw h[illegible] alive on May 7 1921 and that death occurred on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Rupture of Coronary Artery (Duration) 1 Yrs. 0 mos. 6 ds.

Contributory (Secondary) Senility (Duration) yrs. mos. ds.

(Signed) S. F. Richmond M. D.

May 9 1921 (Address) Fayette Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Fayette — DATE OF BURIAL: May 9 1921

20. UNDERTAKER: D. Nudair — ADDRESS: Fayette Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED JUN 3 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Payette Registration District No. 4
City of Payette (No. ..... St.) Primary Registration District No. 1008
File No. 34351
Registered No. 20

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Millie Diedrichsen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Oct (Month) 12 (Day) 1876 (Year)

7. AGE: 44 Yrs. 7 Mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wisconsin

10. NAME OF FATHER: Georg Ferber

11. BIRTHPLACE OF FATHER (State or Country): Switzerland

12. MAIDEN NAME OF MOTHER: Fannie Meyer

13. BIRTHPLACE OF MOTHER (State or Country): Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) .....
(Address) Anders Diedrichsen Payette Idaho

15. Filed May 27 1921 J. C. Woodward Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 26 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5/26 1921, to 5/26 1921, that I last saw h.. alive on 5/26 1921, and that death occurred on the date stated above, at 11:30 M.

The CAUSE OF DEATH* was as follows:
Apoplexy
.....(Duration) ..... Yrs. ..... mos. 1 ds.
Contributory (Secondary)
.....(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.
5/27 1921 (Address) Payette Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Payette Idaho	May 28 1921
20. UNDERTAKER	ADDRESS
Glenn C Landon	Payette Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

34353

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
JUN 9 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH.

Registration No. 25

Primary Registration District No. 2072

County of Power

City of American Falls (If outside limits, give township) (St.)

File No. 3

Registered No. 121

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ella S. Allard

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH. Not Known (Month) (Day) 1 (Year)

7. AGE About 68 years (Yrs.) (Mos.) (ds.)

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): N.Y.

10. NAME OF FATHER: Not Known

11. BIRTHPLACE OF FATHER (State or Country): Not Known

12. MAIDEN NAME OF MOTHER: Not Known

13. BIRTHPLACE OF MOTHER (State or Country): Not Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. S. Schrock

(Address) American Falls, Idaho

15. Filed 6-15 1921 R. F. Nott Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 1st (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 25th 1921, to March 25th 1921, that I last saw h alive on March 25th 1921, and that death occured on the date stated above, at 1 P M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) 9 Yrs. ..... mos. ..... ds.

(Signed) V. G. Logan M. D.

4-1-1921 (Address) American Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days In the State ..... yrs ..... mos ..... days

Where was disease contracted if not at place of death?

Former or usual residence: Roy, Idaho

19. PLACE OF BURIAL OR REMOVAL: Rockland, Idaho

DATE OF BURIAL: April 3 1921

20. UNDERTAKER: Geo Davis

ADDRESS: Am Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYNS - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-12 M. 6-15-17.

34355

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
JUN 9 1921
BUREAU OF VITAL STATISTICS

Registration District No. 25
Primary Registration District No. 2072
File No. 3
Registered No. 128

1. PLACE OF DEATH
County of Power
City of American Falls (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Thomas Collier

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH. Don't know (Month) ..... (Day) ....1..... (Year)

7. AGE
45 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many .... hrs. or .....min.?'

8. OCCUPATION
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE
(State or Country) Ohio

10. NAME OF FATHER Edward Collier

11. BIRTHPLACE OF FATHER
(State or Country) Ireland

12. MAIDEN NAME OF MOTHER Catherine Smith

13. BIRTHPLACE OF MOTHER
(State or Country) Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Charles C. Collier
(Address) 226 South 5th St. Pocatello, Idaho

15.
Filed ..... 191....
..... Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
April (Month) 21 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..... to ..... 191...
that I last saw h.....alive on ..... 191....
and that death occurred on the date stated above, at 8.15A. M.

The CAUSE OF DEATH* was as follows:
Struck by Railway train & Accident
.....
.....
.....(Duration) ..... Yrs..... mos. ..... ds.
Contributory (Secondary) .....
.....(Duration) ..... Yrs..... mos. ..... ds.

(Signed) Coroner M. D.
4-1-1921 (Address) American Falls, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence on farm near American Falls.

19. PLACE OF BURIAL OR REMOVAL American Falls, Idaho
DATE OF BURIAL ..... 191...

20. UNDERTAKER A. W. Davis
ADDRESS Am Falls, Id

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-12 M. 6-15-17.

RECEIVED JUN 9 1921 VITAL STATISTICS

CERTIFICATE OF DEATH

34357 State of Idaho BOARD OF HEALTH
Bureau of Vital Statistics
File No. S
Registered No. 125

1. PLACE OF DEATH
County of Power
Registration District No. 25
Primary Registration District No. 2072
City of American Falls, (If outside limits of city or village, give township, St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lenard Clifford Permann

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. April (Month) 19 (Day) 1918 (Year)

7. AGE: 3 Yrs. 1 Mos. 15 ds. IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Power Co

10. NAME OF FATHER: Fred Permann

11. BIRTHPLACE OF FATHER (State or Country): South Dekota

12. MAIDEN NAME OF MOTHER: Gottlieba Herr

13. BIRTHPLACE OF MOTHER (State or Country): South Dekota

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant)
(Address)

15. Filed June 8 1921 R. F. Moth Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 4th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1 1921 to June 3 1921 that I last saw him alive on June 3 1921 and that death occurred on the date stated above, at 8 A. M.

The CAUSE OF DEATH* was as follows:
Diphtheria and Scarlet fever,
(Duration) Yrs. mos. ds.
Contributory (Secondary)
(Duration) Yrs. mos. ds.
(Signed) V. E. Logan M. D.
19 (Address) American Falls, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days, In the State....yrs....mos....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Amn. Falls. DATE OF BURIAL: 6-4 1921
20. UNDERTAKER: Family ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-12 M. 6-15-17.

RECEIVED JUN 9 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 25 — 34358
File No. 3
Registered No. 126
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Power
City of American Falls
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2072
(No. ....., ... St.)

2. FULL NAME John Francis Bevan

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Divorced

6. DATE OF BIRTH. March (Month) 31 (Day) 1863 (Year)

7. AGE: 58 Yrs. 1 Mos. 28 ds.
IF LESS than 1 day how many .... hrs. or .... min.?'

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wisconsin

10. NAME OF FATHER: Isaac Bevan

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Elizabath Joseph

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Boyd Bevan
(Address) Am. Falls Idaho

15. Filed June 9 1921 R. F. Mock Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 28 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 25 1921 to May 28 1921
that I last saw h.im alive on May 28 1921
and that death occurred on the date stated above, at 2.30 P. M.

The CAUSE OF DEATH was as follows:
Acute Fever with slow Pulmonary and meningeal involvement
(Duration) ..... Yrs. ..... mos. 5 ds.

Contributory (Secondary)
(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) Richard F. Mock M. D.
June 9 1921 (Address) American Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: American Falls — DATE OF BURIAL: May 31 1921

20. UNDERTAKER: Woods — ADDRESS: Am Falls Ida

FORM V. S. No. 5-12 M. 6-15-17.

RECEIVED JUN 9 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

34359

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3
Registered No. 127
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Power ..... Registration District No. 22

(Registration District No. 2172)

City of American Falls, ... (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Zolli Canfield

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. April (Month) 2 (Day) 1894 (Year)

7. AGE: 27 Yrs. 1 Mos. 28 ds.

IF LESS than 1 day how many .... hrs. or .....min.?'

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Texas

10. NAME OF FATHER: Logan S. Field

11. BIRTHPLACE OF FATHER (State or Country): Geo

12. MAIDEN NAME OF MOTHER: Carry K. Kramer

13. BIRTHPLACE OF MOTHER (State or Country): Alla

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) L. Canfield

(Address) American Falls, Idaho

15. June 1st

Filed ..... 191.... .....
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 30 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 15th 21 to June 3rd 1921

that I last saw her alive on June 29th 21

and that death occurred on the date stated above, at 2.15 P.M.

The CAUSE OF DEATH* was as follows:

Double Lobar Pneumonia
and Nephritis
Contributory Cardiac Failure 2nd
Lobar Pneumonia

(Duration) ..... Yrs. ..... mos. 12 ds.

Contributory (Secondary) .....

(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) Richard F. Hoff M. D.

June 10 1921 (Address) American Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: American Falls, Idaho

DATE OF BURIAL: May 31/ 1921

20. UNDERTAKER: W. Davis

ADDRESS: American Falls

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

34360

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No.....

Primary Registration District No.....

File No.....

County of Shoshone

City of Wallace

(Or Township)

Registered No. 30

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
JUN 14 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME Irma Lewis

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): married

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1 (Year)

7. AGE: 50 Yrs. 4 Mos. 4 ds.

IF LESS than 1 day how many..... hrs. or..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER: Mattson Olson

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Stina Erickson

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Irma Lewis
(Address) Missoula Montana

15. Filed May 26 1921 F L Dent Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 23 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 5 1921, to May 23 1921
that I last saw h[illegible] alive on May 23 1921
and that death occurred on the date stated above, at [illegible] M.
The CAUSE OF DEATH* was as follows: Chronic Myocarditis

(Duration) 2 yrs. mos. ds.

Contributory (Secondary) Mucocolaseucha pyo-
(Duration) 15 yrs. mos. ds.

(Signed) Dr. Mowry M. D.
5/26 1921 (Address) Wallace Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence Missoula Montana

19. PLACE OF BURIAL OR REMOVAL [illegible] DATE OF BURIAL
Wallace Ida [illegible] 1921

20. UNDERTAKER: Ward Und Co ADDRESS: Wallace

2da

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-12 M. 6-15-17.

RECEIVED
JUN 14 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34361
Registered No. 40

1. PLACE OF DEATH
County of Shoshone
City of Wallace
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 70
Primary Registration District No. 6th
(No. Wallace Hospital St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Thomas Faraghes

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH. ..... 1 ..... (Month) (Day) (Year)

7. AGE: 41 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many .... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: miner
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: John Faraghes

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Sally Brion

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. Hermode
(Address) Butte Mont.

15. Filed May 10 1921 — G L Jenkins, Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 8 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 6th 1921 to May 8th 1921
that I last saw him alive on 5/8/21 1921
and that death occurred on the date stated above, at 9:30 A. M.
The CAUSE OF DEATH* was as follows:
Lobar Pneumonia both lungs
(Duration) ..... Yrs. ..... mos. 3 ds.
Contributory (Secondary) Hypo Cardiac -
(Duration) 3 days mos. ds.
(Signed) Thomas G. Hamon M. D.
MAY 9 1921 (Address) Wallace Idaho -

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the State....yrs.....mos. 7 days
Where was disease contracted if not at place of death? Wallace
Former or usual residence Wallace Idaho

19. PLACE OF BURIAL OR REMOVAL: Wallace Idaho — DATE OF BURIAL: May 11 1921

20. UNDERTAKER: Bruce G. Worstell — ADDRESS: Wallace Id

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JUN 14 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 10
Primary Registration District No. 1011
File No. 34362
Registered No. 41

1. PLACE OF DEATH
County of Shoshone
City of Wallace (St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Eliza Shannon

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widowed (Write the word.)

6. DATE OF BIRTH: ..... 1..... (Month) (Day) (Year)

7. AGE: 64 Yrs. — Mos. — ds.
IF LESS than 1 day how many..... hrs. or.....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wisconsin

10. NAME OF FATHER: John Ferguson

11. BIRTHPLACE OF FATHER (State or Country): not given

12. MAIDEN NAME OF MOTHER: not given

13. BIRTHPLACE OF MOTHER (State or Country): not given

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Jack Moffitt
(Address) Wallace Ida.

15. Filed May 18 1921 F. L. [illegible] Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 12 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 11 1921, to May 12 1921, that I last saw h[illegible] alive on May 10 1921, and that death occurred on the date stated above, at 8 a. M.

The CAUSE OF DEATH* was as follows: Uraemia Nephritis

(Duration) 1 Yrs. mos. ds.
Contributory (Secondary) Myocarditis
(Duration) yrs. mos. ds.

(Signed) Dr. D. Mowery M. D.
5/13 1921 (Address) Wallace Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence Wallace Idaho

19. PLACE OF BURIAL OR REMOVAL: Wallace Ida — DATE OF BURIAL: May 14 1921

20. UNDERTAKER: Ward Und Co — ADDRESS: Wallace Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-12 M. 6-21-17.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34363
Registered No. 42
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

RECEIVED JUN 14 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Shoshone
City of Wallace
If death occurs away from usual residence, give facts called for under special information.
Registration District No. 10
Primary Registration District No. 1001
No. 402 Maple Street (St.)

2. FULL NAME Winfield James Turner

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single
6. DATE OF BIRTH. Apr. 26th 1879. (Month) (Day) (Year)
7. AGE 42 Yrs. 0 Mos. 23 ds. IF LESS than 1 day how many .... hrs. or .... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: mill shift
(b) General nature of industry, business, or establishment in which employed (or employer): boss
9. BIRTHPLACE (State or Country): Michigan
10. NAME OF FATHER: D. J. Turner
11. BIRTHPLACE OF FATHER (State or Country): Ireland
12. MAIDEN NAME OF MOTHER: Eliza J Sharpe
13. BIRTHPLACE OF MOTHER (State or Country): Canada
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) [signature]
(Address) Wallace Ida.
15. Filed May 22 1921 [signature] Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 19 1921 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from Aug. 1917 to May 19 1921
that I last saw h.....alive on .....191....
and that death occurred on the date stated above, at .....M.
The CAUSE OF DEATH* was as follows:
Edema of Lungs
.....(Duration) ..... Yrs..... mos. 6 ds.
Contributory (Secondary) Fracture of Spine.
.....(Duration) 3 1/2 Yrs..... mos. ..... ds.
(Signed) Wm. T. Turner M. D.
5/20/21 (Address) Wallace Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Wallace Ida — DATE OF BURIAL: May 21 1921
20. UNDERTAKER: Bruce Morrell — ADDRESS: Wallace

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34364
Registered No. 43

RECEIVED
JUN 14 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
Registration District No. 90
Primary Registration District No. 1011
County of Shoshone
City of Wallace (or) County Infirmary
Near
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mike Minn

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.):

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1 (Year)

7. AGE: 67 Yrs. — Mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Day Laborer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): not given

10. NAME OF FATHER: not given

11. BIRTHPLACE OF FATHER (State or Country): not given

12. MAIDEN NAME OF MOTHER: not given

13. BIRTHPLACE OF MOTHER (State or Country): not given

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) County Infirmary
(Address) Wallace Idaho

15. Filed May 27 1921 — F. L. Fuller, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 23 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 1921 to May 23 1921 that I last saw h[e] alive on May 23 1921 and that death occurred on the date stated above, at 12 M.
The CAUSE OF DEATH* was as follows:
Chr Bronchitis
(Duration) 1 Yrs. mos. ds.
Contributory (Secondary) Senility
(Duration) yrs. mos. ds.
(Signed) James R Braw M. D.
5/26 1921 (Address) Wallace

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence Wallace Idaho

19. PLACE OF BURIAL OR REMOVAL: Wallace — DATE OF BURIAL: May 28 1921

20. UNDERTAKER: Ward Lud Co — ADDRESS: Wallace Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51068

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34365
Registered No. 42

1. PLACE OF DEATH
County of Shoshone
City of near Wallace (If not in city or village, give township) Found in River St.)
If death occurs away from usual residence, give facts called for under special information.

RECEIVED
JUN 14 1921
BUREAU OF VITAL STATISTICS

Registration District No. 70
Primary Registration District No. 1011

2. FULL NAME Thenry Watasen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
M.	White	single

6. DATE OF BIRTH ..... 1 .....
(Month) (Day) (Year)

7. AGE 32 Yrs. — Mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Day Laborer
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Finland

10. NAME OF FATHER not given

11. BIRTHPLACE OF FATHER (State or Country) Finland

12. MAIDEN NAME OF MOTHER not given

13. BIRTHPLACE OF MOTHER (State or Country) Finland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. E. Ward.
(Address) Wallace Idaho

15. Filed May 31 1921 F L [illegible]
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Not known 19....
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Found in South Fork Coeur River supposed drowned
No marks of violence
Duration ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) Chas. R. Mowry M. D.
Coroner
5/28 1921 (Address) City

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence not known

19. PLACE OF BURIAL OR REMOVAL Wallace Id. | DATE OF BURIAL May 31 1921

20. UNDERTAKER Ward Und Co | ADDRESS Wallace Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

Form V. S. No. 5 20M.1-16-12

RECEIVED MAY 20 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 70

County of Shoshone Primary Registration District No. 1911

City of Wallace (No. Providence Hospital)

File No. 34366

Registered No. 21

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Philip Summers

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): widower

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1 (Year)

7. AGE: 44 yrs. — mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: miner
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): New Foundland

10. NAME OF FATHER: Philip Summers

11. BIRTHPLACE OF FATHER (State or Country): New Foundland

12. MAIDEN NAME OF MOTHER: Margret Powers

13. BIRTHPLACE OF MOTHER (State or Country): New Foundland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Thos. Summers.
(Address) Canada

15. Filed Apr 5 1921 F L Sutton Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: April (Month) 4 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 1, 1921, to Apr 4 1921, that I last saw him alive on Apr 4 1921, and that death occurred on the date stated above, at 12 45 M.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis

(Duration) yrs. mos. 14 ds.

Contributory (Secondary) Pulmonary Tuberculosis

(Duration) yrs. 6 mos. ds.

(Signed) James R Bean M. D.

4/4 1921 (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence Mullan Idaho

19. PLACE OF BURIAL OR REMOVAL: Mullan Ida — DATE OF BURIAL: Apr 6 1921

20. UNDERTAKER: Harry Thompson — ADDRESS: Wallace Ida

Hood Funeral Co

B. N.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-12 M. 6-15-17.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

RECEIVED
MAY 20 1921
BUREAU OF VITAL STATISTICS

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34368
Registered No. 23

1. PLACE OF DEATH
County of Shoshone Registration District No. 20
City of Wallace Primary Registration District No. 1015
If death occurs away from usual residence, give facts called for under special information. (Ward, Precinct, State of Idaho St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME James Bones

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married
6. DATE OF BIRTH. July (Month) 11 (Day) 1881 (Year)
7. AGE 39 Yrs. 8 Mos. 21 ds. IF LESS than 1 day how many .... hrs. or .... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry, business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Ireland
10. NAME OF FATHER: Barthelmew Bones
11. BIRTHPLACE OF FATHER (State or Country): Ireland
12. MAIDEN NAME OF MOTHER: Mary Galden
13. BIRTHPLACE OF MOTHER (State or Country): Ireland
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs James Bones
(Address) Gem Idaho
15. Filed Apr 4 1921 F L Dunn Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 3 (Day) 1921 (Year)
17. I HEREBY CERTIFY, That I attended deceased from —— 191— to —— 191—
that I last saw him alive on —— 191—
and that death occurred on the date stated above, at 9 00 A. M.
The CAUSE OF DEATH* was as follows:
Pneumonia lobar
Acute
(Duration) Yrs. 1 mos. 2 wks. ds.
Contributory (Secondary) Valvular Endocarditis
(Duration) Yrs. mos. ds.
(Signed) Dr M Murphy M. D.
4/2 1921 (Address) Wallace Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Butte, Mont. DATE OF BURIAL 4-4 1921
20. UNDERTAKER: T. G. Nordell ADDRESS Wallace

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34369
Registered No. 24

RECEIVED MAY 8 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH. Registration District No. 70
County of Shoshone Primary Registration District No. 1011
City of Wallace (No. 139 Rust St. St.)
If death occurs away from usual residence, give facts called for under special information.
2. FULL NAME Myron Topliff
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	white	married

6. DATE OF BIRTH: Sept. (Month) 16 (Day) 1860 (Year)

7. AGE: 60 yrs. mos. ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Contractor
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wisconsin

10. NAME OF FATHER: George M. Topliff

11. BIRTHPLACE OF FATHER (State or Country): not given

12. MAIDEN NAME OF MOTHER: Hannah Conners

13. BIRTHPLACE OF MOTHER (State or Country): not given

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Myron Topliff
(Address) Wallace Ida

15. Apr 6 1921 F L Jordan Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Apr (Month) 3 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1919, to Apr 3 1921, that I last saw h alive on Apr 3 1921 and that death occurred on the date stated above, at 7:45 A.M.

The CAUSE OF DEATH* was as follows: Embolism of brain

(Duration) yrs. mos. 20 Min

Contributory: Cardiac Dilation
(Secondary)

(Duration) yrs. mos. ds.

(Signed) D R Mowery M. D.
4-4 1921 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence: Wallace Idaho

19. PLACE OF BURIAL OR REMOVAL: Wallace Ida — DATE OF BURIAL: Apr. 6 1921

20. UNDERTAKER: Ward Undg Co — ADDRESS: Wallace

Ida

SYMS - YORK CO., PTRS. & BDRS. 19760

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-12 M. 6-15-17.

RECEIVED MAY 20 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3437
Registered No. 23
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Shoshone Registration District No. 70
City of Wallace Registration District No. 6 1916
(No. ....., Hospital (St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Louis Lamare

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. ..... (Month) 1 (Day) ..... (Year)

7. AGE: 27 Yrs. ..... Mos. ..... ds.
IF LESS THAN 1 day how many .... hrs. or .....min.?'

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Franz Bruns

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Christina -

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Moses Lamare
(Address) 69 River St

15. Filed apr 14 1921 F L Zent Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr (Month) 1 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3/30/21 191... to 4/1/21 191...
that I last saw h.. alive on 4/1/21 191...
and that death occurred on the date stated above, at 4:30 P. M.
The CAUSE OF DEATH* was as follows:
..... Cerebral Hemorrhage
.....
.....
(Duration) ..... Yrs. ? mos. ? ds.
Contributory (Secondary) Pregnancy - labor -
(Duration) ..... Yrs. ..... mos. 2 ds.
(Signed) ..... M. D.
4/1/21 19.... (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Wallace Id
DATE OF BURIAL: 4-4-21
20. UNDERTAKER: Dee Worstell
ADDRESS: Wallace

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34371
Registered No. 26

RECEIVED MAY 20 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH. Registration District No. 70
County of Shoshone Primary Registration District No. 1011
City of Mullan (If outside limits, give township) Hunter Ave St.)
If death occurs away from usual residence, give facts called for under special information.
2. USUAL RESIDENCE (No.) Same (Street) Same
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
F.	white	married

6. DATE OF BIRTH: Jan (Month) 4 (Day) 1868 (Year)

7. AGE: 53 yrs. — mos. — ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work housewife
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Sweden.

10. NAME OF FATHER John Seeberg.

11. BIRTHPLACE OF FATHER (State or Country) Sweden

12. MAIDEN NAME OF MOTHER Christine Seeberg

13. BIRTHPLACE OF MOTHER (State or Country) Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Anna Castwright
(Address) Mullan Ida

15. Filed Apr 9 1921 F. L. Sunday Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: April (Month) 8 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 27 1921, to April 8 1921, that I last saw her alive on April 8 1921, and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Gall Stones

(Duration) yrs. mos. ds.

Contributory (Secondary) Perforation of ulcer Duod

(Duration) yrs. mos. 4 ds.

(Signed) H W Ralph M. D.

April 1924 (Address) Mullan Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence Mullan Idaho

19. PLACE OF BURIAL OR REMOVAL: Mullan Ida | DATE OF BURIAL: Apr 10 1921

20. UNDERTAKER: Ward Und Co | ADDRESS: Wallace Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Shoshone
City of Wallace
If death occurs away from usual residence, give facts called for under special information.

RECEIVED MAY 20 1921 BUREAU OF VITAL STATISTICS

Registration District No. 70
Primary Registration District No. 104
No. 1 Providence Hospital

File No. 34372
Registered No. 2
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Peter Bergstrom

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	single

6. DATE OF BIRTH. ..... 1 ..... (Month) (Day) (Year)

7. AGE 41 Yrs. — Mos. — ds. IF LESS than 1 day how many .... hrs. or .....min.?'

8. OCCUPATION
(a) Trade, profession or particular kind of work miner
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Not Known

10. NAME OF FATHER "

11. BIRTHPLACE OF FATHER (State or Country) " "

12. MAIDEN NAME OF MOTHER "

13. BIRTHPLACE OF MOTHER (State or Country) " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Providence Hosp
(Address) Wallace Ida.

15. Filed Apr 11 1921 F L Deatz Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Apr 4 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 6 1921 to Apr 4 1921
that I last saw him alive on Apr 4 1921
and that death occurred on the date stated above, at 2:30 P.M.
The CAUSE OF DEATH* was as follows:
General peritonitis
(Duration) ... Yrs. ... mos. 7 ds.
Contributory (Secondary) Perforation gastric Ulcer
(Duration) ... Yrs. ... mos. ... ds.
(Signed) Dr. Mougeroll M. D.
4/9 1921 (Address) Wallace Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death? ✓
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Wallace Idaho — DATE OF BURIAL 4/13 1921

20. UNDERTAKER Bruce G. Nordstell — ADDRESS Wallace Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

Form V. S. No. 5 20M.1-16-12

RECEIVED MAY 20 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34373

Registered No. 28

1. PLACE OF DEATH. Registration District No. 70

County of Shoshone Primary Registration District No. 1011

City of Wallace (No. Providence Hospital)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Peter Schuee

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1 (Year)

7. AGE: 13 yrs. 5 mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer at
(b) General nature of industry business, or establishment in which employed (or employer): Tamarack Mine

9. BIRTHPLACE (State or Country): Indiana

10. NAME OF FATHER: Peter Schuee

11. BIRTHPLACE OF FATHER (State or Country): France

12. MAIDEN NAME OF MOTHER: Ersel Neigle

13. BIRTHPLACE OF MOTHER (State or Country): Switzland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Mrs. Peter Schuee
(Address): Wallace Idaho

15. Filed Apr 14 1921 F. L. Jensen Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Apr (Month) 12 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 2 1921, to Apr 12 1921, that I last saw him alive on Apr 12 1921, and that death occurred on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows: Pneumonia, Lobar

Acute

(Duration) ..... yrs. ..... mos. 4 ds.

Contributory (Secondary) Influenza

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Dr. Mowry M. D.

4/13 1921 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence: Tamarack Mine near Wallace Idaho 2dd

19. PLACE OF BURIAL OR REMOVAL: Spokane North — DATE OF BURIAL: Apr 14th 1921

20. UNDERTAKER: Ward Mort Co — ADDRESS: Wallace

2dd

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

RECEIVED MAY 20 1921 BUREAU OF VITAL STATISTICS

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No.

County of Shoshone Private Registration District No. File No. 34374

City of Wallace (No.) Providence Hospital Registered No. 59

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Clarence Edward Neuquist

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M.	white	single

6. DATE OF BIRTH ..... (Month) ..... (Day) 1 (Year)

7. AGE 2 yrs. 10 mos. — ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... none
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Burke Idaho

10. NAME OF FATHER John E. Neuquist

11. BIRTHPLACE OF FATHER (State or Country) Sweden

12. MAIDEN NAME OF MOTHER Lena Skonnord

13. BIRTHPLACE OF MOTHER (State or Country) Norway.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mr. John Neuquist
(Address) Burke Idaho

15. Filed Apr 15 1921 F L Jones Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Apr 12 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 1 1921, to Apr 12 1921, that I last saw h alive on Apr 12 1921 and that death occurred on the date stated above, at 9 a.m.

The CAUSE OF DEATH* was as follows:,

Septicaemia

(Duration) ... yrs. ... mos. 7 ds.

Contributory (Secondary) Pulmonary Tuberculosis

(Duration) ... yrs. ... mos. ... ds.

(Signed) W. E. Mowry M. D.

Apr 13 1921 (Address) Wallace Idaho

State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs....mos....days. In the State....yrs....mos....days.

Where was disease contracted if not at place of death?

Former or usual residence Burke Idaho

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Wallace	Apr 15 1921

20. UNDERTAKER	ADDRESS
Ford Hurd Co	Wallace Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34375
Registered No. 30

RECEIVED
MAY 20 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Shoshone
Registration District No. .....
Primary Registration District No. .....
City of Wallace (If outside city limits, write TOWNSHIP)
If death occurs away from usual residence, give facts called for under special information. Providence Hosp. St.

2. FULL NAME John Norton
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)
7. AGE: 70 Yrs. — Mos. — ds. IF LESS than 1 day how many .... hrs. or .... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry, business, or establishment in which employed (or employer) .....
9. BIRTHPLACE (State or Country): Massachusetts
10. NAME OF FATHER: not known
11. BIRTHPLACE OF FATHER (State or Country): " "
12. MAIDEN NAME OF MOTHER: " "
13. BIRTHPLACE OF MOTHER (State or Country): " "
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Welch
(Address) Wallace Ida.
15.
Filed Apr 15 1921 ..... Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 9 (Day) 1921 (Year)
17. I HEREBY CERTIFY, That I attended deceased from April 8 1921 to April 9 1921
that I last saw him alive on Apr. 8 1921
and that death occurred on the date stated above, at 330 A. M.
The CAUSE OF DEATH* was as follows:
Double lobar pneumonia
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... Yrs. ..... mos. ..... ds.
(Signed) James R Bean M. D.
4/9 1921 (Address) Wallace Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the ,State....yrs....mos....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Wallace Ida. DATE OF BURIAL: Apr 15 1921
20. UNDERTAKER: Bruce G. Nordstedt ADDRESS: Wallace

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 70

Primary Registration District No. 10 61

File No. 34376

Registered No. 31

RECEIVED
MAY 20 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Shoshone

City of Wallace (No.) Providence Hospital

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Justlia

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M.	white	single

6. DATE OF BIRTH ..... 1 .....
(Month) (Day) (Year)

7. AGE 11 yrs. — mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... student .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Canada

10. NAME OF FATHER John Justlia

11. BIRTHPLACE OF FATHER (State or Country) Finland

12. MAIDEN NAME OF MOTHER Mary Conners

13. BIRTHPLACE OF MOTHER (State or Country) Finland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mr John Justlia

(Address) Kingston Ida

15.

Filed Apr 15 1921 F. L. Justice
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Apr 14 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 14 1921 to Apr 14 1921 that I last saw h alive on Apr 14 1921 and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar
Acute Double

(Duration) ..... yrs. 4 mos. 2 ds.

Contributory (Secondary) Chronic H. Valvular Disease

(Duration) Several yrs. mos. ds.

(Signed) Dr. M. Mc Evoy M. D.

4/14 1921 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence Kingston Ida Idaho

19. PLACE OF BURIAL OR REMOVAL Kingston Ida — DATE OF BURIAL Apr 15 1921

20. UNDERTAKER Ward Undle — ADDRESS Wallace Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED MAY 20 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 70

Primary Registration District No. 1944

County of Shoshone

City of Wallace (Not in a hospital) Residence Hospital

File No. 34377

Registered No. 32

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Fred Greef

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: ..... 1 ..... (Month) (Day) (Year)

7. AGE: about 45 Yrs. — Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: miner

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER: not given

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: not given

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Hendrickson

(Address) Mullan Ida

15. Filed MAY 20 1921 F L Snyder Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr 17 (Month) (Day) 19 21 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 12 1921 to Apr 17 1921 that I last saw him alive on Apr 17 1921 and that death occurred on the date stated above, at 1230 P.M.

The CAUSE OF DEATH* was as follows: Tuberculosis Pulmonary Chronic

Contributory (Secondary) Tuberculosis Laryngeal

(Duration) 1 yrs. mos. ds.

(Duration) yrs. mos. ds.

(Signed) Dr. M. D. Wright M. D.

(Address) Wallace Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence Silver Mountain

19. PLACE OF BURIAL OR REMOVAL: Mullan Ida — DATE OF BURIAL: Apr 20 1921

20. UNDERTAKER: Reed Undg Co — ADDRESS: Wallace

2 Dy

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-12 M. 6-15-17.

Dr Nauen

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3433
Registered No. .....

RECEIVED
MAY 20 1921

1. PLACE OF DEATH
County of Shoshone Registration District No. .....
Primary Registration District No. .....
City of Wallace (Not in hospital, give street address.) Wallace Hospital
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Infant of Alex Ferrat

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. April (Month) 17 (Day) 1921 (Year)

7. AGE — Yrs. — Mos. 1 ds.
IF LESS than 1 day how many .... hrs. or .....min.?'

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Alex Ferrat

11. BIRTHPLACE OF FATHER (State or Country) Italy

12. MAIDEN NAME OF MOTHER Lena Gioachino

13. BIRTHPLACE OF MOTHER (State or Country) Wyoming

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Alex Ferrat
(Address) Mullan Ida

15. Filed Apr 19 1921 F. L. Jones Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 17 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4/17/21 1921 to 4/17/21 1921
that I last saw h.....alive on 4/17/21 1921
and that death occurred on the date stated above, at 4 P. M.
The CAUSE OF DEATH* was as follows:

Premature Birth (6 Months)

.....(Duration) ..... Yrs..... mos..... ds.
Contributory (Secondary) .....
.....(Duration) ..... Yrs..... mos..... ds.
(Signed) Howard C. Storm M. D.
.....19.... (Address) Kellogg Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 7 hours In the State ....yrs 7 hours days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Mullan Ida — DATE OF BURIAL 4-19 1921

20. UNDERTAKER Kelly Nesbitt — ADDRESS Wallace

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34379
Registered No. 31

1. PLACE OF DEATH

Registration District No.....

Primary Registration District No.....

County of Shoshone

City of Wallace

If death occurs away from usual residence, give facts called for under special information.

RECEIVED MAY 20 1921 BUREAU OF VITAL STATISTICS

Providence Hospital

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Charles Karppinen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): married

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1 (Year)

7. AGE: 51 Yrs. — Mos. — ds.

IF LESS than 1 day how many..... hrs. or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: miner

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Finland

10. NAME OF FATHER: Andrew Karppinen

11. BIRTHPLACE OF FATHER (State or Country): Finland

12. MAIDEN NAME OF MOTHER: unknown

13. BIRTHPLACE OF MOTHER (State or Country): Finland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Anna S. Sipila

(Address) Cumberland Wash.

15. Filed Apr 20 1921

F. L. Jungen
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr (Month) 18 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 12 1921 to Apr 18 1921 that I last saw him alive on Apr 17 1921 and that death occurred on the date stated above, at 1 M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... Yrs. ..... mos. 10 ds.

Contributory (Secondary) Influenza

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F. L. Jungen M. D.

4/20/21 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence Burke Idaho

19. PLACE OF BURIAL OR REMOVAL: Wallace Ida — DATE OF BURIAL: Apr 22 1921

20. UNDERTAKER: Hand Mud Co — ADDRESS: Wallace Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34380
Registered No. 325

1. PLACE OF DEATH
County of Shoshone
City of Wallace
If death occurs away from usual residence, give facts called for under special information.

RECEIVED MAY 20 1921 BUREAU OF VITAL STATISTICS

Registration District No. 70
Primary Registration District No. 4
No. Providence Hospital (St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mrs. Mable Davidson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
6. DATE OF BIRTH. June (Month) 27 (Day) 1868 (Year)
7. AGE: 52 Yrs. 8 Mos. 29 ds. IF LESS than 1 day how many .... hrs. or .... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
9. BIRTHPLACE (State or Country): Canada
10. NAME OF FATHER: G. Lothrop
11. BIRTHPLACE OF FATHER (State or Country): Canada
12. MAIDEN NAME OF MOTHER: Mary N Cunningham
13. BIRTHPLACE OF MOTHER (State or Country): Canada
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Lee Howard
(Address) 205 N. Bell St Spokane
15. Filed Apr 27 1921 F. L. Sunden Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr (Month) 26 (Day) 1921 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Apr. 18 1921 to Apr 26 1921
that I last saw h[illegible] alive on Apr 26 1921
and that death occurred on the date stated above, at 4:20 P.M.
The CAUSE OF DEATH* was as follows:
Pneumonia Lobar left Lung
(Duration) [illegible] Yrs. mos. 7 ds.
Contributory (Secondary) Influenza
(Duration) [illegible] Yrs. mos. several ds.
(Signed) Dr. Mowery M. D.
Apr 27 1921 (Address) Wallace

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days, In the State....yrs....mos....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Spokane Nash — DATE OF BURIAL: Apr 27 1921
20. UNDERTAKER: [illegible] Moretell — ADDRESS: Wallace

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34381

Registered No. 12

RECEIVED MAY 20 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH.
Registration District No. 70
County of Shoshone
Primary Registration District No. 1011
City of Burke (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Bernard Webber

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	white	single

6. DATE OF BIRTH
..... (Month) 1 (Day) ..... (Year)

7. AGE
..... yrs. 9 mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... miner
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Pennsylvania

10. NAME OF FATHER Philip Webber

11. BIRTHPLACE OF FATHER (State or Country) New York

12. MAIDEN NAME OF MOTHER Ethel Starr

13. BIRTHPLACE OF MOTHER (State or Country) Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Philip Webber
(Address) Burke Idaho

15. Filed May 21 1921 F L Jones Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH March 6 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2/28/21 191.., to 3/6/21 191.., that I last saw him alive on 3/5/21 191.., and that death occurred on the date stated above, at 3 A.M.

The CAUSE OF DEATH* was as follows:

Tuberculosis Meningitis

(Duration) ..... yrs. ..... mos. 7 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) James R Bruce M. D.
3/6 1921 (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence Burke Idaho

19. PLACE OF BURIAL OR REMOVAL: Wallace Ida — DATE OF BURIAL: May 7 1921

20. UNDERTAKER: Ward Und Co — ADDRESS: Wallace Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-12 M. 6-16-17.

RECEIVED MAY 20 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34382
Registered No. 37

1. PLACE OF DEATH
County of Shoshone Registration District No. 7
City of Wallace Public Registration District No. 1011
If death occurs away from usual residence, give facts called for under special information. No. ..... Wallace Hospital St.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Henry Simpson Oxley

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	single

6. DATE OF BIRTH. March 28 1860
(Month) (Day) (Year)

7. AGE 60 Yrs. ..... Mos. ..... ds. IF LESS than 1 day how many .... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ... carpenter
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Iowa

10. NAME OF FATHER Wm C. Oxley

11. BIRTHPLACE OF FATHER (State or Country) Kentucky

12. MAIDEN NAME OF MOTHER Henriette Burhan

13. BIRTHPLACE OF MOTHER (State or Country) Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) ... Edmon B. Oxley
(Address) .....

15. Filed May 5 1921 F L Jones Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 30 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apl 19 1921 to April 30 1921
that I last saw h. alive on April 30 1921
and that death occurred on the date stated above, at 10:30 P. M.

The CAUSE OF DEATH* was as follows:
Carcinoma of Liver
.....
.....
.....(Duration) ..... Yrs. 6 mos. ..... ds.

Contributory (Secondary) .....
.....(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) F. E. Hanson M. D.
.....19.... (Address) Wallace Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Murray Idaho DATE OF BURIAL May 3 1921

20. UNDERTAKER W S Horstell ADDRESS Wallace

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

FORM V. S. No. 1-12 M. 6-15-17.

RECEIVED MAY 20 1921 BUREAU OF VITAL STATISTICS STATE OF IDAHO

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3438
Registered No. 38

1. PLACE OF DEATH
County of Shoshone Registration District No. 78
City of Wallace Registration District No. 104
If death occurs away from usual residence, give facts called for under special information.
(No. Providence Hospital St.)

2. FULL NAME Eugene Henry Smith

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH. Oct (Month) 12 (Day) 1915 (Year)

7. AGE: 5 Yrs. 7 Mos. 20 ds.
IF LESS than 1 day how many .... hrs. or .....min.?'

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wis

10. NAME OF FATHER: Lester N Smith

11. BIRTHPLACE OF FATHER (State or Country): Kansas

12. MAIDEN NAME OF MOTHER: Nellie Campbell

13. BIRTHPLACE OF MOTHER (State or Country): Wis.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Lester N Smith
(Address) Wallace Ida.

15. Filed May 6 1921 F L Jones Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 1 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1 1921 to May 1 1921
that I last saw him alive on May 1 1921
and that death occurred on the date stated above, at 11 00P M.

The CAUSE OF DEATH* was as follows:
Fracture of base of Skull
(Duration) Yrs. mos. ds.
Contributory (Secondary) Shock & Hemorrh
(Duration) Yrs. mos. 1 ds.
(Signed) Dr. Mowery M D.
5/2 1921 (Address) Wallace, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Wallace Idaho — DATE OF BURIAL: May 4 1921

20. UNDERTAKER: D&H Postell. — ADDRESS: Wallace

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JUN 9 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34384
Registered No. 14

1. PLACE OF DEATH
County of Latah
City of Deary (St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 77
Primary Registration District No. 2176

2. FULL NAME Eileen Christensen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Widow.

6. DATE OF BIRTH: Oct. 28 1851 (Month) (Day) (Year)

7. AGE: 69 Yrs. 8 Mos. 19 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housekeeper
(b) General nature of industry, business or establishment in which employed (or employer): Housekeeper.

9. BIRTHPLACE (State or Country): Scotland

10. NAME OF FATHER: Donald McLennan

11. BIRTHPLACE OF FATHER (State or Country): Scotland.

12. MAIDEN NAME OF MOTHER: Dont Know.

13. BIRTHPLACE OF MOTHER (State or Country): Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Christesen
(Address) Deary, Idaho

15. Filed June 1st 1921 Martha Marker Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 17 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 20 1920 to May 17 1921, that I last saw h[er] alive on May 17 1921, and that death occurred on the date stated above, at 4:50 P.M.

The CAUSE OF DEATH* was as follows: Chronic Endocarditis, Chronic Nephritis

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas. H. Mason M. D.

May 18 1921 (Address) Deary Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Vista Cemetery — DATE OF BURIAL: May 19 1921

20. UNDERTAKER: W. J. Kinney — ADDRESS: Deary, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
JUN 13 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 2085
File No. 34385
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Infant Pickett

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: May 20 1921 (Month) (Day) (Year)

7. AGE: ½ hr
Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Carlyle

11. BIRTHPLACE OF FATHER (State or Country): Ill

12. MAIDEN NAME OF MOTHER: Dorthy Wright

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Gayle F. Pickett
(Address) Route #3 Twin Falls,

15. Filed May 20 1921 John F. Coughlin Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 20 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased ~~from~~ On 5/20 1921, to 19..
that I last saw ~~him~~ alive on 5/20 1921
and that death occurred on the date stated above, at 4 P M.
The CAUSE OF DEATH* was as follows:
Premature birth.

(Duration) Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) E. D. Weaver M.D.
Emma C. Crossland R.N.
19.. (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Ida — DATE OF BURIAL: May 21 1921

20. UNDERTAKER: E. D. Weaver — ADDRESS: Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34386
Registered No.

RECEIVED
JUN 13 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Twin Falls Registration District No. 37
City of Amsterdam (If outside limits, give township) St.) Primary Registration District No. 2085
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Henry Malmgren
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: July (Month) 22 (Day) 1870 (Year)

7. AGE: 50 Yrs. 10 Mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah.

10. NAME OF FATHER: Sven Malmgrem

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Johana Roseguist

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Henry Malmgren
(Address) Amsterdam

15. Filed May 31 19 21 John S. Coughlin Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 30 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....
and that death occurred on the date stated above, at 1230 a.m.
The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 4 Yrs. ..... mos. ..... ds.
Contributory (Secondary) Hemorrhage from Lungs
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) J. J. Graham M.D.
May 30 19 21 (Address) Twin Falls, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Spanish Fork Utah
DATE OF BURIAL ..... 19.....

20. UNDERTAKER: J. J. Graham
ADDRESS Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34587

Registered No.

1. PLACE OF DEATH

County of Twin Falls

Registration District No. 37

Primary Registration District No. 1085

RECEIVED
JUN 3 1921
BUREAU OF VITAL STATISTICS

City of ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Infant Gager

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: June 7 1921 (Month) (Day) (Year)

7. AGE: 0 Yrs. 0 Mos. 0 ds.

IF LESS than 1 day how many ..... hrs. or 15 min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Milton Gager

11. BIRTHPLACE OF FATHER (State or Country): Kansas

12. MAIDEN NAME OF MOTHER: Pearl Cahren

13. BIRTHPLACE OF MOTHER (State or Country): Ill

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Geo F. Bennett

(Address) 95-8 - 4th E. Twin Falls

15.

Filed June 10 1921

Mrs F. Loughlin
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 7 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 6/5 1921, to 6/8 1921, that I last saw h[illegible] alive on 6/8 1921, and that death occurred on the date stated above, at 8:30 P.M.

The CAUSE OF DEATH* was as follows:

Birth injuries

(Duration) 45 minutes Yrs. mos. ds.

Contributory (Secondary) Hemorrhage

(Duration) yrs. mos. ds.

(Signed) S G Fox M. D.

6/9/1921 (Address) Twin Falls Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Ida. DATE OF BURIAL: June 7-8 1921

20. UNDERTAKER: L C Wescott ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34388
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of " "
(If outside limits of city or village give township) (Hospital or St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 37
Primary Registration District No. 1085
BUREAU OF VITAL STATISTICS
County Hospital

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Chas. E. Coen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): ~~Divorced~~

6. DATE OF BIRTH: March 28 (Month) (Day) 1865 (Year)

7. AGE: 56 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer): Retired

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Don't Know

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Geo. R. Coen
(Address) Casper, Wyo.

15. Filed June 3- 1921 John F. Kreuchler
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 19 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 30, 1921 to May 19 1921 that I last saw h[illegible] alive on May 19 1921 and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis.

(Duration) 2 Yrs. mos. ds.
Contributory (Secondary) Oedema of Glottis
(Duration) yrs. mos. 5 ds.

(Signed) O M McGinnis M. D.
19 (Address) 415 7-E Twin Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Ida
DATE OF BURIAL: 5/23 1921

20. UNDERTAKER: J. J. Grossmeier
ADDRESS: Twin Falls Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34389

1. PLACE OF DEATH

County of Twin Falls

City of ..... (No. County Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 37

Primary Registration District No. 1085

2. FULL NAME T. G Rockel

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Not Known (Month) ..... 1 (Day) ..... (Year)

7. AGE: about 50 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Traveling Salesman

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J E Dewitt

(Address) .....

15. Filed June 7 1921 John F. Longhurst Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 6 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 4th, 1921, to June 6th 1921 that I last saw h[illegible] alive on June 6 1921 and that death occurred on the date stated above, at 1 P. M.

The CAUSE OF DEATH* was as follows:

Acute Dilitation of Heart.

..... (Duration) ..... Yrs. ..... mos. 1 ds.

Contributory (Secondary) Cirritosis & Gall Stones

Obstruction gall duct (Duration) ..... yrs. ..... mos. 5 ds.

(Signed) Duncan L Strand M. D.

6/6 1921 (Address) Twin Falls Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. 1 days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence Los Angeles Cal.

19. PLACE OF BURIAL OR REMOVAL: Sunset Memorial Park DATE OF BURIAL ..... 19.....

20. UNDERTAKER: J E Dewitt ADDRESS Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

Registration District No. 37

Primary Registration District No. 10 85

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34390

Registered No.

1. PLACE OF DEATH

County of Twin Falls

City of " "

(St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Annie Belle Arrington

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
girl	white	Single

6. DATE OF BIRTH: June (Month) 24 (Day) 1918 (Year)

7. AGE: 2 Yrs. 11 Mos. 6 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Salt Lake City, Utah.

10. NAME OF FATHER Robert Lemuel Arrington

11. BIRTHPLACE OF FATHER (State or Country) Rockhill, S. Carolina.

12. MAIDEN NAME OF MOTHER Annie Lauretta Cutler

13. BIRTHPLACE OF MOTHER (State or Country) Meadow, Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) R. L. Arrington

(Address) Twin Falls Ida

15.

Filed 19

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 1 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 20 1921, to June 1 1921

that I last saw her alive on June 1 1921

and that death occurred on the date stated above, at 1:30 P.M.

The CAUSE OF DEATH* was as follows:

Littles Disease

(Duration) 2 Yrs. 11 mos. 6 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) H. L. Sawyer M. D.

6-1 1921 (Address) Twin Falls, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Ida — DATE OF BURIAL: June 2 1921

20. UNDERTAKER: J. F. Grossman — ADDRESS: Twin Falls Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
JUN 13 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 237.

Primary Registration District No. 1085

County of Twin Falls

City of (Twin Falls) No. 536 (Blue Lakes Blvd. Ensign St.)

File No. 34391

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Stanley Albert Goff

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Single

6. DATE OF BIRTH: May 19 (Month) (Day) 1921 (Year)

7. AGE: ..... Yrs. ..... Mos. 14 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ohio Idaho

10. NAME OF FATHER: Stanley Goff

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Emma Hochstrasser

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Stanley A. Goff

(Address) 1036 B. L. Blvd. T. F. Idaho

15. Filed June 2 1921 John B. Coughlin Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 2 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 19, 1921, to June 2 1921, that I last saw h.. alive on June 1 1921 and that death occurred on the date stated above, at 9:30 A.M.

The CAUSE OF DEATH* was as follows: Congenital cystic kidneys

..... (Duration) ..... Yrs. ..... mos. 14 ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. D. Weaver M. D.

..... 19..... (Address) Twin Falls.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Idaho | DATE OF BURIAL: 6-3 1921

20. UNDERTAKER: J. E. Wood | ADDRESS: Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JUN 13 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1085

File No. 34392

Registered No. ●

1. PLACE OF DEATH

County of Twin Falls

City of ..... (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Henry Hunt Howe

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Feb 23 (Month) (Day) 1856 (Year)

7. AGE: 60 Yrs. 3 Mos. 6 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Sheep Man
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Vermont

10. NAME OF FATHER: John Howe

11. BIRTHPLACE OF FATHER (State or Country): Vermont

12. MAIDEN NAME OF MOTHER: Ellen Martha Hunt

13. BIRTHPLACE OF MOTHER (State or Country): New Hampshire

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Nettie A. Howe
(Address) .....

15. Filed May 31 1921 John T. Coughlin Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 29 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1 1921, to May 29 1921, that I last saw h-- alive on May 29 1921, and that death occurred on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:
Heart Disease
(Fatty degeneration)
(Duration) 5 6 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H W Wilson M. D.
May 31 1921 (Address) Twin Falls, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Ida — DATE OF BURIAL: May 30 1921

20. UNDERTAKER: L S Dewitt — ADDRESS: Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34398

Registered No.

1. PLACE OF DEATH

County of Twin Falls.

City of Twin Falls (No. , St.)

Registration District No. 37

Primary Registration District No. 1085

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Maud Imagine Cole

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Present

6. DATE OF BIRTH: Feb 20. (Month) (Day) 1920 (Year)

7. AGE: 1 Yrs. 3 Mos. 6 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work:

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Hallister

10. NAME OF FATHER: Garage Cole

11. BIRTHPLACE OF FATHER (State or Country): Mo

12. MAIDEN NAME OF MOTHER: Hellen Blackstock

13. BIRTHPLACE OF MOTHER (State or Country): Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E. E. Cole

(Address) Hallister Idaho

15. Filed May 27 1921 John F. Forsman Local Registrar

SYMS-YORK CO. PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 26 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 14 1921, to May 26 1921 that I last saw h.. alive on May 26 1921, and that death occurred on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:

Erysipelas

(Duration) Yrs. mos. 12 ds.

Contributory (Secondary): Peritonitis

(Duration) yrs. mos. 7 ds.

(Signed) C. D. Weaver M. D.

19 (Address) Twin Falls, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Ida | DATE OF BURIAL: May 28 1921

20. UNDERTAKER: J. E. Devitt | ADDRESS: Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Dr Eames

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34394
Registered No.

1. PLACE OF DEATH

County of Twin Falls

City of " "

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 37

Primary Registration District No. 1085

RECEIVED JUN 13 1921 BUREAU OF VITAL STATISTICS

2. FULL NAME Daisy Dean Bruce

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: May (Month) 14 (Day) 1921 (Year)

7. AGE: ....Yrs. ....Mos. 4 ds.

IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Twin Falls Ida

10. NAME OF FATHER: W.R. Bruce Jr

11. BIRTHPLACE OF FATHER (State or Country): Kan.

12. MAIDEN NAME OF MOTHER: Alice Kibler

13. BIRTHPLACE OF MOTHER (State or Country): Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W R Bruce Jr

(Address) Twin Falls Ida

15. Filed May 21 1921. John F. Youngkeiser. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 18 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5/14 1921, to 5/18 1921 that I last saw h.er alive on 5/18 1921 and that death occurred on the date stated above, at .... M.

The CAUSE OF DEATH* was as follows:

Premature birth 2d failure
of foramen ovale 7 d closure.

(Duration) .... Yrs. .... mos. .... ds.

Contributory (Secondary) Anemia of mother

(Duration) .... yrs. .... mos. .... ds.

(Signed) C.C. Eames M. D.

5/18 1921 (Address) Twin Falls Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .... yrs. .... mos. .... days. In the State .... yrs. .... mos. .... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Idg — DATE OF BURIAL: May 18 1921

20. UNDERTAKER: J.F. Grossman — ADDRESS: Twin Falls Idg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1085
File No. 34395
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of ( ) St.)

If death occurs away from usual residence, give facts called for under special information.

JUN 23 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME Mrs Christiane Svenson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Dec (Month) 2 (Day) 1877 (Year)

7. AGE: 43 Yrs. 4 Mos. 16 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer): -

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER: Hans Larsen

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Don't Know

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Lars Svenson
(Address) Eden Idaho

15. Filed May 12 1921 John T. Coughlin Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 7 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 27 1921, to May 7 1921
that I last saw her alive on May 7 1921
and that death occurred on the date stated above, at 430 M.
The CAUSE OF DEATH* was as follows:
Intestinal paresis

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. W. Steinhoff M. D.
19..... (Address) Twin Falls, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF ~~BURIAL~~ OR REMOVAL: Twin Falls Idg — DATE OF BURIAL: May 10 1921

20. UNDERTAKER: F. G. Grassman — ADDRESS: Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Twin Falls — Registration District No. 37
City of " " (No. ..... St.) — Primary Registration District No. 1085
File No. 3436
Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

JUN 15 BUREAU OF VITAL STATISTICS

2. FULL NAME Florence Louise Bruce

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: May (Month) 14 (Day) 1921 (Year)

7. AGE: ..... Yrs. ..... Mos. 6 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Twin Falls Ida

10. NAME OF FATHER: W.R. Bruce Jr.

11. BIRTHPLACE OF FATHER (State or Country): Kan

12. MAIDEN NAME OF MOTHER: Alice Kibler

13. BIRTHPLACE OF MOTHER (State or Country): Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W.R. Bruce Jr
(Address) Twin Falls Ida

15. Filed May 26 1921 John F. Kunkel
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 20 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5/14 1921, to 5/20 1921
that I last saw h.er alive on 5/20 1921
and that death occurred on the date stated above, at 8:00 P.M.
The CAUSE OF DEATH* was as follows:
Premature birth
Non closure of foramen ovale
(Duration) ..... Yrs. ..... mos. 6 ds.
Contributory (Secondary) Premature birth & Anemia
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) C A Kruse M. D.
5/20 1921 (Address) Twin Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Ida — DATE OF BURIAL: 5/21 1921

20. UNDERTAKER: P.J. Grossman — ADDRESS: Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Twin Falls

City of ..... St.)

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 37

Primary Registration District No. 2085

File No. 34397

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Infant Pickett

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Infant

6. DATE OF BIRTH: May (Month) 20 (Day) 1921 (Year)

7. AGE: ..... Yrs. ..... Mos. 1 hr ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Carlyle Pickett

11. BIRTHPLACE OF FATHER (State or Country): Ill

12. MAIDEN NAME OF MOTHER: Dorthy Vorhyes

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Carlyle F. Pickett

(Address) Route 3 Twin Falls

15. Filed May 20 1921 Johan D. Lee Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 20 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from on 5/20 1921, to ..... 19.....

that I last saw h.. alive on 5/20 1921

and that death occurred on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Premature birth

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. D. Reeves M. D.
Emma E. Crouch-Reeves M.D.

..... 19..... (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Idaho

DATE OF BURIAL: May 21 1921

20. UNDERTAKER: L. E. Wendt

ADDRESS: Twin Falls

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Milford.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Registrar's Registration District No. 2085
File No. 34398
Registered No.

RECEIVED
JUN 13 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Twin Falls
City of " "
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs Addie A. Stevens
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write word)
Female	White	Married

6. DATE OF BIRTH: Oct (Month) 2 (Day) 1868 (Year)

7. AGE: 52 Yrs. 7 Mos. 10 ds. IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Tenn.

10. NAME OF FATHER: ~~Don~~ Monroe

11. BIRTHPLACE OF FATHER (State or Country): Tenn.

12. MAIDEN NAME OF MOTHER: Don't Know

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. Stevens
Address Kimberly — Ida

15. Filed May 31 1921 — John T. Coughlin, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 14 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 11th 1921, to May 14th 1921, that I last saw her alive on May 14th 1921, and that death occurred on the date stated above, at 9:30 AM.

The CAUSE OF DEATH* was as follows:

Pleuritis

(Duration) 8 Yrs. ... mos. ... ds.

Contributory (Secondary) Myocarditis

(Duration) ... yrs. ... mos. ... ds.

(Signed) Gilbert Telford D.C. ~~M.D.~~

5/14 1921 (Address) Twin Falls Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Ida — DATE OF BURIAL: May 17 1921

20. UNDERTAKER: L E Wright — ADDRESS: Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

COUNTY, No. ____ CERTIFICATE OF DEATH State of Idaho BOARD OF HEALTH Bureau of Vital Statistics

PLACE OF DEATH

Registration District No. 1321

Primary Registration District No. 1321

File No. 34399

County of Lincoln

City of ____ St.) Registered No. ____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Harvey Kelso

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	white	Married

6. DATE OF BIRTH: Sept 29 (Month) (Day) 1876 (Year)

7. AGE: 45 Yrs. 7 Mos. 24 ds. IF LESS than 1 day how many ____ hrs. or ____ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer): ____

9. BIRTHPLACE (State or Country): Mo

10. NAME OF FATHER: John Kelso

11. BIRTHPLACE OF FATHER (State or Country): Tenn

12. MAIDEN NAME OF MOTHER: Symantha Tackett

13. BIRTHPLACE OF MOTHER (State or Country): Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Miss Louella McNabb
(Address) ____

15. Filed May 22 1921 John F. Cupiler. Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 22 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 6 1921, to May 23 1921
that I last saw h[illegible] alive on May 22 1921,
and that death occurred on the date stated above, at 4:40 P.M.
The CAUSE OF DEATH* was as follows:
Bright's disease

(Duration) ____ Yrs. ____ mos. ____ ds.

Contributory (Secondary) ____

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) H W Goudek M. D.
5/24 1921 (Address) Twin Falls, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days
Where was disease contracted if not at place of death? ____
Former or usual residence ____

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Twin Falls Idaho	May 24 1921
20. UNDERTAKER	ADDRESS
L E Wescott	Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34400

1. PLACE OF DEATH
County of Twin Falls
City of [illegible]
Registration District No. 37
Primary Registration District No. 2085
(No. ..... St.)
Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Samuel Powell Atherton

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Aug 11 (Month) (Day) 1861 (Year)

7. AGE: 59 Yrs. 9 Mos. 5 ds.
IF LESS than 1 day: how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ill

10. NAME OF FATHER: Richard Atherton

11. BIRTHPLACE OF FATHER (State or Country): Nat Known

12. MAIDEN NAME OF MOTHER: Doras Powell

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Dewitt S. Atherton
(Address) .....

15. Filed May 16 1921 John T. Coughlin Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 14 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5/8 1921, to 5/14 1921
that I last saw h~~im~~ alive on 5/14 1921
and that death occurred on the date stated above, at 6:00 P.M.
The CAUSE OF DEATH* was as follows:
Lobar Pneumonia

(Duration) ..... Yrs. ..... mos. 7 ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. O. Weaver M. D.
19..... (Address) Twin Falls.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Idaho — DATE OF BURIAL: May 18 1921

20. UNDERTAKER: [illegible] — ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-[illegible] M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED JUN 11 1921 BUREAU OF VITAL STATISTICS

Registration District No. 36
Primary Registration District No.
File No. 3440[illegible]
Registered No. 6

1. PLACE OF DEATH
County of Twin Falls
City of [illegible] (No. [illegible] St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME David R. Morgan
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: May (Month) 14 (Day) 1 (Year)

7. AGE: 11 Yrs. [illegible] Mos. 1 ds.
IF LESS than 1 day how many [illegible] hrs. or [illegible] min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: School boy
(b) General nature of industry, business or establishment in which employed (or employer): (Farmer.)

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: M. D. Morgan

11. BIRTHPLACE OF FATHER (State or Country): Utah.

12. MAIDEN NAME OF MOTHER: Mary E. Morrill

13. BIRTHPLACE OF MOTHER (State or Country): Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) M. D. Morgan
(Address) Kimberly Ida

15.
Filed [illegible] 19[illegible]
J. N. Davis
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 15 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from [illegible] 19[illegible], to May 15 1921
that I last saw him alive on May 13 1921
and that death occurred on the date stated above, at [illegible] M.
The CAUSE OF DEATH* was as follows:
Chronic Valvular heart disease
(Duration) 2 Yrs. [illegible] mos. [illegible] ds.
Contributory (Secondary) [illegible]
(Duration) [illegible] yrs. [illegible] mos. [illegible] ds.
(Signed) J. N. Davis M. D.
[illegible] 19[illegible] (Address) Kimberly Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death [illegible] yrs. [illegible] mos. [illegible] days. In the State [illegible] yrs. [illegible] mos. [illegible] days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls | DATE OF BURIAL: May 16 1921
20. UNDERTAKER: J. P. Boorman | ADDRESS: Twin Falls

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JUN 11 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. .....
Primary Registration District No. .....
File No. 3440 2
Registered No. 5

1. PLACE OF DEATH
County of Kimberly
City of Kimberly (If outside limits, give township) .....
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jay Dunn

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Aug (Month) 25 (Day) 1916 (Year)

7. AGE: 4 Yrs. 9 Mos. 16 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Milton Oregon

10. NAME OF FATHER: W. E. Dunn

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Eva Lillian Wilson

13. BIRTHPLACE OF MOTHER (State or Country): Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. E. Dunn
(Address) Kimberly Idaho

15. Filed May 8 1921
J. M. Davis
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 8 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr-16 1921, to May 8 1921
that I last saw h— alive on May 7 1921
and that death occurred on the date stated above, at 6 AM.
The CAUSE OF DEATH* was as follows:
Pulmonal Hemorrhage

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Davis M. D.
5/8 1921 (Address) Kimberly, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Ida — DATE OF BURIAL: 5/9 1921

20. UNDERTAKER: J. J. Grossman — ADDRESS: Twin Falls Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JUN 1 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 39
Primary Registration District No. 2087
File No. 34403
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of Buhl (or Township) (St.)
If death occurs away from usual residence, give facts called for under special information.

FULL NAME Richard M. Reams

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH: April (Month) 25. (Day) 1876 (Year)

7. AGE: 45 Yrs. Mos. 24 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Pennsylvania

10. NAME OF FATHER Wm. Reams

11. BIRTHPLACE OF FATHER (State or Country) Pennsylvania

12. MAIDEN NAME OF MOTHER Henrietta Smead

13. BIRTHPLACE OF MOTHER (State or Country) Pennsylvania

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs R. M. Reams
(Address) Buhl Ida

15. Filed 5-23 1921 J. N. Mundy Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 21 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 19 1921, to May 21 1921, that I last saw him alive on May 21, 1921, and that death occurred on the date stated above, at 7 P. M.
The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) ? Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) George Jennings M. D.
5-27 1921 (Address) Buhl, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Buhl Ida — DATE OF BURIAL: 5-23 1921

20. UNDERTAKER: Homer B. Evans — ADDRESS: Buhl

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

RECEIVED
MAY 20 1921
BUREAU OF VITAL STATISTICS

Registration District No. 39
Primary Registration District No. 2087
File No. 34404
Registered No.

County of Lewis
City of Burke (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sarah Elizabeth Crawley

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widdow (Write the word.)

6. DATE OF BIRTH: Oct (Month) 19 (Day) 1848 (Year)

7. AGE: 72 Yrs. 5 Mos. 18 ds.
IF LESS than 1 day how many..... hrs. or.....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Tennessee.

10. NAME OF FATHER: James Oakes

11. BIRTHPLACE OF FATHER (State or Country): Arkansas.

12. MAIDEN NAME OF MOTHER: Dont Know

13. BIRTHPLACE OF MOTHER (State or Country): Dont Know.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. A. Rickett
(Address) Burke Ida.

15. Filed April 6 1921 J. H. Murphy Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 6 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3-20-1921, to 4-6-1921, that I last saw her alive on 4-6-1921 and that death occurred on the date stated above, at 11 A. M.

The CAUSE OF DEATH* was as follows:

Bronchial Asthma

(Duration) 2 Yrs. mos. ds.

Contributory (Secondary) Organic Heart Disease

(Duration) 2 yrs. mos. ds.

(Signed) Geo. Jennings M. D.

4-6 1921 (Address) Burke, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF ~~BURIAL~~ OR REMOVAL: Rockland. Idaho — DATE OF BURIAL: ..... 19.....

20. UNDERTAKER: Homer B. Evans — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34405
Registered No.

RECEIVED MAY 20 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Twin Falls Registration District No. 39
City of Burke (Ward) Primary Registration District No. 7087 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lemuella Duncan Chamberlin

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widowed

6. DATE OF BIRTH: July (Month) 16 (Day) 1847 (Year)

7. AGE: 73 Yrs. 9 Mos. 10 ds.
IF LESS than 1 day how many..... hrs. or..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): La.

10. NAME OF FATHER: Lemuel Duncan

11. BIRTHPLACE OF FATHER (State or Country): Virginia

12. MAIDEN NAME OF MOTHER: Sylvia Cook

13. BIRTHPLACE OF MOTHER (State or Country): Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Lemuella Chamberlin
(Address) Burke

15. Filed 4-27 1921 J. H. Murphy Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 26 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 30 1919, to Apr. 26- 1921, that I last saw h.. alive on Apr. 26- 1921, and that death occurred on the date stated above, at 6 P M.
The CAUSE OF DEATH* was as follows:

Cancer of Liver

(Duration) 2 Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) Geo Jennings M. D.
4-27 1921 (Address) Burke, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Burke Ida. DATE OF BURIAL: 4/27 1921

20. UNDERTAKER: Homer B Evans ADDRESS: Burke

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-12 M. 6-15-17.

RECEIVED
JUN 9 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34406
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Twin Falls ... Registration District No. .....
City of Filer ... Ward ... Registration District No. .....
If death occurs away from usual residence, give facts called for under special information. (No. ....., ... St.)

2. FULL NAME Minnie Gertrude Barber Zitt

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. ~~July~~ (Month) 22 (Day) 1 (Year)

7. AGE: 37 Yrs. 9 Mos. 11 ds.
IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) Wife

9. BIRTHPLACE (State or Country) Kansas

10. NAME OF FATHER John E Metcalf

11. BIRTHPLACE OF FATHER (State or Country) Iowa

12. MAIDEN NAME OF MOTHER Cynthia Persell

13. BIRTHPLACE OF MOTHER (State or Country) Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) L. A. Barberzit
(Address) Filer

15. Filed 5/11/21 191.... A. A. Newberry
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 2 o'clock
May (Month) 11 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 1920 to May 21 191..
that I last saw h[er] alive on May 4 191..
and that death occurred on the date stated above, at 2a M.

The CAUSE OF DEATH* was as follows:
Chondro Sarcoma
(Duration) 2 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) A. A. Newberry M. D.
5-11 1921 (Address) Filer Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the ,State....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Sawtooth Cemetery — DATE OF BURIAL May 12 1921

20. UNDERTAKER H. E. Drake — ADDRESS Filer

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 7-12 M. 6-15-17.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED JUN 9 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34407
Registered No. .....

1. PLACE OF DEATH
County of Twin Falls
Registration District No. 38
Primary Registration District No. 2086
City of Filer
(Street and No. or R. F. D. No. ..... St.)
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.
If death occurred away from usual residence, give facts called for under special information.

2. FULL NAME Maybell Phillips

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Sept (Month) 4 (Day) 1881 (Year)

7. AGE: 39 Yrs. 7 Mos. 12 ds.
IF LESS than 1 day how many .... hrs. or .... min.?'

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) Wife

9. BIRTHPLACE (State or Country) Nebraska

10. NAME OF FATHER Hyrum Greathouse

11. BIRTHPLACE OF FATHER (State or Country) Indiana

12. MAIDEN NAME OF MOTHER Caroline Albertson

13. BIRTHPLACE OF MOTHER (State or Country) Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) M. E. Phillips
(Address) Filer

15. Filed May 18 1921. A. A. Newberry Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 16 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 3rd 1921 to May 16 1921
that I last saw her alive on May 16 1921
and that death occurred on the date stated above, at 1.0 P. M.
The CAUSE OF DEATH* was as follows:

Cancer Uterus

(Duration) Yrs. 18 mos. ds.
Contributory (Secondary) Secondary to Return of Pregnancy
(Duration) Yrs. 5 mos. ds.
(Signed) D. K. Hyland M. D.
5/17 1921. (Address) Twin Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL I.O.O.F. Cemetery — DATE OF BURIAL May 17 1921

20. UNDERTAKER S. E. Drake — ADDRESS Filer

FORM V. S. No. 5-12 M. 6-15-17.

RECEIVED JUN 8 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34408
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Twin Falls Registration District No. 35
City of Filer Registry Registration District No. 208
If death occurs away from usual residence, give facts called for under special information. (No. ....., ... St.)

2. FULL NAME Vera May Casey

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Nov. (Month) 25 (Day) 1916 (Year)

7. AGE 4 Yrs. 5 Mos. 5 ds. IF LESS than 1 day how many .... hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER N. J. Casey

11. BIRTHPLACE OF FATHER (State or Country) Texas

12. MAIDEN NAME OF MOTHER Goldie Metcalf

13. BIRTHPLACE OF MOTHER (State or Country) Nebraska

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) N. J. Casey
(Address) Filer

15. Filed May 19 1921. G. A. Meade Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 19 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 15 1921 to May 19 1921 that I last saw h. ev. alive on May 19 1921 and that death occurred on the date stated above, at 9 a. M.

The CAUSE OF DEATH* was as follows:

Endocarditis

(Duration) ..... Yrs. 1 mos. 4 ds.

Contributory (Secondary) .....

(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) Geo Jennings M. D.
5-20 1921. (Address) Buhl, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Twin Falls Cemetery — DATE OF BURIAL May 21 1921.

20. UNDERTAKER F. E. Drake — ADDRESS Filer

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
JUN 9 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 86
Primary Registration District No. 1010.
File No. 34409
Registered No. 23

1. PLACE OF DEATH
County of Washington
City of Weiser (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charles A. Amburgey
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Divorced

6. DATE OF BIRTH: Dec (Month) 16 (Day) 1852 (Year)

7. AGE: 68 Yrs. 5 Mos. 1 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Virginia

10. NAME OF FATHER: Alfred Amburgey

11. BIRTHPLACE OF FATHER (State or Country): — — —

12. MAIDEN NAME OF MOTHER: — — —

13. BIRTHPLACE OF MOTHER (State or Country): — — — —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. A. J. McMillon
(Address) Weiser 260

15. Filed May 18th 1921 Dr. R. Hamilton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 17th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 11th 1921, to May 17th 1921, that I last saw h-- alive on May 17th 1921, and that death occurred on the date stated above, at 4 P.M.
The CAUSE OF DEATH* was as follows: Rocky Mountain Tick Fever
(Duration) ..... Yrs. ..... mos. 7 ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) M. R. Hamilton M. D.
5/18 1921 (Address) Weiser Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Hillcrest Cemetery — DATE OF BURIAL: 5-19 1921

20. UNDERTAKER: Northam & McCann — ADDRESS: Weiser Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
JUN 9 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 46
Primary Registration District No. 1010.
File No. 34410
Registered No. 24

1. PLACE OF DEATH
County of Washington
City of Weiser
If death occurs away from usual residence, give facts called for under special information.
(No. ..... St.)

2. FULL NAME Baby Tilford

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: May (Month) 21 (Day) 1921 (Year)

7. AGE: — Yrs. — Mos. 1 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ida

10. NAME OF FATHER: Elmer Tilford

11. BIRTHPLACE OF FATHER (State or Country): Ida

12. MAIDEN NAME OF MOTHER: Leah Sanford

13. BIRTHPLACE OF MOTHER (State or Country): Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) .....
(Address) Elmer Tilford, Weiser

15. Filed May 21st 1921 — Dr. R. K. Hamilton, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 5 (Month) 21 (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 21st 1921, to ..... 19..., that I last saw him alive on May 21st 1921, and that death occurred on the date stated above, at 6 P.M.
The CAUSE OF DEATH* was as follows:
Immaturity
Immediate Death.
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) M. R. Hamilton M. D.
5/21/1921 (Address) Weiser

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Hillcrest Cemetery
DATE OF BURIAL: 5—22—1921
20. UNDERTAKER: Northam McCann
ADDRESS: Weiser Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JUN 9 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 86

Primary Registration District No. 2112

File No. 34411

County of Washington

City of Weiser (Ward) (No. St.)

Registered No. 25

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME C. T. Grier

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White American

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widowed (Write the word.)

6. DATE OF BIRTH: Do not Know (Month) (Day) 1 (Year)

7. AGE: About 68 Yrs. — Mos. — ds.

IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farm Laborer

(b) General nature of industry, business or establishment in which employed (or employer): I arm off just above elbow.

9. BIRTHPLACE (State or Country): Do not Know

10. NAME OF FATHER: " Thomas Grier Ire Springfield Mo

11. BIRTHPLACE OF FATHER (State or Country): " Ireland

12. MAIDEN NAME OF MOTHER: " Frances Grier Bro Kansas City Mo

13. BIRTHPLACE OF MOTHER (State or Country): " Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) G. W. Rauch

(Address) Probate Judge Weiser Ida

15. Filed May 24th. 1921 — W. R. Hamilton — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 23 (Month) (Day) 23 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1, 1921 to May 23 1921 that I last saw him alive on May 23 1921 and that death occurred on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:

Cancer of Stomach

2 Yrs (Duration) 2 Yrs. mos. ds.

Contributory (Secondary) ... (Duration) ... yrs. ... mos. ... ds.

(Signed) C. C. Conant M. D.

5/25 1921 (Address) Weiser Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: County Plot. Hillcrest Cem. | DATE OF BURIAL: 5/25 1921

20. UNDERTAKER: Northam & McCon | ADDRESS: Weiser

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DIATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 86
Primary Registration District No. 2112.
File No. 3412
Registered No. 26

1. PLACE OF DEATH

County of Washington
City of Weiser (St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Nora West Taylor

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widow

6. DATE OF BIRTH: April 25 1856 (Month) (Day) (Year)

7. AGE: 65 Yrs. 0 Mos. 29 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housemaker
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ill.

10. NAME OF FATHER: Edward M West

11. BIRTHPLACE OF FATHER (State or Country): Va.

12. MAIDEN NAME OF MOTHER: Julia Atwater

13. BIRTHPLACE OF MOTHER (State or Country): Ill

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) G Morris Taylor
(Address) 529 Portland ave St Paul Minn

15. Filed May 25 1921 W R Hamilton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 24 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 19 1921 to May 24 1921 that I last saw her alive on May 24 1921 and that death occurred on the date stated above, at 10.50 P.M.
The CAUSE OF DEATH* was as follows:
Coronary Thrombosis
(Duration) ..... Yrs. ..... mos. 5 ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) C C Conant M. D.
May 25 1921 (Address) Weiser Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: St Paul Minn. DATE OF BURIAL: 19

20. UNDERTAKER: Northam & McCann ADDRESS: Weiser

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 3443

Registered No. 18

1. PLACE OF DEATH

County of Washington

City of Weiser

(If outside limits of city or village, write the word "Not" before "In")

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
JUN 9 1921
BUREAU OF VITAL STATISTICS

Registration District No. 86

Primary Registration District No. 1010

(Ward) St.)

2. FULL NAME Ida H Garrett

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: — — 1 (Month) (Day) (Year)

7. AGE: 47 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mich

10. NAME OF FATHER: Isaac S. Dean

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Almira Boulton

13. BIRTHPLACE OF MOTHER (State or Country): N. Y.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Geo. W. Garrett
(Address) Weiser Ida.

15. Filed April 3rd 1921 M. R. Hamilton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr (Month) 2 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 1 1920 to Apr 2 1921 that I last saw her alive on Mar 28 1921, and that death occurred on the date stated above, at 4 A. M.

The CAUSE OF DEATH* was as follows:
Cancer of breast

1 (Duration) 1 Yrs. 2 mos. 2 ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) C C Conant M. D.
Apr 3rd 1921 (Address) Weiser Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Hillcrest Cemetery — DATE OF BURIAL: 4-3-1921

20. UNDERTAKER: Northam McCann — ADDRESS: Weiser Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JUN 9 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Washington
City of Weiser (If outside limits, give township.) St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 86
Primary Registration District No. 2112
File No. 34414
Registered No. 19

2. FULL NAME Annie F. Buchanan
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Dec 15 1 (Month) (Day) (Year)

7. AGE: 36 Yrs. 4 Mos. 4 ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Robert Browning

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Annie F Cook

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): J. H. Buchanan
(Address): Weiser Idaho

15. Filed 4/21/21 19 ... Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr (Month) 19 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 7 1921, to April 18 1921, that I last saw h[illegible] alive on March 18 1921, and that death occurred on the date stated above, at 1P M.
The CAUSE OF DEATH* was as follows:
Duration of illness

(Duration) ... Yrs. ... mos. 45 ds.
Contributory (Secondary)
(Duration) ... yrs. ... mos. ... ds.
(Signed) G. M. Walenhauer M. D.
4/20 1921 (Address) Weiser Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Fullerest Cemetery | DATE OF BURIAL: 4-20 1921
20. UNDERTAKER: Northam & McCann | ADDRESS: Weiser Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
JUN 9 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 86
Primary Registration District No. 1010
File No. 34415
Registered No. 26

1. PLACE OF DEATH
County of Washington
City of Weiser
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charlie Igreen Wong.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	Mongl	Widower

6. DATE OF BIRTH March 16 1861
(Month) (Day) (Year)

7. AGE 60 Yrs. 1 Mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) Dishwasher

9. BIRTHPLACE (State or Country) China

10. NAME OF FATHER Chow Lenn

11. BIRTHPLACE OF FATHER (State or Country) China

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER (State or Country) China

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. C. Wang
(Address) Weiser & Ida

15. Filed May 5-K 1921 W. K. Hamilton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 16 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 16 1921 to Apr. 16 1921
that I last saw him alive on Apr. 15 1921,
and that death occurred on the date stated above, at 8.30 P.M.
The CAUSE OF DEATH* was as follows:
Pulmonary Embolism
Fr. Thrombus in Vein of Leg.
(Duration) ..... Yrs. 15 mins. mos. ..... ds.
Contributory (Secondary) Senility.
(Duration) ..... yrs. 10 mos. ..... ds.
(Signed) Ernest O. Finney M. D.
4/14 1921 (Address) Weiser Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence Ohio

19. PLACE OF REMOVAL Hong Kong China | DATE OF REMOVAL 5-7 1921

20. UNDERTAKER Northam McCoy | ADDRESS Weiser

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
JUN 9 1921
BUREAU OF VITAL STATISTICS

Registration District No. 86
Primary Registration District No. 1010.
File No. 34416
Registered No. 21

1. PLACE OF DEATH
County of Washington
City of Weiser (If not in incorporated territory, write St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ella J Abernethy

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widowed (Write the word.)

6. DATE OF BIRTH: Dec 17th 1860 (Month) (Day) (Year)

7. AGE: 60 Yrs. 4 Mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country)

10. NAME OF FATHER: Geo Groves

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER: Rebecca J. Waters

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mat. B. Hart
(Address) Weiser. Idaho

15. Filed April 20th 1921 — W. R. Hamilton, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 20 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 1921, to April 20 1921 that I last saw h in alive on April 20 1921 and that death occurred on the date stated above, at 4 A.M.

The CAUSE OF DEATH* was as follows:
Cancer of liver

7 (Duration) 7 Yrs. 2 mos. 4 ds.

Contributory (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C C Conant M. D.
Apr. 19 21 (Address) Weiser Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Hillcrest Cemetry — DATE OF BURIAL: 4-21 1921

20. UNDERTAKER: Northam McCann — ADDRESS: Weiser Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3447
Registered No. 22

1. PLACE OF DEATH
County of Washington
City of Weiser (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

RECEIVED
JUN 9 1921
BUREAU OF VITAL STATISTICS

Registration District No. 86
Primary Registration District No. 2112

2. FULL NAME Francis J Hallenbeck
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Feb (Month) 26 (Day) 1855 (Year)

7. AGE: 66 Yrs. 1 Mos. 25 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Patrick O Donnell

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Bridget Kilday

13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) James Hallenbeck
(Address) Weiser Idaho R 7d #1

15. Filed 4/22/ 1921 W R Hamilton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 21 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 10. 1920, to Apr. 1921 that I last saw her alive on Apr. 1921 and that death occurred on the date stated above, at 4:30 M.

The CAUSE OF DEATH* was as follows:

Cardiac insufficiency + Dilatation

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary): Paralysis

..... (Duration) ..... yrs. ..... mos. 1 ds.

(Signed) W A Marshall M. D.

Apr 22 1921 (Address) Weiser

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Fullerest Cemetery | DATE OF BURIAL: 4-23 1921

20. UNDERTAKER: Northam & McCann | ADDRESS: Weiser Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34418

RECEIVED JUN 4 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No.
Primary Registration District No.

County of Washington
City of Cambridge (or Village or Township) St.)

If death occurs away from usual residence, give facts called for under special information.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary Ann Lorton

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	married

6. DATE OF BIRTH: Mar (Month) 16 (Day) 1837 (Year)

7. AGE: 84 Yrs. Mos. 3 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Montgomery Co. Mo.

10. NAME OF FATHER: W. H. Lorton

11. BIRTHPLACE OF FATHER (State or Country): Kentucky,

12. MAIDEN NAME OF MOTHER: Mary Ann Sailor

13. BIRTHPLACE OF MOTHER (State or Country): Missouri, Montgomery Co

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Edward E. Lorton
(Address) Cambridge, Idaho

15. Filed 3/23/21 19.....
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 19 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 1 1921, to May 19 1921, that I last saw her alive on May 18 1921, and that death occurred on the date stated above, at 7:30 P.M.

The CAUSE OF DEATH* was as follows:
Diabetes Mellitus —
Diabetic Gangrene.

(Duration) Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) W. M. Coleman M. D.
19 (Address) Cambridge Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Cambridge Ida. DATE OF BURIAL May 20 1921

20. UNDERTAKER Jas. E. Anderson ADDRESS Cambridge Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED JUN 4 19[illegible] BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No.
Registration District No.
File No. 34419
Registered No.

1. PLACE OF DEATH
County of Washington
City of Cambridge (No. St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Wilda L Craddock
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: May (Month) 23 (Day) 1921 (Year)

7. AGE: Yrs. Mos. 0 Ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Cambridge

10. NAME OF FATHER R L Craddock

11. BIRTHPLACE OF FATHER (State or Country) Oregon

12. MAIDEN NAME OF MOTHER Ida Ermeent

13. BIRTHPLACE OF MOTHER (State or Country) Nebraska

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R L Craddock
(Address) Cambridge Idaho

15. Filed 6/2/21 19 W M Mc[illegible] Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 23 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 23 1921, to May 23 1921, that I last saw h[illegible] alive on May 23 1921, and that death occurred on the date stated above, at [illegible] P.M.

The CAUSE OF DEATH was as follows:* Pneumonia Both

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed) W W Mc[illegible] M. D.

6/2 1921 (Address) Cambridge Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Cambridge — DATE OF BURIAL: May 24 1921

20. UNDERTAKER [illegible] — ADDRESS Cambridge

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34420

JUN 4 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. .....
Primary Registration District No. .....

County of Washington
City of ..... (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Eloa Pearl Babb.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Married

6. DATE OF BIRTH Jan. 31 1886
(Month) (Day) (Year)

7. AGE 35 Yrs. 2 Mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Kansas.

10. NAME OF FATHER Emmerson Bennett Babb.

11. BIRTHPLACE OF FATHER (State or Country) U.S.A.

12. MAIDEN NAME OF MOTHER .....

13. BIRTHPLACE OF MOTHER (State or Country) U.S.A.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. M. Babb
(Address) .....

15. Filed 6/2/21 19..... W. W. Thomas Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Apr. 3. 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1921, to Apr 3 1921, that I last saw h.e. alive on Apr 3 1921, and that death occurred on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:
Edema of Lungs
.....
.....
(Duration) ..... Yrs. ..... mos. 2 ds.
Contributory (Secondary) Chronic Bright's disease
(Duration) 2 or 3 yrs. ..... mos. ..... ds.

(Signed) C. W. Simmons M. D.
4/4 1921 (Address) Cambridge Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Salubria	6/4 1921
20. UNDERTAKER	ADDRESS
Gallentine	Cambridge

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34421
Registered No. 158

1. PLACE OF DEATH
County of Boise
City of ..... St.)
If death occurs away from usual residence, give facts called for under special information.

RECEIVED
JUL 5 1921
BUREAU OF VITAL STATISTICS

Registration District No. 2
Primary Registration District No. 1607

2. FULL NAME Cordelia B. Auburn
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.
4. COLOR OR RACE: White.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widow.

6. DATE OF BIRTH: May 20 1842 (Month) (Day) (Year)

7. AGE: 79 Yrs. — Mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Penn.

10. NAME OF FATHER: Jacob Baker

11. BIRTHPLACE OF FATHER (State or Country): Penn

12. MAIDEN NAME OF MOTHER: Margaret E. Warfel

13. BIRTHPLACE OF MOTHER (State or Country): Penn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Louise A Hyde
(Address) .....

15. Filed June 1 1921 — C. H. Platt — Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 30 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I ~~attended~~ last deceased ~~from~~
May 30 1921 ~~to~~ ~~19~~
~~that I last saw her~~ ..... alive on ..... ~~19~~
and that death occurred on the date stated above, at 12:30 A M.

The CAUSE OF DEATH* was as follows:
Valvular Heart trouble
.....
.....
(Duration) 3 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Clyde E. Dunnmore Coroner
5/31 1921 (Address) Boise Idaho Ada Co

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL ..... 19 .....

20. UNDERTAKER: Summers & Grebe. — ADDRESS: Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
JUL 5 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 2

Primary Registration District No. 1004

County of Ada

City of Boise (If outside limits of city or village, give township.) No. 1223 Franklin St.)

If death occurs away from usual residence, give facts called for under special information.

File No. 34422

Registered No. 1642

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Arthur Morris Grant

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. ~~SINGLE~~, ~~MARRIED~~, WIDOWED ~~OR DIVORCED~~ (Write the word.): Widower

6. DATE OF BIRTH: Dec (Month) 1 (Day) 1839 (Year)

7. AGE: 81 Yrs. 6 Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Engineer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Solomon S. Grant

11. BIRTHPLACE OF FATHER (State or Country): Connecticut

12. MAIDEN NAME OF MOTHER: Lucinda Rees

13. BIRTHPLACE OF MOTHER (State or Country): U.S.A.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W R. Grant

(Address) Boise

15. Filed Jan 2 — 1921 R. H. Pratt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 5 (Month) 31 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5/28 1921 to 5/31 1921 that I last saw him alive on 5/31 1921 and that death occurred on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:

Senility

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) H. A. Tuttle M. D.

6/1 1921 (Address) Overland Bldg.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Salt Lake City Utah | DATE OF BURIAL: 6/2 1921

20. UNDERTAKER: Schreiber & Sidenfaden | ADDRESS: Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Ada — Registration District No. 2

City of Boise — Primary Registration District No. 1004

(No. ..... St.)

File No. 34423

Registered No. 161

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

RECEIVED
JUL 5 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME William Sloan

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M.	W	Married

6. DATE OF BIRTH: July (Month) 8 (Day) 1879 (Year)

7. AGE: 41 Yrs. 10 Mos. 22 ds.

IF LESS than 1 day: how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Indiana

10. NAME OF FATHER: Robert Sloan

11. BIRTHPLACE OF FATHER (State or Country): Unknown.

12. MAIDEN NAME OF MOTHER: Unknown.

13. BIRTHPLACE OF MOTHER (State or Country): Unknown.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Virginia Sloan
(Address) Boise Idaho

15. Filed Jun 3 1921 — R. H. Smith, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 29 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I ~~attended~~ saw deceased ~~from~~ May 29 1921, to ..... 19....., that I ~~last~~ saw h~~im~~ alive on dead May 29 1921, and that death occurred on the date stated above, at 2:20 P.M.

The CAUSE OF DEATH* was as follows:

Suicide, Gun shot wound in head

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Clyde E Summers Coroner M.D.

6/3 1921 (Address) Boise Idaho Co.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cem — DATE OF BURIAL: Jun 3 1921

20. UNDERTAKER: Summers & Gibbs. — ADDRESS: Boise Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 10 Rev. 1918

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Statistics

No. 4424

County of Ada

City of Boise (If outside limits of city or village, write the word "Rural" and give name of township.) St.)

Registered No. 162

If death occurs away from usual residence, give facts called for under special information.

JUL 8 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME Margaret N. Blair.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widowed (Husband of)

6. DATE OF BIRTH: Feb 12 (Month) (Day) 1852 (Year)

7. AGE: 69 Yrs. 3 Mos. 21 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: Neal Anderson

11. BIRTHPLACE OF FATHER (State or Country): Kentucky.

12. MAIDEN NAME OF MOTHER: Martha McCoy.

13. BIRTHPLACE OF MOTHER (State or Country): Kentucky.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15. Filed June 4 1921 P. J. Pratt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 2 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apl 20 1921, to June 1 1921, that I last saw h.r alive on June 1 1921, and that death occurred on the date stated above, at 4 P M.

The CAUSE OF DEATH* was as follows:

Apoplexy.

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. W. Williams M.D.

6-4 1921 (Address) 404 Empire Bldg

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cem — DATE OF BURIAL: June 5 1921

20. UNDERTAKER: Summers & Gebo. — ADDRESS: Boise Ida.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Stewart

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED JUL 5 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 2

Primary Registration District No. 1004

County of Ada

City of Boise (No. 208 No 28 St.)

File No. 34425

Registered No. 764

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Linnie Martin

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word.)
F.	White	Married

6. DATE OF BIRTH: Jan 28 (Month) (Day) 1866 (Year)

7. AGE: 55 Yrs. 4 Mos. 9 ds. IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: William Knowles.

11. BIRTHPLACE OF FATHER (State or Country): Indiana

12. MAIDEN NAME OF MOTHER: Hanna Wilbanks

13. BIRTHPLACE OF MOTHER (State or Country): Illinois.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E C Markle
(Address) Eagle Ida

15. Filed June 6 1921 P. H. Gratt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 6 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 12 1920 to June 6 1921 that I last saw h... alive on June 4 1921 and that death occurred on the date stated above, at 2.30 P.M.

The CAUSE OF DEATH* was as follows:
Cancer of Sigmoid

(Duration) ... Yrs. 1 mos. ... ds.

Contributory (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) James F Stewart M. D.

6/6 1921 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Morris Hill Cemetery	June 7 1921
20. UNDERTAKER: Summers & Crebs.	ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SIMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JUL 5 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34426

Registered No. 165

1. PLACE OF DEATH

County of Ada Registration District No. 2

City of Boise Primary Registration District No. 1004

St Alphonsus Hospital

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Pine Mikez

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widower

6. DATE OF BIRTH: about 1858 (Month) (Day) (Year)

7. AGE: 63 Yrs. — Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Austria

10. NAME OF FATHER: Dont Know

11. BIRTHPLACE OF FATHER (State or Country): Austria

12. MAIDEN NAME OF MOTHER: Dont Know

13. BIRTHPLACE OF MOTHER (State or Country): Austria

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mike Zaprow

(Address) 116 S. 6th St.

15. Filed June 6 1921 W. V. Pratt Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 6 (Month) 3 (Day) 21 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 20 1921 to 6-3 1921 that I last saw h[illegible] alive on 6-2 1921, and that death occurred on the date stated above, at 8 P.M.

The CAUSE OF DEATH* was as follows:

Septic Arthritis with general Sepsis

(Duration) ..... Yrs. 1½ mos. ..... ds.

Contributory (Secondary) Pulmonary tuberculosis

(Duration) Unknown yrs. ..... mos. ..... ds.

(Signed) W. S. Sutton M. D.

6-6-21 (Address) Boise

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence Boise, Idaho

19. PLACE OF BURIAL OR REMOVAL: St Johns Cemetery — DATE OF BURIAL: 6/8 1921

20. UNDERTAKER: Schreiber & Sidenfaden — ADDRESS: Boise Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JUL 5 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34427
Registered No. 166

1. PLACE OF DEATH

County of Ada Registration District No. 2

City of Boise (If outside limits of village or town, give township) No. 910 State St.) Registration District No. 1004

If death occurs away from usual residence, give facts called for under special information.

FULL NAME Jack Zupan

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: May (Month) 15 (Day) 1916 (Year)

7. AGE: 5 Yrs. ~ Mos. 19 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Riverside Ore.

10. NAME OF FATHER: Mike Zupan

11. BIRTHPLACE OF FATHER (State or Country): Austria

12. MAIDEN NAME OF MOTHER: Annie Starkovitch

13. BIRTHPLACE OF MOTHER (State or Country): Austria

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mike Zupan

(Address) Boise, Ida.

15. Filed June 6 1921 R. H. Pratt Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 4 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 15 1921, to June 4 1921, that I last saw h.. alive on June 4 1921, and that death occurred on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows: Tuberculosis Meningitis

(Duration) ..... Yrs. ..... mos. 15 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) M. V. Tallman M. D.

6/6 1921 (Address) Boise

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence Boise, Idaho.

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
St Johns Cemetery	6/6 1921
20. UNDERTAKER	ADDRESS
Schreiber & Liebenfeden	Boise

Tallman

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY; PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34428

Registered No. 167

RECEIVED
JUL 5 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 2

Primary Registration District No. 1004

County of Ada

City of Boise (If outside limits, give township) 710 E. Fremont St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Edwin Merritt Stilson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	White	Married

6. DATE OF BIRTH: Jan (Month) 1 (Day) 1 (Year)

7. AGE: 62 Yrs. Mos. ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Carpenter,
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New York.

10. NAME OF FATHER: Merritt Stilson

11. BIRTHPLACE OF FATHER (State or Country): New York.

12. MAIDEN NAME OF MOTHER: Elizabeth Merritt

13. BIRTHPLACE OF MOTHER (State or Country): New York.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Mabel Stilson
(Address) 2036 N. 16 st Boise Idg

15.
Filed June 7 1921 R. H. Pratt, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 6 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1 1921, to June 6 1921, that I last saw h[illegible] alive on June 6 1921, and that death occurred on the date stated above, at [illegible] M.

The CAUSE OF DEATH* was as follows:
Coronary thrombosis

(Duration) Yrs. mos. 1 ds.
Contributory (Secondary) Cystic insanity.
(Duration) 10 yrs. mos. ds.

(Signed) M. H. Sullivan M. D.
6/7 1921 (Address) Boise

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery DATE OF BURIAL: June 8 1921

20. UNDERTAKER: Summers & Kirby ADDRESS: Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED
JUL 5 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Ada — Registration District No. 2

City of Boise (No. 511 No 11th St.) — Registration District No. 2004

File No. 34429

Registered No. 169

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sylvester C. Trout

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: June (Month) 20 (Day) 1844 (Year)

7. AGE: 76 Yrs. 11 Mos. 18 ds.

IF LESS than 1 day, how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Penn

10. NAME OF FATHER: Edward Trout

11. BIRTHPLACE OF FATHER (State or Country): Penn.

12. MAIDEN NAME OF MOTHER: Rebecca Caroline Lantz

13. BIRTHPLACE OF MOTHER (State or Country): Maryland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wm. McBratney
(Address) Boise Idaho

15. Filed June 10 1921 — R. N. Gratt, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 8 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 12 - 1921 to June 8 1921 that I last saw him alive on June 7 1921 and that death occurred on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

Arterio sclerosis.

(Duration) 2w Yrs. mos. ds.

Contributory (Secondary) Complete heart block

(Duration) yrs. 6 mos. ds.

(Signed) W. H. Tallman M. D.

6/8/21 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 6/11/21

20. UNDERTAKER: Wm. McBratney — ADDRESS: Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34430
Registered No. 170.

1. PLACE OF DEATH

RECEIVED JUL 5 1921 BUREAU OF VITAL STATISTICS

County of Ada Registration District No. 2
City of Boise (If outside limits of city or village, give township) Primary Registration District No. 1004
If death occurs away from usual residence, give facts called for under special information. 1012 Hale St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lucian Tracy Smith.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
male	white	single (Write the word.)

6. DATE OF BIRTH: March (Month) 15 (Day) 1839 (Year)

7. AGE: 82 Yrs. 2 Mos. 23 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: Daniel Smith.

11. BIRTHPLACE OF FATHER (State or Country): U. S. A.

12. MAIDEN NAME OF MOTHER: Emily Kimo

13. BIRTHPLACE OF MOTHER (State or Country): U. S. A.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) [illegible] Hall
(Address) Boise Idaho

15. Filed June 10 1921 R. N. Pratt Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 9 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..., to June 8 19...
that I last saw h... alive on ... 19...
and that death occurred on the date stated above, at 12:30 P.M.

The CAUSE OF DEATH* was as follows:
Pneumonia

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary) .....
(Duration) ... yrs. ... mos. ... ds.

(Signed) Geo Callister M. D.
19... (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Masonic Cemetery	6/10 1921
20. UNDERTAKER	ADDRESS
Schneider & Eckenstein	Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34431

Registered No. 174

1. PLACE OF DEATH

Registration District No. 2

Primary Registration District No. 2004

County of Ada

City of Boise (If outside limits of city or village, give township.) St. Natatoriums

If death occurs away from usual residence, give facts called for under special information.

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JUL 5 1921
BUREAU OF VITAL STATISTICS

2. USUAL RESIDENCE Theodore Culver.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widower

6. DATE OF BIRTH: (Month) (Day) 1836 (Year)

7. AGE: 84 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession particular kind of work: Carpenter
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE, TO THE BEST OF MY KNOWLEDGE
(Informant) E. G. Burnet
(Address) Gardens House

15. Filed June 16 1921 R N Pratt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 15 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 6/15 1921, to 6-15 1921
that I last saw h[illegible] alive on + 1921,
and that death occurred on the date stated above, at 11 P. M.

The CAUSE OF DEATH* was as follows:

Valvular Heart disease

(Duration) Yrs. mos. ds.

Contributory (Secondary) Rheumatism

(Duration) 5 yrs. mos. ds.

6/15 1921 (Signed) Dr Downey M. D.
(Address) Boise Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: June 17 1921

20. UNDERTAKER: Summers & Turbet — ADDRESS: Boise Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3443
Registered No. 176

RECEIVED
JUL 5 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 2
Primary Registration District No. 1004
County of Ada
City of Boise (No. 1212 E. Bannock St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Hong Chong

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: Yellow

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: (Month) (Day) 1861 (Year)

7. AGE: 60 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Gardiner
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): China

10. NAME OF FATHER: Dont Know

11. BIRTHPLACE OF FATHER (State or Country): China

12. MAIDEN NAME OF MOTHER: Dont Know

13. BIRTHPLACE OF MOTHER (State or Country): China

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant)
(Address) P.O. Morey Hose

15. Filed June 18 1921 P.W. Pratt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 15th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 10 1921 to June 15th 1921 that I last saw him alive on June 15th 1921 and that death occurred on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:
Arteriosclerosis Followed by
Paralysis
(Duration) Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) John Bank M. D.
June 17 1921 (Address) Boise Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. 10 days. In the State yrs. mos. days
St Lukes Hospital
Where was disease contracted if not at place of death?
Former or usual residence Boise, Idaho

19. PLACE OF BURIAL OR REMOVAL: Chinese Cemetery — DATE OF BURIAL: 6/18 1921

20. UNDERTAKER: Schreiber & Sidenfaden — ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED JUL 5 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34435

Registered No. 178

1. **PLACE OF DEATH**

Registration District No. 2

Primary Registration District No. 1004

County of Ada

City of Boise. (No. 506 Fairview St.)

If death occurs away from usual residence, give facts called for under special information.

2. **FULL NAME** Ida Louise Weybright

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Single

6. **DATE OF BIRTH** June 13 1921
(Month) (Day) (Year)

7. **AGE** — Yrs. — Mos. 4 ds.

IF LESS than 1 day how many ____ hrs. or ____ min.?

8. **OCCUPATION**
(a) Trade, profession or particular kind of work: None.
(b) General nature of industry, business or establishment in which employed (or employer):

9. **BIRTHPLACE** (State or Country) Boise. Idaho.

10. **NAME OF FATHER** K. N. Weybright

11. **BIRTHPLACE OF FATHER** (State or Country) Ohio.

12. **MAIDEN NAME OF MOTHER** Hazel Seaman

13. **BIRTHPLACE OF MOTHER** (State or Country) Idaho.

14. **THE ABOVE IS TRUE TO THE BEST OF MY ~~KNOWLEDGE~~**
(Informant) Wm McBratney
(Address) Boise. Idaho.

15. Filed June 18 1921 O. W. Pratt
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH** June 17 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 13 1921, to June 17 1921
that I last saw h~~e~~r alive on June 13 1921
and that death occurred on the date stated above, at 7a M.
The CAUSE OF DEATH* was as follows:
Uraemia.

(Duration) Yrs. mos. 4 ds.
Contributory (Secondary) Premature

(Duration) yrs. mos. ds.

(Signed) WS Lewis M. D.
6/17 1921 (Address) Boise. Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. ~~LENGTH~~ OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Morris Hill Cemetery	6/17 1921
20. UNDERTAKER W McBratney	ADDRESS Boise Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED JUL 5 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3431
Registered No. 179

1. **PLACE OF DEATH**

County of Ada — Registration District No. 2

City of Boise — Registration District No. 1094

(If not in hospital or institution, give street address or location.) St. Lukes Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. **FULL NAME** Wilmot York

PERSONAL AND STATISTICAL PARTICULARS

3. **SEX**: Male

4. **COLOR OR RACE**: White.

5. **SINGLE, MARRIED, WIDOWED OR DIVORCED** (Write the word.): Single

6. **DATE OF BIRTH**: Sept. 30. 1914 (Month) (Day) (Year)

7. **AGE**: 6 Yrs. 9 Mos. 18 ds.

IF LESS than 1 day how many ... hrs. or ... min.?

8. **OCCUPATION**

(a) Trade, profession or particular kind of work: In School

(b) General nature of industry, business or establishment in which employed (or employer):

9. **BIRTHPLACE** (State or Country): Idaho

10. **NAME OF FATHER**: R. L. York

11. **BIRTHPLACE OF FATHER** (State or Country): Indiana

12. **MAIDEN NAME OF MOTHER**: Lettie M. Haines.

13. **BIRTHPLACE OF MOTHER** (State or Country): Nebraska

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**

(Informant) Wm. McC Bratney

(Address) Boise Idaho.

15. Filed June 21 1921 — R. H. Pratt, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH**: June 18 — 1921 (Month) (Day) (Year)

17. **I HEREBY CERTIFY, That I attended deceased from** 6-18 1921, to 6-18 1921 that I last saw h[illegible] alive on 6-18 1921 and that death occurred on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

Peritonitis

(Duration) ... Yrs. ... mos. 10 ds.

Contributory (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) P. P. French M. D.

6/20 1921 (Address) Boise. Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. **PLACE OF BURIAL OR REMOVAL**: Morris Hill Cemetery — **DATE OF BURIAL**: 6/21 1921

20. **UNDERTAKER**: W. McC Bratney Jr. — **ADDRESS**: Boise Idaho.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
JUL 5 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34435
Registered No. 180

1. PLACE OF DEATH
Registration District No. 2
County of Ada
Primary Registration District No. 1004
City of Boise (No. 410 State St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Morris O'Connell
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word.): Single

6. DATE OF BIRTH: .....1..... (Month) (Day) (Year)

7. AGE: About 75 years ..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Ireland

10. NAME OF FATHER: Don't Know

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Don't Know

13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Sister M. Finian
(Address) .....

15. Filed January 22 1921 — R. H. Pratt, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 20th 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from .....19....., to .....19.....,
that I last saw h..... alive on .....19.....,
and that death occurred on the date stated above, at .....M.
The CAUSE OF DEATH* was as follows:
No Doctor
Pneumonia
.....(Duration) .....Yrs. .....mos. .....ds.
Contributory (Secondary) .....
.....(Duration) .....yrs. .....mos. .....ds.
(Signed) Sister M. Finian M. D.
.....19..... (Address) St. Alphonsus Hosp

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs. .....mos. .....days. In the State .....yrs. .....mos. .....days
Where was disease contracted if not at place of death? .....
Former or usual residence Boise County, Idaho

19. PLACE OF BURIAL OR REMOVAL: St Johns Cemetery — DATE OF BURIAL: 6/22 1921

20. UNDERTAKER: Schreiber & Sidenfaden — ADDRESS: Boise, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JUL 5 1921 BUREAU OF VITAL STATISTICS

Titus

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34430
Registered No. 181

1. PLACE OF DEATH
County of Ada — Registration District No. 2
City of Boise. — Registration District No. 6 (Hospital) St Alphonsus Hospital

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John I. Wells.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M.	White	Married

6. DATE OF BIRTH: Feb 14 (Month) (Day) 1865 (Year)

7. AGE: 56 Yrs. 4 Mos. 9 ds. — IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Real Estate
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Iowa.

10. NAME OF FATHER: Samuel A. Wells

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Hackmower

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Albert E. Wells
(Address): #3 Belgravia Terrace

15. Filed 6/25 1921 — R. H. Pratt, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 23 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 5 1921, to June 23 1921, that I last saw h[im] alive on June 22 1921, and that death occurred on the date stated above, at 7:30 P.M.

The CAUSE OF DEATH* was as follows:
Acute Par. Nephritis.

(Duration) ..... Yrs. 4 mos. ..... ds.
Contributory (Secondary): Chronic nephritis
(Duration) several yrs. ..... mos. ..... ds.

(Signed) W. J. Titus M. D.
6-24 1921 (Address) Boise

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Morris Hill Cem	June 25 1921
20. UNDERTAKER	ADDRESS
Summers & Gebe.	Boise Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO. PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JUL 5 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 11437
Registered No. 187

1. PLACE OF DEATH
County of Ada Registration District No. 2
City of So. Boise Primary Registration District No. 10 at
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James C. Mauss.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: White.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (write the word.)

6. DATE OF BIRTH: Nov. 27 (Month) (Day) 1914 (Year)

7. AGE: 6 Yrs. 6 Mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Arthur O. Mauss.

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Nora L. Ewing.

13. BIRTHPLACE OF MOTHER (State or Country): Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Clyde E. Summers
(Address) Boise Idaho

15. Filed 6/25/21 19..... R. H. Pratt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 23 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 6/22, 1921, to 6/23 1921, that I last saw him alive on 6/23 19....., and that death occurred on the date stated above, at 7:30 P.M.

The CAUSE OF DEATH* was as follows:

~~Diphtheria~~ Septicemia,

(Duration) ..... Yrs. 1 mos. ..... ds.

Contributory (Secondary) Intestinal Intoxication

(Duration) ..... yrs. 1 mos. ..... ds.

(Signed) H. H. Pittenger M. D.

6/25 1921 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cem. DATE OF BURIAL: June 26 1921

20. UNDERTAKER: Summers & Gebs. ADDRESS: Boise Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
JUL 5 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 34438
Registered No. 183

1. PLACE OF DEATH
County of Ada
City of Boise, Idaho (No. ....., St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Lyons,
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	

6. DATE OF BIRTH
..... 1.....
(Month) (Day) (Year)

7. AGE
65
.....Yrs.....Mos.....ds.
IF LESS than 1 day how many..... hrs. or.....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business or establishment in which employed (or employer).....

9. BIRTHPLACE
(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER
(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) L. M. Gibbons
(Address) Boise, Idaho

15. Filed 6/24 1921 R. H. Pratt
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
June 22nd 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 7 1921, to June 22 1921, that I last saw h.. alive on June 21 1921, and that death occurred on the date stated above, at .....M.
The CAUSE OF DEATH* was as follows:
Cancer of stomach
.....(Duration) .....Yrs.....mos.....ds.
Contributory (Secondary).....
.....(Duration) .....yrs.....mos.....ds.
(Signed) Geo Collister M. D.
.....19..... (Address).....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Penitentiary Cemetery	6/24 1921
20. UNDERTAKER	ADDRESS
Schneider & Heidenfelder	Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JUL 5 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34439
Registered No. 184

1. PLACE OF DEATH

Registration District No. 2
Primary Registration District No. 1004

County of Ada
City of Boise (No. 410, State St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Henry Johan Renk

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: March (Month) 1 (Day) 1874 (Year)

7. AGE: 47 Yrs. 3 Mos. 20 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer on Rock River
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wisconsin

10. NAME OF FATHER: Nicholaus Renk

11. BIRTHPLACE OF FATHER (State or Country): Germany.

12. MAIDEN NAME OF MOTHER: Margaret Schmid.

13. BIRTHPLACE OF MOTHER (State or Country): U. S.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wm F Renk
(Address) San Francisco Cal.

15. Filed 6/25/1921 R H Pratt, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 22 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19....., to ..... 19.....,
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
I was called to see this man after he was dead. Probably
Cause of death. Heart disease.
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) L. A. McCall M. D.
6/24/1921 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
St. Johns Cemetery	6/27/1921
20. UNDERTAKER	**ADDRESS**
Schreiber & Lieuallen	Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JUL 5 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34410

Registered No. 185

1. PLACE OF DEATH

County of Ada

City of Boise (No. ..... St.)

Registration District No. 2

Primary Registration District No. 1004

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Agnes Scully

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: single (Write the word.)

6. DATE OF BIRTH: April (Month) 1st (Day) 1882 (Year)

7. AGE: 39 Yrs. 1 Mos. 22 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Milliner

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Nebraska

10. NAME OF FATHER: James Scully

11. BIRTHPLACE OF FATHER (State or Country): Canada

12. MAIDEN NAME OF MOTHER: Margaret O'Sullivan

13. BIRTHPLACE OF MOTHER (State or Country): Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Margaret E. Scully

(Address) Boise Idaho

15. Filed 6/25 1921 R. H. Pratt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 23 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 21 1921, to June 23 1921, that I last saw h.er alive on June 22 1921, and that death occurred on the date stated above, at 9.30 a. M.

The CAUSE OF DEATH* was as follows:

Primary. Pernicious Anaemia

(Duration) 3 Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) L. O. McCalla M. D.

6/24/1921 (Address) Boise, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
St Johns Cemetery	6/25 1921
20. UNDERTAKER	**ADDRESS**
Schreiber & Liedenfader	Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
JUL 5 1921
BUREAU OF VITAL STATISTICS

Shurtz.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Ada
City of Boise
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2
Primary Registration District No. 1004
(No. St Alphonsus Hospital St.)

File No. 34441
Registered No. 187
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Joshua Kerley.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Widower

6. DATE OF BIRTH: Nov 24 1847 (Month) (Day) (Year)

7. AGE: 73 Yrs. 7 Mos. 4 ds.
IF LESS than 1 day how many..... hrs. or.....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Tennessee

10. NAME OF FATHER: Samuel O. Kerley.

11. BIRTHPLACE OF FATHER (State or Country): Tennessee.

12. MAIDEN NAME OF MOTHER: Catherine Gibbs.

13. BIRTHPLACE OF MOTHER (State or Country): Tennessee

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) L.O. Kerley
(Address) Boise Idaho

15. Filed June 30 1921 P. V. Pratt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 28 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I ~~attended~~ saw deceased from June 28 1921, to ~~19..~~ that I last saw h.. alive on ~~19..~~ and that death occurred on the date stated above, at 2.30 P.M.

The CAUSE OF DEATH* was as follows:
Paralysis

(Duration) Yrs. 5 mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) Clyde E. Summers Coroner Ada County M.D.
6/29 1921 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..yrs..mos..days. In the State ..yrs..mos..days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: June 30 1921

20. UNDERTAKER: Summers & Cobb. — ADDRESS: Boise, Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34412

Registered No. 185

RECEIVED
JUL 5 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 2

Primary Registration District No. 1004

County of Ada

City of Boise (If outside limits, give township) 611 Bannock St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Daniel W. Masterson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word)

6. DATE OF BIRTH: Oct (Month) 1 (Day) 1843 (Year)

7. AGE: 77 Yrs. 8 Mos. 28 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Blacksmith
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: William Masterson

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Jas Stewart
(Address) Boise Idaho.

15. Filed June 30 1921 — R. V. Pratt, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 29 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 21st 1921, to June 29th 1921, that I last saw him alive on June 29 1921, and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Nephritis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Alan Bower M. D.

6-29 1921 (Address) Boise Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Middleton Idaho — DATE OF BURIAL: July 1 1921

20. UNDERTAKER: Summers & Trefts — ADDRESS: Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34443

Registered No. 43

1. PLACE OF DEATH

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 8

Primary Registration District No. 2077

(No.) Soldiers Home Hospital St.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

RECEIVED
JUL 5 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME Chasteen Dunavan

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word.): Single

6. DATE OF BIRTH: June (Month) 1 (Day) 1879 (Year)

7. AGE: 92 Yrs. — Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Veteran Mexican

(b) General nature of industry, business or establishment in which employed (or employer): Wars.

9. BIRTHPLACE (State or Country): Unknown.

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Harry Tebbs.

(Address) Boise Idaho.

15. Filed Jun 4 1921

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 3 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1921, to June 3 1921, that I last saw h.. alive on June 2 1921 and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Senility

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Fred A. Fellows M. D.

6/4 1921 (Address) Overland

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cem

DATE OF BURIAL: June 4 1921

20. UNDERTAKER: Summers & Tebbs.

ADDRESS: Boise Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JUL 5 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 8
Primary Registration District No. 2004
File No. 34444
Registered No. 44

1. PLACE OF DEATH

County of Ada
City of Boise
(No. near White Cross St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Emil Johnson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
M	White	Single (Write the word.)

6. DATE OF BIRTH May 18 1881 (Month) (Day) (Year)

7. AGE 40 Yrs. — Mos. 16 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Silver City, Idaho

10. NAME OF FATHER Andrew W. Johnson

11. BIRTHPLACE OF FATHER (State or Country) Sweden

12. MAIDEN NAME OF MOTHER Catherine L. Brunzell

13. BIRTHPLACE OF MOTHER (State or Country) Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) P. H. Carter

(Address)

15. Filed June 6 1921 P. H. Peadon Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 4 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 9 1921 to June 2 1921 that I last saw him alive on June 2 1921 and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis — contributed to by Bronchopneumonia

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) P L Dutton M. D.

June 6 1921 (Address) Overland Bldg. Boise

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence: Ada County, Idaho

19. PLACE OF BURIAL OR REMOVAL Joplin Cemetery — **DATE OF BURIAL** 6/6 1921

20. UNDERTAKER Schreiber & Siebenfaden — **ADDRESS** Boise, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

RECEIVED JUL 5 1921 BUREAU OF VITAL STATISTICS

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 8
Primary Registration District No. 2004
File No. 34445
Registered No. 745

1. PLACE OF DEATH
County of Ada
City of Boise (Ward) (St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Hiram Henry McGuire
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: April 2 (Month) (Day) 1884 (Year)

7. AGE: 37 Yrs. 2 Mos. 12 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farming
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mo.

10. NAME OF FATHER: J. W. McGuire

11. BIRTHPLACE OF FATHER (State or Country): Tenn

12. MAIDEN NAME OF MOTHER: Adie Hillard

13. BIRTHPLACE OF MOTHER (State or Country): U. S. A.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Katherine McGuire
(Address)

15. Filed June 16 1921 — R. N. Pratt, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 14 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 2 1921, to June 14 1921, that I last saw him alive on June 14 1921, and that death occurred on the date stated above, at 11 P M.

The CAUSE OF DEATH* was as follows:
Diabetes

(Duration) 2 Yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. L. Fraser M. D.
6/15 1921 (Address) 515 Overland Bldg Boise

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 6/17 1921

20. UNDERTAKER: Scheubes Widenfeld — ADDRESS: Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JUL 5 1921 BUREAU OF STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34446
Registered No. 46

1. PLACE OF DEATH
County of Ada
City of
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 8
State Registration District No. 3 or 4
(No. Ada County Hospital)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ben F. Turner.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M.	White.	Single

6. DATE OF BIRTH
— (Month) — (Day) 1847 (Year)

7. AGE
74 Yrs. — Mos. — ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business or establishment in which employed (or employer) —

9. BIRTHPLACE (State or Country) England.

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (State or Country) Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Harry Krebs.
(Address) Boise Idaho.

15.
Filed June 18 1921 R. H. Pratt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
June 17 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1919, to June 17 1921, that I last saw him alive on June 11 1921, and that death occurred on the date stated above, at 8 a M.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
(Duration) Yrs. mos. 5 min ds.
Contributory (Secondary) Paralysis
(Duration) yrs. mos. 5 min ds.

(Signed) R. H. Pratt M. D.
June 18 1921 (Address) Boise, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Morris Hill Cemetery | DATE OF BURIAL June 18 1921

20. UNDERTAKER Summers & Krebs | ADDRESS Boise Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JUL 5 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34447

Registered No. 47

1. PLACE OF DEATH

Registration District No. 6

Primary Registration District No. 200 4

County of Ada

City of Near Boise (No. 2 Miles West of Boise St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Allen Jolley

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M

4. COLOR OR RACE White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH June (Month) 3 (Day) 1921 (Year)

7. AGE Yrs. Mos. 13 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER T. F. Jolley

11. BIRTHPLACE OF FATHER (State or Country) Idaho

12. MAIDEN NAME OF MOTHER Anna Gardner

13. BIRTHPLACE OF MOTHER (State or Country) Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Fallin Jolley

(Address) Boise Idaho

15. Filed June 17 1921 R. H. Pratt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 16 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 3, 1921, to June 16 1921, that I last saw h[illegible] alive on June 16 1921, and that death occurred on the date stated above, at 9:30 M.

The CAUSE OF DEATH* was as follows:

Toxemia

(Duration) Yrs. mos. 14 ds.

Contributory (Secondary) Submental Abscess

(Duration) yrs. 2 mos. 14 ds.

(Signed) Edward Kmpa M. D.

6/17 1921 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Morris Hill Cemetery

DATE OF BURIAL June 17 1921

20. UNDERTAKER Summers & Krebs

ADDRESS Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

Stewart

CERTIFICATE OF DEATH

RECEIVED JUL 5, 1921 BUREAU OF VITAL STATISTICS

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 8
Primary Registration District No. 2004
File No. 34448
Registered No. 48

1. PLACE OF DEATH

County of Ada.
City of 3 mi west of Fair Grounds (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Margaret L. Shafer.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word.): Married

6. DATE OF BIRTH: Feb 26 (Month) (Day) 1898 (Year)

7. AGE: 23 Yrs. 3 Mos. 23 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: John Mc Pherson.

11. BIRTHPLACE OF FATHER (State or Country): Scotland.

12. MAIDEN NAME OF MOTHER: Laura N. Anderson.

13. BIRTHPLACE OF MOTHER (State or Country): Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Robert B. Mc Pherson.

(Address) Boise. Idaho.

15. Filed June 20 19 21

R. N. Pratt
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 18 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 4 1921, to June 18 1921, that I last saw h[illegible] alive on June 19 1921, and that death occurred on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:

Malignant Endocarditis

(Duration) ..... Yrs. 2 mos. 15 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Harold W Lane M. D.

6/21 1921 (Address) 410 Overland Bldg

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: June 21 1921

20. UNDERTAKER: Summers & Cobb — ADDRESS: Boise Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Powell

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JUL 5 1921 BUREAU OF VITAL STATISTICS STATE OF IDAHO

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34419
Registered No. 49

1. PLACE OF DEATH
County of Ada
City of Boise
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 8
Primary Registration District No. 7004
Riverside Station St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Susan Brushwood.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F.	White	Married

6. DATE OF BIRTH
Oct (Month) ..... 1864 (Year)

7. AGE
56 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE
(State or Country) Illinois

10. NAME OF FATHER
Unknown

11. BIRTHPLACE OF FATHER
(State or Country) Unknown

12. MAIDEN NAME OF MOTHER
Unknown

13. BIRTHPLACE OF MOTHER
(State or Country) Unknown.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) S. J. Brushwood
(Address) .....

15.
Filed June 25 1921
R. N. Traft
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
June (Month) 24 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 26, 1921, to June 24 1921, that I last saw h-er alive on June 24, 1921, and that death occurred on the date stated above, at 9 P.M.

The CAUSE OF DEATH* was as follows:
Carcinoma of liver & stomach.

..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Anemia
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Joseph M. Powell M. D.
6/25/1921 (Address) Boise, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mattoon Illinois — DATE OF BURIAL: June 27 1921

20. UNDERTAKER: Summers & Gebs. — ADDRESS: Boise Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

34450 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
JUL 12 1921
BUREAU OF VITAL STATISTICS

Registration District No. 124
Primary Registration District No. 2202
File No. 1
Registered No. 36

1. PLACE OF DEATH.
County of Ada
City of ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ralph W Sorensen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH.
3 (Month) 30 (Day) 1920 (Year)

7. AGE
1 Yrs. 3 Mos. 5 ds.
IF LESS than 1 day how many ... hrs. or ... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Ida

10. NAME OF FATHER: Merlin C Sorensen

11. BIRTHPLACE OF FATHER (State or Country): Ida

12. MAIDEN NAME OF MOTHER: Ora Miller

13. BIRTHPLACE OF MOTHER (State or Country): Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Merlin C Sorensen
(Address) Kuna Ida

15.
Filed July 5 1921
W C Stevens
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
7 (Month) 4 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from — 191..., to — 191...,
that I last saw h... alive on ... 191...,
and that death occured on the date stated above, at ... M.

The CAUSE OF DEATH* was as follows:
Drowning, while the child was apparently dead when I arrived, I kept up artificial respiration for about one and one half hours with no apparent results.
(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary) ...
(Duration ... yrs. ... mos. ... ds.

(Signed) T J Coleman M. D.
7-5 1924 (Address) Kuna Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Kuna Cemetary — DATE OF BURIAL: July 5 1921

20. UNDERTAKER: Parents — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. ASSOC. 24853

FORM V. S. No. 5-25 M. 1-19.

Taylor

CERTIFICATE OF DEATH

State of [redacted]
BOARD OF [redacted]
Bureau of Vi[redacted]

1. PLACE OF DEATH

County of Ada

City of

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No. Sexton Stations St.)

5 mi N.W. of Boise.

File No. 34451

Registered No. 52

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Diantha Sexton

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widow (~~Write~~ this ~~word~~.)

6. DATE OF BIRTH: Oct (Month) 6 (Day) 1845 (Year)

7. AGE: 75 Yrs. 9 Mos. 3 ds.

IF LESS than 1 day how many..... hrs. or.....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: At Home.

(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Penn.

10. NAME OF FATHER: William Wilson

11. BIRTHPLACE OF FATHER (State or Country): Penn.

12. MAIDEN NAME OF MOTHER: — Frask.

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) L L Sexton

(Address) Boise Idaho.

15. Filed July 11 1924 B. A. Pratt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 9 (Day) 1924 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1st 1924, to July 9th 1924, that I last saw her alive on July 7th 1924, and that death occurred on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:

Apoplexy —

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary) Senility

(Duration) ... yrs. ... mos. ... ds.

(Signed) J. M. Taylor (Taylor) M. D.

7/11 1924 (Address) Boise, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Dry Creek Cem — DATE OF BURIAL: July 10 1924

20. UNDERTAKER: Clemmons & Cobb. ADDRESS: Boise Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34452
Registered No.

1. PLACE OF DEATH
County of Ada
City of Meridian (If outside limits of city or village, write the name of township.) St.)
If death occurs away from usual residence, give facts called for under special information.

RECEIVED JUL 10 BUREAU OF VITAL STATISTICS

Registration District No.
Primary Registration District No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Bertie O Mayer

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Married

6. DATE OF BIRTH: Dec 17 1891 (Month) (Day) (Year)

7. AGE: 29 Yrs. 6 Mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Home Keeper
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Goshen Ark.

10. NAME OF FATHER: J G. Oxford.

11. BIRTHPLACE OF FATHER (State or Country): Ark.

12. MAIDEN NAME OF MOTHER: Eugenia Kirby

13. BIRTHPLACE OF MOTHER (State or Country): Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W.H. Mayer
(Address) Meridian Idaho

15. Filed 6-21 1921 H F Neal Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 20 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from October 1920, to June 20 1921 that I last saw h.er alive on June 20 1921, and that death occurred on the date stated above, at 8 P. M.
The CAUSE OF DEATH* was as follows:

General Carcinomatosis

(Duration) Yrs. 7 mos. ds.
Contributory (Secondary) Carcinoma of Uterus
(Duration) 2 yrs. mos. ds.

(Signed) J R Numbers M. D.
6/21 1921 (Address) Meridian Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Meridian Idaho — DATE OF BURIAL: June 20 1921
20. UNDERTAKER: W Bliss — ADDRESS: Meridian I.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34453
Registered No. 12

1. PLACE OF DEATH
County of Ada
City of Meridian (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. .....
Primary Registration District No. 11

JUL 10 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME Franklin D. Fulcher.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male.	White	Married

6. DATE OF BIRTH: April (Month) 23 (Day) 1856 (Year)

7. AGE: 65 Yrs. 1 Mos. 25 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: Levi T. Fulcher

11. BIRTHPLACE OF FATHER (State or Country): Virginia

12. MAIDEN NAME OF MOTHER: Mary Turley

13. BIRTHPLACE OF MOTHER (State or Country): North Carolina

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Earl E. Fulcher
(Address) Meridian R. D.

15. Filed 6-17 1921 H. F. Neal Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 17 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1 1921 to June 17 1921 that I last saw h[e] alive on June 17 1921 and that death occurred on the date stated above, at 8.30 A.M.

The CAUSE OF DEATH* was as follows: Cirrhosis Peritonitis

(Duration) 2 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. F. Neal M. D.
6-17 1921 (Address) Meridian Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL 19 .....
Morris Hill	
20. UNDERTAKER	ADDRESS
W. J. Mathes	Meridian Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED JUL 10 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34454
Registered No. 13

1. PLACE OF DEATH
Registration District No.
Primary Registration District No. 71
County of Ada
City of Meridian (If outside limits, give township) St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Richard E. Burns

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (write the word)

6. DATE OF BIRTH: June (Month) 6. (Day) 1921 (Year)

7. AGE: ..... Yrs. ..... Mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Meridian Ida.

10. NAME OF FATHER: Montie Burns

11. BIRTHPLACE OF FATHER (State or Country): Ada Co Idaho

12. MAIDEN NAME OF MOTHER: Nell Pollard

13. BIRTHPLACE OF MOTHER (State or Country): South Dakota

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Montie Burns
(Address) Barns Id. R-2-

15. Filed 6-17 1921 H. H. Neal Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 17 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 6 1921, to June 17 1921, that I last saw him alive on June 14 1921, and that death occurred on the date stated above, at 2:30 A.M.
The CAUSE OF DEATH* was as follows:

Accidental asphyxiation

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. R. Numbers M. D.
6/17 1921 (Address) Meridian Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Joplin Cemetery — DATE OF BURIAL: June 18 1921
20. UNDERTAKER: W. B. Mathews — ADDRESS: Meridian Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED JUL 12 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

24455

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 24

Primary Registration District No. 241

File No. 41

Registered No. 391

1. PLACE OF DEATH

County of Bannock

City of Pocatello (No. 244 Centhomys Has St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sarah Elizabeth Powell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Female	white	Married

6. DATE OF BIRTH Feb. (Month) 7 (Day) 1869 (Year)

7. AGE 52 Yrs. 4 Mos. 19 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Missouria

10. NAME OF FATHER Calvin Harper

11. BIRTHPLACE OF FATHER (State or Country) Not Known

12. MAIDEN NAME OF MOTHER Sarah Morrow

13. BIRTHPLACE OF MOTHER (State or Country) Not Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Luther M. Powell

(Address) 446 N Main

15. Filed June 29 1921 — Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 26 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 15th 1921, to June 26th 1921, that I last saw her alive on June 26th 1921, and that death occurred on the date stated above, at 7:15 P.M.

The CAUSE OF DEATH* was as follows:

Hyperthyroidism

(Duration) Unknown Yrs. ..... mos. ..... ds.

Contributory (Secondary) Carcinoma breast & axilla

(Duration) 7 yrs. ..... mos. ..... ds.

(Signed) W. A. Wright M. D.

6/27 1921 (Address) Pocatello, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients or Recent Residents.)

At place of death 7 yrs. ..... mos. ..... days. In the State 7 yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence Washington State

19. PLACE OF BURIAL OR REMOVAL Mt View Cem. — **DATE OF BURIAL** June 28 1921

20. UNDERTAKER H. L. McHan — **ADDRESS** Pocatello, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED JUL 12 1921 BUREAU OF VITAL STATISTICS

Dr. Leach

CERTIFICATE OF DEATH

28 34456

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 2641 File No. 41

County of Bannock Primary Registration District No. Registered No. 357

City of Pocatello (No. St. Anthony Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Infant Gonzales

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Mexican

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: June 1 (Month) (Day) 1921 (Year)

7. AGE: Yrs. Still Born Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work:

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: John Gonzales

11. BIRTHPLACE OF FATHER (State or Country): Mexico

12. MAIDEN NAME OF MOTHER: unknown

13. BIRTHPLACE OF MOTHER (State or Country): unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Gonzales

(Address) 160 Wilson ave

15. Filed 6/2 1921 J. H. Bowman Jr. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 1 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1 1921 to June 1 1921 that I last saw him alive on June 1 1921 and that death occurred on the date stated above, at 10:50 P.M.

The CAUSE OF DEATH* was as follows:

Respiratory examinations of unknown Cause. Incoherent respiration. Child alive while in bed.

(Duration) Yrs. mos. ds.

Contributory (Secondary) Illness of mother (partial)

(Duration) yrs. mos. ds.

(Signed) Carl W Clark M. D.

June 2 1921 (Address) Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: mountain View — DATE OF BURIAL: June 2 1921

20. UNDERTAKER: Schumacher — ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED JUL 12 1921 BUREAU OF VITAL STATISTICS

34457

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 25

Primary Registration District No. 491

File No. 41

Registered No. 3593

1. PLACE OF DEATH

County of Bannock

City of Pocatello (No. General Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ida Alvine Longatz

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: June (Month) 23 (Day) 1862 (Year)

7. AGE: 58 Yrs. 11 Mos. 8 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Stone wife

(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: John Kuther

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Carline Patratse

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs A Longatz

(Address) 631 - So Main

15. Filed 6/3 1921

J P Young
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 1 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 23 1921, to May 31 1921, that I last saw h. alive on May 31 1921, and that death occurred on the date stated above, at 1:20 A.M.

The CAUSE OF DEATH* was as follows:

Tuberculosis of cervix uteri & intestinal stasis & neurasthenia.

Operation - Vaginal hysterectomy 5/26/21

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Carcinoma cervix

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. C. Irwin M. D.

6/2 1921 (Address) Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain View Cem — DATE OF BURIAL: June 3 1921

20. UNDERTAKER: Schumacher & Hall — ADDRESS: Pocatello

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED
JUL 12 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

34458

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bannock — Registration District No. 28

City of Pocatello — Registration District No. 2161
(No. Lynn Bros Hospital St.)

File No. 41

Registered No. 5594

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Frank L. Kay

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widower

6. DATE OF BIRTH: Feby 12 1854
(Month) (Day) (Year)

7. AGE: 67 Yrs. 3 Mos. 22 Ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Pike Fitter
(b) General nature of industry, business or establishment in which employed (or employer): O.S.L.R. Ry

9. BIRTHPLACE (State or Country): Kristiana Norway

10. NAME OF FATHER: Bernt O. Kay

11. BIRTHPLACE OF FATHER (State or Country): Norway

12. MAIDEN NAME OF MOTHER: Annie Hansen

13. BIRTHPLACE OF MOTHER (State or Country): Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Myrtle Kay
(Address) Pocatello

15. Filed 6/4 1921 — Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 3 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feby 13 1921, to June 3 1921, that I last saw him alive on June 3 1921, and that death occurred on the date stated above, at 4:25 a. M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Rectum

(Duration) ..... Yrs. 6 mos. ..... ds.

Contributory (Secondary) Shock following operation

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas Lynn M. D.

June 3 1921 (Address) Pocatello Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. 2 mos. 21 days Lynn Bros. Hosp

Where was disease contracted if not at place of death? at Pocatello.

Former or usual residence Pocatello Ida.

19. PLACE OF BURIAL OR REMOVAL: Mt View Cemetery — DATE OF BURIAL: June 6 1921

20. UNDERTAKER: P. V. Parker — ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A--25 M. 1-19.

CERTIFICATE OF DEATH

34459

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
JUL 12 1921
BUREAU OF VITAL STATISTICS

Registration District No. 26
Primary Registration District No. 2141
File No. 41
Registered No. 3545

1. PLACE OF DEATH
County of Bannock
City of Pocatello (No. Residence Lo Main St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Infant Ranstrom

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Infant (Write the word.)

6. DATE OF BIRTH: June (Month) 3 (Day) 1921 (Year)

7. AGE: — Yrs. — Mos. — ds.
IF LESS than 1 day: how many 6 hrs. or — min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Pocatello Ida.

10. NAME OF FATHER: Carl Ranstrom

11. BIRTHPLACE OF FATHER (State or Country): London

12. MAIDEN NAME OF MOTHER: Matilda Carlson

13. BIRTHPLACE OF MOTHER (State or Country): London

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Carl Ranstrom
(Address) Pocatello

15. Filed 6/14 1921
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 4 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 4 1921 to June 4 1921 that I last saw h. alive on June 4 1921 and that death occurred on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:
Still born
Premature

(Duration) Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) J. P. Young M. D.
6/4 1921 (Address) Pocatello

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain View Cem. DATE OF BURIAL: June 4 1921
20. UNDERTAKER: Schumacher & Hall ADDRESS: Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

34462

RECEIVED JUL 15 1921 BUREAU OF VITAL STATISTICS

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 28

Primary Registration District No. 3161

File No. 41

Registered No. 3598

1. PLACE OF DEATH

County of Bannock

City of Pocatello (If outside limits, give township) Latter Day Saints Hospital (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George Fry

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6. DATE OF BIRTH: ..... (Month) ..... (Day) ..... (Year)

7. AGE: About 76 years — Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business or establishment in which employed (or employer): ....

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: /

11. BIRTHPLACE OF FATHER (State or Country): /

12. MAIDEN NAME OF MOTHER: /

13. BIRTHPLACE OF MOTHER (State or Country): /

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) General information

(Address) ....

15. Filed 6/9 1921 — J. R. Young, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 8 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1 1921 to June 8 1921 that I last saw h[illegible] alive on June 8 1921 and that death occurred on the date stated above, at 10.9 M.

The CAUSE OF DEATH* was as follows:

Senility

..... (Duration) 2 Yrs. ..... mos. ..... ds.

Contributory (Secondary) nothing

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.

June 9th 1921 (Address) Pocatello Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? ....

Former or usual residence ....

19. PLACE OF BURIAL OR REMOVAL: New Cemetery — DATE OF BURIAL: June 10 1921

20. UNDERTAKER: W. W. Parker — ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

34463

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
JUL 12 1921
BUREAU OF VITAL STATISTICS

Registration District No. 28
Primary Registration District No. 2141
File No. 41
Registered No. 3599

1. PLACE OF DEATH
County of Bannock
City of Pocatello (No. 1 Lee Morgan St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME G B Watson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widower

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1 (Year)

7. AGE: about 80 years
Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer): /

9. BIRTHPLACE (State or Country) /

10. NAME OF FATHER /

11. BIRTHPLACE OF FATHER (State or Country) /

12. MAIDEN NAME OF MOTHER /

13. BIRTHPLACE OF MOTHER (State or Country) /

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Full Information
(Address) /

15. Filed 6/9 1921 J. P. Young Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 9 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 7th 1915 to June 9 1921 that I last saw him alive on June 8 1921 and that death occurred on the date stated above, at 1-2a M.

The CAUSE OF DEATH* was as follows:
Pneumonia

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Wm A Mooney M. D.
June 9 1921 (Address) Pocatello Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mt View Cemetery
DATE OF BURIAL: 6/10 1921

20. UNDERTAKER: Walker
ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

34464

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 28
Primary Registration District No. 2161
File No. 41
Registered No. 3400

1. PLACE OF DEATH

County of Bannock

City of Pocatello (No. 538 N. Stayes St.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
JUL 12 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME Mrs Margaret Snnail

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): widowed

6. DATE OF BIRTH: Dec 4th 1833
(Month) (Day) (Year)

7. AGE: 87 Yrs. 6 Mos. 5 ds.

IF LESS than 1 day how many..... hrs. or.....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Scotland

10. NAME OF FATHER: William Milne

11. BIRTHPLACE OF FATHER (State or Country): Scotland

12. MAIDEN NAME OF MOTHER: Margaret Keith

13. BIRTHPLACE OF MOTHER (State or Country): Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Margaret Whittington
(Address) 538 N. Stayes.

15. Filed 6/9 1921

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 9th 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1 1921, to June 9 1921, that I last saw h.. alive on June 7 1921, and that death occurred on the date stated above, at 2 P.M.
The CAUSE OF DEATH* was as follows:
Chronic Nephritis.

(Duration) Yrs. mos. ds.

Contributory (Secondary) yrs. mos. ds.

(Signed) [illegible] M. D.
19 (Address) Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Palisade Neb — DATE OF BURIAL: June 12 1921

20. UNDERTAKER: Schumacher Hall — ADDRESS: Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

34465

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 41

Registered No. 3601

RECEIVED
JUL 12 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Bannock

City of Pocatello

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 28

Primary Registration District No. 2141

(No. Pocatello Gen. Hos. St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Claes Wade Mechan

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): single

6. DATE OF BIRTH: Dec. (Month) 23. (Day) 1921 (Year)

7. AGE: 1 Yrs. 5 Mos. 20 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Hirth Idaho.

10. NAME OF FATHER: Leroy Mechan

11. BIRTHPLACE OF FATHER (State or Country): Idaho.

12. MAIDEN NAME OF MOTHER: Grace Dyer Mechan

13. BIRTHPLACE OF MOTHER (State or Country): Hirth Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Grace D. Mechan.

(Address) Hirth Idaho.

15. Filed June 10 1921

J. W. Young
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 10 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 9 1921, to June 10 1921, that I last saw him alive on June 10 1921, and that death occurred on the date stated above, at 7 M.

The CAUSE OF DEATH* was as follows:

Pneumonia Bronchus.

(Duration) ..... Yrs. ..... mos. 4 ds.

Contributory (Secondary) Whooping cough

(Duration) ..... yrs. 1 mos. ..... ds.

(Signed) W. W. Brothers M. D.

Jan 10 1921 (Address) Pocatello, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. 2 days. In the State Life yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence Hirth Idaho.

19. PLACE OF BURIAL OR REMOVAL: Hirth Idaho. DATE OF BURIAL: June 10 1921

20. UNDERTAKER: H. L. McClain ADDRESS: Pocatello

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train —accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

34466

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
JUL 12 1921
BUREAU OF VITAL STATISTICS

Registration District No. 25
Primary Registration District No. 2161
File No. 41
Registered No. 360

1. PLACE OF DEATH
County of Bannock
City of Pocatello (If outside city limits, give township.) Ross Hospital (If in hospital, institution or camp, give its NAME instead of street and number.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sarah Ethel Adamson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Child (Write the word.)

6. DATE OF BIRTH: May (Month) 7 (Day) 1912 (Year)

7. AGE: 9 Yrs. 1 Mos. 1 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry, business or establishment in which employed (or employer): At School

9. BIRTHPLACE (State or Country): Tooele Utah.

10. NAME OF FATHER: W. K. Adamson

11. BIRTHPLACE OF FATHER (State or Country): Tooele Utah. June 6th 21

12. MAIDEN NAME OF MOTHER: Margaret Whitaker.

13. BIRTHPLACE OF MOTHER (State or Country): Scotland.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. K. Adamson
(Address) 446 - No 6th

15. Filed 6/10 1921

Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 8 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 8th 11 a.m. 1921, to June 8th 10 p.m. 1921, that I last saw h.er alive on June 8th 1921 and that death occurred on the date stated above, at 10 p.m.

The CAUSE OF DEATH* was as follows:

Tuberculosis

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Appendicitis (ruptured) Removed,

..... (Duration) ..... yrs. ..... mos. 7 ds.

(Signed) [signature] M. D.

June 9th 1921 (Address) Pocatello Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. 11 days. In the city of Pocatello State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? 446 No 6th
Former or usual residence Pocatello, Ida.

19. PLACE OF BURIAL OR REMOVAL: Salt Lake City Utah — DATE OF BURIAL: June 1921

20. UNDERTAKER: Schumacher & [illegible] — ADDRESS: Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A--25 M. 1-19.

34467

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
JUL 12 1921
BUREAU OF VITAL STATISTICS

Registration District No. 28
Primary Registration District No. 2141
File No. 41
Registered No. 3603

1. PLACE OF DEATH

County of Bannock
City of Pocatello (No. 336 - So Garfield St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Celestia Adeline Hoff

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widow (Write the word.)

6. DATE OF BIRTH: October 10 1854 (Month) (Day) (Year)

7. AGE: 66 Yrs. 8 Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Salt Lake City Utah

10. NAME OF FATHER: Chauncey Bacon

11. BIRTHPLACE OF FATHER (State or Country): New York N.Y.

12. MAIDEN NAME OF MOTHER: Celestia Sisson

13. BIRTHPLACE OF MOTHER (State or Country): Michigan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Jamie Budge
(Address) 336 - So Garfield

15. Filed 6/16 1921

Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 10 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 12 1921 to June 10 1921 that I last saw h— alive on June 10 1921 and that death occurred on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:
Pneumonia acute
Myocarditis —

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) L. Guy A. Dargen M. D.
June 1921 (Address) Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Montpelier Ida — DATE OF BURIAL: June 13 1921

20. UNDERTAKER: Schumacher & Hall — ADDRESS: Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

34468

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
JUL 12 1921
BUREAU OF VITAL STATISTICS

Registration District No. 28
Primary Registration District No. 241
File No. 41
Registered No. 3604

1. PLACE OF DEATH
County of Bannock
City of Pocatello (If outside limits, give township) No. 308 So. 9th ave (If not in hospital or institution, give street address or location) St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Eunice Block

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	white	Single

6. DATE OF BIRTH: Jan. 31 (Month) (Day) 1921 (Year)

7. AGE: — Yrs. 4 Mos. 13 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Pocatello, Idaho

10. NAME OF FATHER: Yancey D. Block

11. BIRTHPLACE OF FATHER (State or Country): Nebraska.

12. MAIDEN NAME OF MOTHER: Alice Kelsey

13. BIRTHPLACE OF MOTHER (State or Country): Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Yancey D. Block
(Address) 308 So. 9th ave. Pocatello, Idaho.

15. Filed June 14 1921 — J. W. Young, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 13. (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 2 1921, to June 13 1921
that I last saw h[illegible] alive on June 13 1921
and that death occurred on the date stated above, at 3 20 P. M.
The CAUSE OF DEATH* was as follows:

Whooping cough

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John J. Root M. D.
6/14 1921 (Address) Pocatello Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? Life in Pocatello
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mt View Cem — DATE OF BURIAL: June 15 1921

20. UNDERTAKER: H. L. McHan — ADDRESS: Pocatello Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED
JUL 12 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

34469

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 25
Primary Registration District No. 2141
File No. 41
Registered No. 3665

1. PLACE OF DEATH
County of Bannock
City of Pocatello (If outside limits of city or village, write RURAL.) (No. ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Fred Esser

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: May (Month) 24 (Day) 1889 (Year)

7. AGE: 32 Yrs. — Mos. 19 ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Lake Shore Utah.

10. NAME OF FATHER: Edward Esser

11. BIRTHPLACE OF FATHER (State or Country): St Louis

12. MAIDEN NAME OF MOTHER: Mary S Davis

13. BIRTHPLACE OF MOTHER (State or Country): Salt Lake City Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Fred Esser
(Address) 235 - So 8th

15. Filed 6/15 1921

J H Mowry
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 13 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 1921 to June 12 1921 that I last saw h[illegible] alive on June 12 1921 and that death occurred on the date stated above, at [illegible] M.
The CAUSE OF DEATH* was as follows:
Carcinoma of Sigmoid

(Duration) ... Yrs. ... mos. ... ds.
Contributory (Secondary)
(Duration) ... yrs. ... mos. ... ds.

(Signed) D C Ray M. D.
6/15 1921 (Address) Pocatello Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Bancroft Ida. DATE OF BURIAL: June 16 1921

20. UNDERTAKER: Schumacher & Hall ADDRESS: Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

34470

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 25
Primary Registration District No. 2161
File No. 41
Registered No. 3604

1. PLACE OF DEATH

County of Bannock

City of Pocatello (No. 245 No Hayes St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

RECEIVED
JUL 12 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME Mrs Julia Nancy Olmsted

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widow (Write the word.)

6. DATE OF BIRTH: April (Month) 16th (Day) 1845 (Year)

7. AGE: 76 Yrs. 2 Mos. 2 ds.

IF LESS than 1 day how many..... hrs. or.....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Williams County Ohio

10. NAME OF FATHER: Cady James Puffer

11. BIRTHPLACE OF FATHER (State or Country): "

12. MAIDEN NAME OF MOTHER: Charlotte Gibber

13. BIRTHPLACE OF MOTHER (State or Country): "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
Mrs H.E Ray
(Informant)
(Address) Pocatello Idaho

15. Filed 6 20 1921

Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 18th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1920 to June 17th 1921 that I last saw her alive on June 17th 1921 and that death occurred on the date stated above, at 5:15 P.M.

The CAUSE OF DEATH* was as follows:

Nephritis

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. Sam D. Doherty M. D.

6/18/1921 (Address) Pocatello

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mt View Cemetery — DATE OF BURIAL: 6/20/21

20. UNDERTAKER: Will T. Walker — ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

34471

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
JUL 12 1921
BUREAU OF VITAL STATISTICS

Registration District No. 28
Primary Registration District No. 241
File No. 41
Registered No. 607

1. PLACE OF DEATH
County of Bannock
City of Pocatello (No. 324 - La Mann St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Emma Lydia Jones
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: September 26 1897 (Month) (Day) (Year)

7. AGE: 23 Yrs. 8 Mos. 22 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Coalville Utah.

10. NAME OF FATHER: Wm H Stones

11. BIRTHPLACE OF FATHER (State or Country): Wyoming

12. MAIDEN NAME OF MOTHER: Martha McWright

13. BIRTHPLACE OF MOTHER (State or Country): Coalville Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Frank Jones
(Address): 513 - La Mann

15. Filed 6/20 1921
J P Young
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 18 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 10 1921, to June 18 1921, that I last saw h[illegible] alive on June 17 1921, and that death occurred on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:
Myocarditis & Nephritis

(Duration) 0 Yrs. 7 mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) J P Young M. D.
6/20 1921 (Address) Pocatello

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain View Cem — DATE OF BURIAL: June 20 1921

20. UNDERTAKER: Schumacher & Hall — ADDRESS: Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED JUL 12 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

28 34472

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bannock Registration District No. 2161 File No. 41

City of Pocatello (No. 365 So. 6th Ave. St.) Registered No. 2608

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Leo Leroy Agnew

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6. DATE OF BIRTH: July (Month) 2 (Day) 1905 (Year)

7. AGE: 15 Yrs. 11 Mos. 17 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Montana

10. NAME OF FATHER: Dan Agnew

11. BIRTHPLACE OF FATHER (State or Country): Minnesota

12. MAIDEN NAME OF MOTHER: Rosella Ryon

13. BIRTHPLACE OF MOTHER (State or Country): Minnesotta

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Dan Agnew
(Address) 305 so 6th ave Pocatello

15. Filed June 20 1921 — J. Mc Kean, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 19 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 19 1921, to June 19 1921, that I last saw h... alive on June 19 1921, and that death occurred on the date stated above, at 3.0 P. M.,
The CAUSE OF DEATH* was as follows:
Thrombus Tuberculosis - accidental
Typhoid about week
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) [illegible] M. D.
June 20 1921 (Address) Pocatello, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 10 yrs. ..... mos. ..... days. In the State 16 yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence Montana

19. PLACE OF BURIAL OR REMOVAL: Mt View Cem. DATE OF BURIAL: June 22 1921

20. UNDERTAKER: H. L. McHan ADDRESS: Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

34473

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
JUL 12 19
BUREAU OF STATISTICS

1. PLACE OF DEATH

County of Bannock — Registration District No. 28

City of Pocatello — Primary Registration District No. 7161

(No.) Lynn Bros Hospital (St.)

File No. 41

Registered No. 3609

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ruth C Bolander

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Oct (Month) 9 (Day) 1901 (Year)

7. AGE: 18 Yrs. 8 Mos. 14 ds.

IF LESS than 1 day how many..... hrs. or.....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Telephone Operator

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Salt Lake City Utah

10. NAME OF FATHER: Andrew C.Bolander

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: Annie Crane

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Andrew C.Bolander

(Address) Ogden Utah,

15. Filed 6/24 19 21

Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 23 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 16th 1921 to June 23rd 1921 that I last saw her alive on June 23rd 1921 and that death occurred on the date stated above, at 4:30 P.M.

The CAUSE OF DEATH* was as follows:

Meningitis

(Duration) ..... Yrs. ..... mos. 5 ds.

Contributory (Secondary): none

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. W. Lynn M. D.

6/24/21 (Address) Pocatello

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence Ogden utah

19. PLACE OF BURIAL OR REMOVAL: Ogden Utah — DATE OF BURIAL: 6/29/21

20. UNDERTAKER: Will T Walker — ADDRESS: Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

34474

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
JUL 12 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 28

Primary Registration District No. 2141

File No. 41

Registered No. 2410

County of Bannock

City of Pocatello (Lynn Bros Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Logan Wester

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Male	White	Single (Write the word.)

6. DATE OF BIRTH: Sept (Month) 7 (Day) 1888 ~~921~~ (Year)

7. AGE: 32 Yrs. 9 Mos. 17 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Chaufeer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mo

10. NAME OF FATHER: John Wester

11. BIRTHPLACE OF FATHER (State or Country): Mo

12. MAIDEN NAME OF MOTHER: Livina Tyler

13. BIRTHPLACE OF MOTHER (State or Country): Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Wester

(Address) Pocatello

15. Filed 7/7 1921

J. R. Young, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 24th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 23 1921, to June 24 1921, that I last saw him alive on June 24 1921, and that death occurred on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:

Shock following
Dr Losing Of High Pressure
Collapse & Intracranial Hemorrhage

(Duration) ..... Yrs. ..... mos. 1 ds.

Contributory (Secondary): none

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Dr Lynn M. D.

June 24 1921 (Address) Pocatello Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: [illegible] | DATE OF BURIAL: 7/7 1921

20. UNDERTAKER: [illegible] | ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED JUL 12 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

34475

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bannock Registration District No. 25

City of Pocatello (No. General Hospital St.) Primary Registration District No. 2641

File No. 41

Registered No. 3411

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James Stuart Higham

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Infant (Write the word.)

6. DATE OF BIRTH: June (Month) 26 (Day) 1921 (Year)

7. AGE: — Yrs. — Mos. 2 ds.

IF LESS than 1 day: how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Pocatello Ida.

10. NAME OF FATHER: Thos B. Higham

11. BIRTHPLACE OF FATHER (State or Country): Salt Lake City Utah

12. MAIDEN NAME OF MOTHER: Ida Hutchinson

13. BIRTHPLACE OF MOTHER (State or Country): Florida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Thos B. Higham

(Address) Pocatello

15. Filed 6/28 1921 J. H. Mooney Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 28 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 6-26 1921, to 6-28 1921, that I last saw h. alive on 6-28 1921, and that death occurred on the date stated above, at 12:30 M.

The CAUSE OF DEATH* was as follows:

Status Lymphaticus

(Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.

6/28 1921 (Address) Pocatello

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Salt Lake City, Ut. DATE OF BURIAL: June 29 1921

20. UNDERTAKER: Schumacher & Holt ADDRESS: Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

34476

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
JUL 19 1921
BUREAU OF VITAL STATISTICS

Registration District No. 28
Primary Registration District No. 2141
File No. 42
Registered No. 3612

1. PLACE OF DEATH
County of Bannock
City of Pocatello (If not in hospital, give street address.) General Hospital St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lavernia R.Pease

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: March (Month) 18 (Day) 1858 (Year)

7. AGE: 63 Yrs. 3 Mos. 10 ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Crown Point N.Y.

10. NAME OF FATHER: Dr Doolittle

11. BIRTHPLACE OF FATHER (State or Country): *

12. MAIDEN NAME OF MOTHER: Lavernia Rawson

13. BIRTHPLACE OF MOTHER (State or Country): *

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E.A.Pease
(Address) 333 N.Main St

15. Filed 6/24 1921 [signature] Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 28 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 20 1921, to June 28 1921, that I last saw h... alive on June 28 1921, and that death occurred on the date stated above, at 7 A.M.

The CAUSE OF DEATH* was as follows:

[illegible]

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) [signature] M. D.

June 28 1921 (Address) [illegible]

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Mt View Cemetery	6/29/21
20. UNDERTAKER: Will T.Walker	ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A--25 M. 1-19.

RECEIVED
JUL 12 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

34477

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 28
Primary Registration District No. 2141
File No. 42
Registered No. 3613

1. PLACE OF DEATH
County of Bannock
City of Pocatello (Gem Bros Hospital St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Peter Christen Petersen
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: July (Month) 22 (Day) 1877 (Year)

7. AGE: 43 Yrs. 11 Mos. 6 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Carpenter
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Denmark

10. NAME OF FATHER: Anders C Petersen

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: Pauline C. Hojyer

13. BIRTHPLACE OF MOTHER (State or Country): Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Peter C Petersen
(Address) 245 — No 13th

15. Filed 6/30 1921 — [signature] Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 28 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 9 1921, to June 28 1921, that I last saw h. alive on June 28 1921, and that death occurred on the date stated above, at 4P M.
The CAUSE OF DEATH* was as follows: Typhoid Fever

(Duration) — Yrs. — mos. 18 ds.
Contributory (Secondary)
(Duration) ... yrs. ... mos. ... ds.
(Signed) [signature] M. D.
June 30 1921 (Address) Pocatello Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain View Cem — DATE OF BURIAL: June 30 1921

20. UNDERTAKER: Schumacher & Hall — ADDRESS: Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
JUN 28 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 12
Primary Registration District No. 12
File No. 34478
Registered No. 5

1. PLACE OF DEATH
County of Boise
City of Grimes Pass (If outside limits of city or village, give township.) St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Grace Bunts

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH: June 5 1921 (Month) (Day) (Year)

7. AGE: 1 day. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Grimes Pass

10. NAME OF FATHER: Ariel Bunts

11. BIRTHPLACE OF FATHER (State or Country): Salt Lake.

12. MAIDEN NAME OF MOTHER: Grace Bunts

13. BIRTHPLACE OF MOTHER (State or Country): Boise

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Goddard
(Address)

15. Filed 19 Mrs E S Kolrow
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 6 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 19, to 19, that I last saw h alive on 19, and that death occurred on the date stated above, at M.
The CAUSE OF DEATH* was as follows:

(Duration) Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) M. D.
19 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Grimes Pass
DATE OF BURIAL: June 7 1921

20. UNDERTAKER
ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

1528

ONLY ONE DEATH CERT FILED FOR WHICH TWIN UNKNOWN

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL *septicemia,*" "PUERPERAL *peritonitis,*" etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

TWINS (F) BUNCE

1921 - 91335 OR
1921 - 91409

FORM V. S. No. 5-A--25 M. 1-19.

CERTIFICATE OF DEATH

34479

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 1 85

Primary Registration District No. 2185

File No. 1

County of Bonner

City of Priest River (No. ..... St.)

Registered No. 41

RECEIVED
JUL 5 1921
BUREAU OF VITAL STATISTICS

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Patrecia June Mears.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Single

6. DATE OF BIRTH: June (Month) 10 (Day) 1921 (Year)

7. AGE: ---- Yrs. ---- Mos. 20 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Idaho,

10. NAME OF FATHER Paul Mears

11. BIRTHPLACE OF FATHER (State or Country) ~~XXX~~ Wis.

12. MAIDEN NAME OF MOTHER Sylvia Douglas

13. BIRTHPLACE OF MOTHER (State or Country) Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Paul.L. Mears

(Address) Priest River

15. Filed July 1 1921

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 30 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 10 1921, to Junen 30 1921, that I last saw her alive on June 24 1921, and that death occurred on the date stated above, at 3 A. M.

The CAUSE OF DEATH* was as follows:

Hemarrhage of lung.

(Parents found child dead in its bed)

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) [signature] M. D.

July 1 1921 (Address) Priest River, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF ~~BURIAL~~ OR REMOVAL Priest River Idaho

DATE OF BURIAL July 1 1921

20. ~~UNDERTAKER~~ Paul Mears

ADDRESS Priest River

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34480
Registered No.

1. PLACE OF DEATH

Registration District No. 59
Primary Registration District No. 2129

County of Butte
City of Arco (If outside limits, give township) St.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED JUL 8 1921 BUREAU OF VITAL STATISTICS

2. FULL NAME John H. Johnson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Jan 8, 1860 (Month) (Day) (Year)

7. AGE: 61 Yrs. 5 Mos. 22 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Dalarna, Sweden

10. NAME OF FATHER: John Hansen

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Anna —

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): himself
(Address):

15. Filed 7-1-1921 H. M. Cannon
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 30, 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5-28-1921, to 6-30-1921
that I last saw him alive on 6-30-1921
and that death occurred on the date stated above, at 3 P. M.
The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 2 Yrs. 6 mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) H. M. Cannon M. D.
6-30 1921 (Address) Arco, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Arco, Ida — DATE OF BURIAL: 7-1-1921

20. UNDERTAKER: Hendricks — ADDRESS: Arco

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JUL 8 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34481

Registered No.

1. PLACE OF DEATH

Registration District No. 59

Primary Registration District No. 2129

County of Butte

City of Arco (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Clara C. Mitton

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Aug. 1, 1885
(Month) (Day) (Year)

7. AGE: 35 Yrs. 0 Mos. 9 ds.

IF LESS than 1 day how many..... hrs. or.....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housf.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah.

10. NAME OF FATHER: James Jensen

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: Anna Larsen

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Mitton
(Address): Arco

15. Filed 6/23 1921 H. McCann
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 22 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 6-21- 1921, to 6-22- 1921
that I last saw her alive on 6-23- 1921
and that death occurred on the date stated above, at 9.50 A. M.
The CAUSE OF DEATH* was as follows:

Puerperal Hemorrhage

(Duration) Yrs. mos. 1 ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) H. McCann M. D.
6/23 1921 (Address) Arco Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Hyrum Utah | DATE OF BURIAL 19

20. UNDERTAKER: E. J. Peck | ADDRESS: Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 58d

Primary Registration District No. 2138

File No. 34482

County of Canas

City of Manard (No. ..... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

RECEIVED JUL 10 1921 BUREAU OF VITAL STATISTICS

2. FULL NAME Edna Vandiver

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: married (Write the word.)

6. DATE OF BIRTH: October (Month) 26th (Day) 1884 (Year)

7. AGE: 36 Yrs. 7 Mos. 25 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: Chester Woods

11. BIRTHPLACE OF FATHER (State or Country): Wisconsin

12. MAIDEN NAME OF MOTHER: Maggie Sleeth

13. BIRTHPLACE OF MOTHER (State or Country): Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jesse P. Vandiver

(Address) Manard, Idaho.

15. Filed July 6th 1921 L Wilencheck Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 20th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 17th 1921 to June 20th 1921 that I last saw h[e]r alive on June 19th 1921 and that death occurred on the date stated above, at 6:00 A.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

..... (Duration) ..... Yrs. ..... mos. 2½ ds.

Contributory (Secondary) Puerperium (Duration) ..... yrs. ..... mos. 3½ ds.

(Signed) L Wilencheck M. D.

July 6th 1921 (Address) Fairfield, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL ..... 19.....

20. UNDERTAKER | ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JUL 10 19 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 58

County of Camas — County Registration District No. 2138

File No. 34483

City of Fairfield (No. ....., ... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Thomas Gillett Brandon

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: August (Month) 2d (Day) 1880 (Year)

7. AGE: 40 Yrs. 10 Mos. 22 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Rancher

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Woodman, Wisc.

10. NAME OF FATHER: Robert Brandon

11. BIRTHPLACE OF FATHER (State or Country): Pennsylvania

12. MAIDEN NAME OF MOTHER: Maria Rands

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Bert Rands

(Address) Fairfield, Idaho

15. Filed July 6d 19 21 — L Wilencheck, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 24th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 9d 1921, to June 24th 1921, that I last saw him alive on June 23rd 1921, and that death occurred on the date stated above, at 6 00 A.M.

The CAUSE OF DEATH* was as follows:

Rocky Mountain Spotted Fever

..... (Duration) ..... Yrs. ..... mos. 20 ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) L Wilencheck M. D.

July 6d 1921 (Address) Fairfield, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL ..... 19 .....

20. UNDERTAKER | ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34484
Registered No.

RECEIVED
JUL 10 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Canyon
City of Smith's Ward (No. ..... St.)
Registration District No.
Primary Registration District No. 2224

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sally L. Tucker

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Nov (Month) 24 (Day) 1850 (Year)

7. AGE: [illegible] Yrs. 6 Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mo.

10. NAME OF FATHER: Elizabeth Rucker

11. BIRTHPLACE OF FATHER (State or Country): Kenty.

12. MAIDEN NAME OF MOTHER: Jeremiah Barnes

13. BIRTHPLACE OF MOTHER (State or Country): Kenty.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Willie C Tucker
(Address) Emmett Idaho

15. Filed July 8 1921 Pearle Dodd Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 28 (Day) 21 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 23 1921 to June 28 1921, that I last saw h.er alive on June 28 1921, and that death occurred on the date stated above, at 11 P.M.
The CAUSE OF DEATH* was as follows:
Pneumonia
(Duration) ..... Yrs. ..... mos. 5 ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) H. H. Rowe M. D.
July 9 1921 (Address) Nampa Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Fohrlaun Cem. DATE OF BURIAL: 7/2 1921
20. UNDERTAKER: Fred T. Robinson ADDRESS: Nampa

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34485
Registered No.

1. PLACE OF DEATH

Registration District No. 7
Primary Registration District No. 2006
County of Canyon
City of Melba (If outside limits, give township) St.)

RECEIVED
JUL 10 1921
BUREAU OF VITAL STATISTICS

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Halvor Evon Halverson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widowed
6. DATE OF BIRTH: July 16 1847 (Month) (Day) (Year)
   June 23 1921 (Month) (Day) (Year)
7. AGE: 74 Yrs. 11 Mos. 8 ds.
   IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
   (a) Trade, profession or particular kind of work: Farmer.
   (b) General nature of industry, business or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Norway.
10. NAME OF FATHER: Thurston Halverson
11. BIRTHPLACE OF FATHER (State or Country): Norway.
12. MAIDEN NAME OF MOTHER: Not Known
13. BIRTHPLACE OF MOTHER (State or Country): Not Known
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
    (Informant) [signature]
    (Address) Melba, Ida.
15. Filed July 9 1921 Pearle Dodds
    Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 23 (Day) 1921 (Year)
17. I HEREBY CERTIFY, That I attended deceased from June 22 1921, to June 23 1921
    that I last saw him alive on June 22 1921
    and that death occurred on the date stated above, at 11:30 P.M.
    The CAUSE OF DEATH* was as follows:
    Cardiac decompensation
    cardiac dilitation.
    (Duration) ..... Yrs. ..... mos. 2 ds.
    Contributory (Secondary) Senility
    (Duration) ..... yrs. ..... mos. 2 ds.
    (Signed) Samuel M. Wagstaff M. D.
    19 ..... (Address) Melba, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
    At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
    Where was disease contracted if not at place of death?
    Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Kohlerlawn Cem. DATE OF BURIAL: 6/25 1921
20. UNDERTAKER: Fred A. Peterson ADDRESS: Nampa

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34486

RECEIVED
JUL 10 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
Registration District No. 7
Primary Registration District No. 2006
County of Ada
City of Nampa St.)
If death occurs away from usual residence, give facts called for under special information.

Registered No.

2. FULL NAME Thomas M. Brown
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Dec (Month) 3 (Day) 1879 (Year)

7. AGE: 42 Yrs. 8 Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mo.

10. NAME OF FATHER: Francis M. Brown

11. BIRTHPLACE OF FATHER (State or Country): Penn

12. MAIDEN NAME OF MOTHER: Sarah Morris

13. BIRTHPLACE OF MOTHER (State or Country): Kentucky.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. T. E. Brown
(Address) Nampa Ida.

15. Filed July 8 1921 Pearle Dodds Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 8 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 2, 1921, to July 8, 1921, that I last saw h[illegible] alive on July 8 1921 and that death occurred on the date stated above, at 4 P. M.
The CAUSE OF DEATH* was as follows:
Perforating Duodenal Ulcer
(Duration) Yrs. mos. 6 ds.
Contributory (Secondary) Peritonitis
(Duration) yrs. mos. ds.
(Signed) Marion J. Funk M. D.
July 9 1921 (Address) Nampa Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Riverside Cal. DATE OF BURIAL: 7/12 1921

20. UNDERTAKER: H. K. Robinson ADDRESS: Nampa

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

Finke

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34487
Registered No.

RECEIVED
JUL 10 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Canyon Registration District No. 7
Primary Registration District No. 2 [illegible]
City of Nampa (No.) St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John M. Phillips

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Feb (Month) 9 (Day) 1829 (Year)

7. AGE: 92 Yrs. 5 Mos. * ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Maryland

10. NAME OF FATHER: Jesse Phillips

11. BIRTHPLACE OF FATHER (State or Country): unknown

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. A. Phillips
(Address) Nampa Ida

15. Filed July 9 1921 Pearle Dodds Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 7 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 6 1921, to July 7 1921, that I last saw h[illegible] alive on July 7 1921, and that death occurred on the date stated above, at 3 P. M.
The CAUSE OF DEATH* was as follows:

Senile paralysis

(Duration) ..... Yrs. ..... mos. 2 ds.
Contributory (Secondary): old age
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. P. Murray M. D.
7/8 1921 (Address) Nampa Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rohrlaugh Cem. DATE OF BURIAL: 7/9 1921

20. UNDERTAKER: Fred T. Robinson ADDRESS: Nampa

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A--25 M. 1-19.

RECEIVED
JUL 10 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. ____
Primary Registration District No. 1956
File No. 34488
Registered No. ____

1. PLACE OF DEATH

County of Canyon
City of Nampa (No. ____, ____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Frances A. Dennis

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Dec (Month) 20 (Day) 1857 (Year)

7. AGE: 69 Yrs. 5 Mos. 23 ds.
IF LESS than 1 day how many ____ hrs. or ____ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer): ____

9. BIRTHPLACE (State or Country): Tenn

10. NAME OF FATHER: Jim Pippen

11. BIRTHPLACE OF FATHER (State or Country): Tenn.

12. MAIDEN NAME OF MOTHER: Alice Barnes

13. BIRTHPLACE OF MOTHER (State or Country): Tenn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. E. Dennis.
(Address) Nampa

15. Filed July 1921 Pearle Woods Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 13 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ____ 19____, to ____ 19____, that I last saw h____ alive on ____ 19____, and that death occurred on the date stated above, at 3 A.M.

The CAUSE OF DEATH* was as follows:
Senility with Arteriosclerosis - did not see (See Over)
(Duration) ____ Yrs. ____ mos. ____ ds.
Contributory (Secondary) Pleurisy with effusion one month ago
(Duration) ____ Yrs. 2 mos. ____ ds.
(Signed) Geo. R. Proctor M. D.
Jun 13 1921 (Address) Nampa Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days
Where was disease contracted if not at place of death? ____
Former or usual residence ____

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Mo.	6/1 1921
20. UNDERTAKER	ADDRESS
L. T. Robinson	Nampa

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A--25 M. 1-19.

RECEIVED
JUL 10 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 1086
File No. 34489
Registered No.

1. PLACE OF DEATH
County of Canyon
City of Nampa (No. St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Odella Warmouth

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.):

6. DATE OF BIRTH: April (Month) 6 (Day) 1919 (Year)

7. AGE: 2 Yrs. 3 Mos. 14 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Minn.

10. NAME OF FATHER: Wm. Warmouth

11. BIRTHPLACE OF FATHER (State or Country): Minn.

12. MAIDEN NAME OF MOTHER: Ramona Marks

13. BIRTHPLACE OF MOTHER (State or Country): Minn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H. O. Mark
(Address) Nampa, Ida

15.
Filed July 1921 Pearle Dodds Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 20 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 10 1921, to June 20 1921, that I last saw her alive on June 20 1921, and that death occurred on the date stated above, at 9a M.
The CAUSE OF DEATH* was as follows:

Diphtheria

(Duration) ..... Yrs. ..... mos. 10 ds.
Contributory (Secondary)
(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) Marion C. Frank M. D.
June 29 1921 (Address) Nampa Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Nampa	June 1921
20. UNDERTAKER	ADDRESS
H. P. Emerson	Nampa

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34490
Registered No.

Registration District No. 7
Primary Registration District No. 1004

RECEIVED
JUL 10 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Canyon
City of Nampa
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Elizabeth Meglemre

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem.
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word)

6. DATE OF BIRTH: Oct. (Month) 6 (Day) 1842 (Year)

7. AGE: 78 Yrs. 8 Mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife,
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: Hamm

11. BIRTHPLACE OF FATHER (State or Country): ✓

12. MAIDEN NAME OF MOTHER: ✓

13. BIRTHPLACE OF MOTHER (State or Country): ✓

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Geo. W. Meglemre
(Address) Nampa, Idaho

15.
Filed July 8 1921 Pearle Dodds
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) - 8 (Day) - 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1921 to June 8 1921 that I last saw h.. alive on June 8th 1921, and that death occurred on the date stated above, at 4 P M.
The CAUSE OF DEATH* was as follows:
Mitral Insufficiency

..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Thos. E. Maguire M. D.
..... 19..... (Address) Nampa Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Pullman Wash. | DATE OF BURIAL: 6-27 1921
20. UNDERTAKER: Fred G Robinson | ADDRESS: Nampa

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A--25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34491

Registration District No. 7
Primary Registration District No. 1006
Registered No.

RECEIVED JUL 10 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Canyon
City of Nampa (If outside limits of city or village, give township.) St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME W. A. Redman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Feb (Month) 16 (Day) 1840 (Year)

7. AGE: 81 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ken.

10. NAME OF FATHER: Janet Redman

11. BIRTHPLACE OF FATHER (State or Country): Kentucky

12. MAIDEN NAME OF MOTHER: Galey

13. BIRTHPLACE OF MOTHER (State or Country): Ken.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) James G. Lupton
(Address)

15. Filed July 8 1921 Pearle Dodds Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 18 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2-25 1921, to 6-10 1921, that I last saw him alive on 6-10 1921, and that death occurred on the date stated above, at 1. P.M.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) Yrs. mos. ds.

Contributory (Secondary) Arterio-sclerosis

(Duration) Several yrs. mos. ds.

(Signed) H G Robinson M. D.

6-21 1921 (Address) Nampa

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Kohlerstown Cem. DATE OF BURIAL: 6-21 1921

20. UNDERTAKER: Fred H Robinson ADDRESS: Nampa

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED
JUL 10 1921
BUREAU OF STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 1056
File No. 34492
Registered No.

1. PLACE OF DEATH
County of Canyon
City of Nampa (No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elder Wood Blythe
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Aug (Month) 8 (Day) 1840 (Year)

7. AGE: 61 Yrs. 9 Mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mo.

10. NAME OF FATHER: Smith

11. BIRTHPLACE OF FATHER (State or Country): Mo.

12. MAIDEN NAME OF MOTHER: unknown

13. BIRTHPLACE OF MOTHER (State or Country): Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. Blythe
(Address) Bellevue Ida

15. Filed July 8 1921 Pearle Dodds Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 14 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1920, to Dec 1921, that I last saw her alive on Dec 1920, and that death occurred on the date stated above, at about 7-30 P.M.
The CAUSE OF DEATH* was as follows:
Apoplexy

(Duration) about 1 Yrs. mos. ds.
Contributory (Secondary) Arterio Sclerosis
(Duration) about 1 yrs. mos. ds.
(Signed) H C Robinson M. D.
19 (Address) Nampa

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Forestview Cem | DATE OF BURIAL: 7-2 1921

20. UNDERTAKER: Fred R Peterson | ADDRESS: Nampa

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
JUL 10 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 7

Primary Registration District No. 1856

File No. 34493

County of Canyon

City of Nampa (St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Thos Quinn

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Dec (Month) 25 (Day) 1843 (Year)

7. AGE: 78 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Watchman R.R. Service

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ireland

10. NAME OF FATHER: unknown

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country): unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs P H Donovan

(Address)

15. Filed July 8 1921 Pearle Dodds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 12 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 4th 1921 to June 12th 1921 that I last saw h[illegible] alive on June 12 1921 and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Result of being struck by automobile while on duty on railroad crossing.

(Duration) Yrs. mos. 39 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Thos. B. Scott M. D.

June 14 1921 (Address) Nampa, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rohlerbaugh Cem — DATE OF BURIAL: 6/14 1921

20. UNDERTAKER: Fred R Robinson — ADDRESS: Nampa

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED
JUL 10 1921
BUREAU OF STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 7

Primary Registration District No. 1506

File No. 34494

County of Canyon

City of Nampa (No. ..... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Clement V. Whallon

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
male	white	married

6. DATE OF BIRTH: Sept. (Month) 2 (Day) 1866 (Year)

7. AGE: 54 Yrs. 9 Mos. 26 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Superintendent
(b) General nature of industry, business or establishment in which employed (or employer): City Water Works

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Thomas Whallon

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. C. V. Whallon
(Address) Nampa

15. Filed July 8 1921 Pearle Dodds Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 28 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Crushing of head and body by an accidental cave in of a 16 ft sewer ditch.

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Paul L. Coats M.D.
County Coroner, Caldwell Idaho
19 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Rohlerdawn Cem	7/1 1921
20. UNDERTAKER	ADDRESS
Ford & Robinson	Nampa

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34495

Registration District No. 7
Primary Registration District No. 1102

RECEIVED
JUL 10 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Canyon
City of Nampa (or Village or Township) St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John F Pugh

Registered No.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Sept (Month) 4 (Day) 1 (Year)

7. AGE: 32 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: John Pugh

11. BIRTHPLACE OF FATHER (State or Country): Ill.

12. MAIDEN NAME OF MOTHER: Ruth Connor

13. BIRTHPLACE OF MOTHER (State or Country): Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Ida Gilman
(Address) 1109 4th St N Nampa

15. Filed July 8 1921 Pearle D. Dodds Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 28 1921 (Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Crushing of head and body by an accidental cave in of a 16 ft sewer ditch.

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. L. Evans M. D.
County Coroner, Caldwell Idaho
19..... (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rohlsburg Cem — DATE OF BURIAL: 6/30 1921

20. UNDERTAKER: Fred T Hartman — ADDRESS: Nampa

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
JUL 10 1921
BUREAU OF VIT STATISTICS

1. PLACE OF DEATH

County of Canyon Registration District No. 7

City of Nampa Primary Registration District No. 1864

(St.)

File No. 34496

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Joanna McGuire

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: W.S.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: married (Write the word.)

6. DATE OF BIRTH: March 30 (Month) 1855 (Day) (Year)

7. AGE: 65 Yrs. 3 Mos. 25 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Jane Mo.

10. NAME OF FATHER: Carslile Russell

11. BIRTHPLACE OF FATHER (State or Country): Mo.

12. MAIDEN NAME OF MOTHER: Allie Davenport

13. BIRTHPLACE OF MOTHER (State or Country): Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. W. Mangum
(Address) 1016 10th Ave South

15. Filed July 8 1921 Pearle Dodds Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 25 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1 - 1920, to June 25 - 1921 that I last saw her alive on June 25 1921, and that death occurred on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:
Cancer of Rectum

(Duration) Yrs. 18 mos. ds.

Contributory (Secondary)

(Duration) — yrs. mos. ds.

(Signed) Thos J. Mangum M. D.

June 26 1921 (Address) Nampa

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 1 yrs. mos. days. In the State yrs. 14 mos. days

Where was disease contracted if not at place of death? Ardmore, Okla

Former or usual residence Ardmore "

19. PLACE OF BURIAL OR REMOVAL: Fohlenlawn Cem — DATE OF BURIAL: 6/26/1921

20. UNDERTAKER: Fred R Robinson — ADDRESS: Nampa

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A--25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34497
Registered No.

RECEIVED
JUL 10 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
Registration District No. 7
Primary Registration District No. 1086
County of Canyon
City of Nampa (Ward) (St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jessie M. Clapp
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem.
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.):

6. DATE OF BIRTH: May 31 (Month) (Day) 1921 (Year)

7. AGE: Yrs. 2 Mos. 9 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: ✓
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Washington

10. NAME OF FATHER: Henry Clapp

11. BIRTHPLACE OF FATHER (State or Country): Arkansas

12. MAIDEN NAME OF MOTHER: Mary L Kinner

13. BIRTHPLACE OF MOTHER (State or Country): ✓

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Frank C. Clapp
(Address) Nampa, Idaho

15.
Filed July 8 1921 Pearle Dodds
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 11 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 11 1921 to Jun 11 1921 that I last saw her alive on Jun 11 - 10 AM 1921, and that death occurred on the date stated above, at 1 P. M.
The CAUSE OF DEATH was as follows:
Acute Gastro Enteritis

(Duration) — Yrs. — mos. 7 ds.
Contributory (Secondary)
(Duration) — yrs. — mos. — ds.

(Signed) Les W Chilton M. D.
(Address) Nampa Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rohrbaugh Cem. DATE OF BURIAL: 6/11/1921
20. UNDERTAKER: Fred T Robinson ADDRESS: Nampa

MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34498

Registered No.

RECEIVED
JUL 10 1921
BUREAU OF VIT STATISTIC

1. PLACE OF DEATH

Registration District No. 7

Primary Registration District No. 1006

County of Canyon

City of Nampa No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sherman Rhodes

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	White	Widowed

6. DATE OF BIRTH: Oct. (Month) 23 (Day) 1906 (Year)

7. AGE: 14 Yrs. 7 Mos. 27 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: At home

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Washington

10. NAME OF FATHER: John F. Rhodes

11. BIRTHPLACE OF FATHER (State or Country): Illinois

12. MAIDEN NAME OF MOTHER: Sarah F. Jones

13. BIRTHPLACE OF MOTHER (State or Country): Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John F. Rhodes

(Address) Nampa

15. Filed July 8 1921 Pearle Dodds Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 20 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 19 1921 to June 20 1921 that I last saw him alive on June 20 1921 and that death occurred on the date stated above, at 9a. M.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(Duration) ? Yrs. ? mos. ? ds.

Contributory (Secondary) Acidosis & Coma

(Duration) yrs. mos. 1 ds.

(Signed) Marion C. Finch M. D.

June 29 1921 (Address) Nampa Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Rohlerlawn Cem	6-22-1921
20. UNDERTAKER	ADDRESS
Fred H Peterson	Nampa

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED
JUL 10 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34499
Registered No.

1. PLACE OF DEATH
Registration District No. 7
County of Canyon
Primary Registration District No. Nampa
City of Nampa (No. , St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Duane T. Goodnight

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: June (Month) 21 (Day) 1921 (Year)

7. AGE: 0 Yrs. 0 Mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ida.

10. NAME OF FATHER: E. L. Goodnight

11. BIRTHPLACE OF FATHER (State or Country): Ida.

12. MAIDEN NAME OF MOTHER: Grace Lyons

13. BIRTHPLACE OF MOTHER (State or Country): Wash.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. L. Goodnight
(Address)

15. Filed July 9 1921 Pearle Dodds Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 25 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 20 1921, to ..... 19.....
that I last saw him alive on June 25 1921
and that death occurred on the date stated above, at 11 A. M.
The CAUSE OF DEATH* was as follows:
Pneumonia.

(Duration) ..... Yrs. ..... mos. 2 ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) J. B. Smith M. D.
7/9 1921 (Address) Nampa Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rolleda Cem. DATE OF BURIAL: 6/27 1921
20. UNDERTAKER: Fred H Robinson ADDRESS: Nampa

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34500
Registered No. 47

RECEIVED
JUN 30 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
Registration District No. 117
Primary Registration District No. 216
County of Cassia
City of Burley (If outside limits, give township) St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jennie Thomas Nielsen
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: July (Month) 16 (Day) 1891 (Year)

7. AGE: 31 Yrs. 10 Mos. 7 ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Spanish Fork Utah.

10. NAME OF FATHER: Llewellyn Thomas.

11. BIRTHPLACE OF FATHER (State or Country): Wales.

12. MAIDEN NAME OF MOTHER: Mary Jane Thomas.

13. BIRTHPLACE OF MOTHER (State or Country): Cedar City Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. Filbert Nielsen
(Address) R.F.D. 3. Burley Ida.

15. Filed June 22, 1921 Dr. J.C. Patterson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 23 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 16. 1921, to May 23 - 1921, that I last saw her alive on May 23 - 1921, and that death occurred on the date stated above, at 7:00 a.M.
The CAUSE OF DEATH* was as follows:
Appendicitis.
(Duration) — Yrs. — mos. 10 ds.
Contributory (Secondary)
(Duration) ... yrs. ... mos. ... ds.
(Signed) H.H. Cooper M. D.
6/22 1921. (Address) Burley Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Burley Ida. DATE OF BURIAL: May 25 1921.

20. UNDERTAKER: L.B. Talloyy ADDRESS: Burley Ida.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 2A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34501
Registered No. 317

RECEIVED
JUN 30 1921
BUREAU OF VITAL STATISTICS

Registration District No. 117
Primary Registration District No. 2196

1. PLACE OF DEATH

County of Cassia
City of Burley
If death occurs away from usual residence, give facts called for under special information.

No. 25 N. Malta St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Louis Eddie Gibson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH: April (Month) 28 (Day) 1921 (Year)

7. AGE: # Yrs. # Mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Burley Ida.

10. NAME OF FATHER: George W. Gibson

11. BIRTHPLACE OF FATHER (State or Country): Richmond Utah

12. MAIDEN NAME OF MOTHER: Lida Wise

13. BIRTHPLACE OF MOTHER (State or Country): Blackfoot Ida.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) George W. Gibson
(Address) Box 655 Burley Ida.

15. Filed June 27 1921 Dr. J. C. Patterson Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 11 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 7 1921, to May 11 1921, that I last saw him alive on May 11 1921, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Incompetency of Rt Heart

(Duration) ..... Yrs. ..... mos. 4 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. H. Cutler M. D.
19..... (Address) Burley

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Pella Ida.	May 12 1921
20. UNDERTAKER	**ADDRESS**
L. D. Jaeggy.	Burley Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

Patterson

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED JUN 30 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH 7

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 11

County of Cassia

Primary Registration District No. 2196

File No. 34502

City of Burley (St.)

Registered No. 342

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Carl Willie Schow

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: May (Month) 24 (Day) 1919 (Year)

7. AGE: 2 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Lehi. Utah

10. NAME OF FATHER: Floyd Schow

11. BIRTHPLACE OF FATHER (State or Country): Lehi Utah

12. MAIDEN NAME OF MOTHER: Goldie Horton

13. BIRTHPLACE OF MOTHER (State or Country): Lehi Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Floyd Schow

(Address) Burley Idaho

15. Filed 6-22-21 19 Dr. J. C. Patterson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 23rd (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 21 1921, to May 23 1921, that I last saw h[illegible] alive on May 23 1921, and that death occurred on the date stated above, at 20' M.

The CAUSE OF DEATH* was as follows:

Measles

(Duration) Yrs. mos. 10 ds.

Contributory (Secondary) Pneumonia

(Duration) yrs. mos. 2 ds.

(Signed) J. C. Patterson M. D.

6-22 1921 (Address) Burley, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Burley Ida. DATE OF BURIAL: May 26 1921.

20. UNDERTAKER: L. B. Jaccoby. ADDRESS: Burley Ida.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-12 M. 6-15-17.

RECEIVED JUN 30 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34503
Registered No. 216

1. PLACE OF DEATH
County of Cassia Registration District No. 117
City of Burley Primary Registration District No. 2196
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Winfield Scott Higgs

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Oct (Month) 16 (Day) 1847 (Year)

7. AGE: 73 Yrs. 6 Mos. 29 ds.
IF LESS than 1 day how many .... hrs. or .....min.?'

8. OCCUPATION
(a) Trade, profession or particular kind of work: School Teacher
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ind

10. NAME OF FATHER: William Higgs

11. BIRTHPLACE OF FATHER (State or Country): Ind

12. MAIDEN NAME OF MOTHER: Amanda Buel

13. BIRTHPLACE OF MOTHER (State or Country): Ky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mamie A Higgs
(Address) Burley Ida

15.
Filed June 22 1921 Dr. J. E. Patterson Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
May (Month) 14 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 3, 1921 to May 14 1921
that I last saw h[illegible] alive on May 14 1921
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Carcinoma Prostate

(Duration) 20 Yrs. ..... mos. ..... ds.
Contributory (Secondary) Pneumonia
(Duration) ..... Yrs. ..... mos. ..... ds.
(Signed) Joseph Henstead M. D.
19 .. (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Pleasant View Cemetery — DATE OF BURIAL: May 16 1921

20. UNDERTAKER: Nuwatt — ADDRESS: Burley Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34504

RECEIVED
JUN 30 1921
BUREAU OF VITAL STATISTICS

Registration District No. 117
Primary Registration District No. 296
Registered No. 310

1. **PLACE OF DEATH**
County of Cassia
City of Burley (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. **FULL NAME** Sarah Elvira Robinson.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. **SEX** Female
4. **COLOR OR RACE** White
5. **SINGLE, MARRIED, WIDOWED OR DIVORCED** Married. (Write the word.)

6. **DATE OF BIRTH** June (Month) 2 (Day) 1856 (Year)

7. **AGE** 64 Yrs. 11 Mos. 1 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. **OCCUPATION**
(a) Trade, profession or particular kind of work Housewife.
(b) General nature of industry, business or establishment in which employed (or employer)

9. **BIRTHPLACE** (State or Country) Nebraska.

10. **NAME OF FATHER** Joseph Huff.

11. **BIRTHPLACE OF FATHER** (State or Country) U. Canada.

12. **MAIDEN NAME OF MOTHER** Lucy.

13. **BIRTHPLACE OF MOTHER** (State or Country) Unknown.

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**
(Informant) S. E. Robinson.
(Address) R.F.D. #4 Burley Ida.

15. Filed June 22 1921 Dr. J. C. Patterson Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH**
May (Month) 3 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....
and that death occurred on the date stated above, at 3:30 P. M.
The CAUSE OF DEATH* was as follows:
Insanity, & Senile debility.
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) L. B. Scoggy - Coroner - M. D.
May 4 1921 (Address) Burley Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. **PLACE OF BURIAL OR REMOVAL** Burley Ida. **DATE OF BURIAL** May 4 1921.

20. **UNDERTAKER** L. B. Scoggy. **ADDRESS** Burley Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34505
Registered No. 509

RECEIVED
JUN 30 1921
BUREAU OF VITAL STATISTICS

Registration District No. 117
Primary Registration District No. 2196

1. PLACE OF DEATH
County of Cassia
City of Burley (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ellen Lamb Brown

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widow (Write the word.)

6. DATE OF BIRTH: Aug. (Month) 22 (Day) 1839 (Year)

7. AGE: 81 Yrs. 8 Mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Scotland.

10. NAME OF FATHER: William Nish

11. BIRTHPLACE OF FATHER (State or Country): Scotland

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Solomon Hansen
(Address) R. F. D. # 2. Burley Ida.

15. Filed January 22 1921 Dr. J. C. Patterson Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 2 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19....., that I last saw h..... alive on ..... 19....., and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
General Debility

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) L. B. Talloghy - Coroner M. D.

19..... (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Burley Idaho. DATE OF BURIAL: May 3 1921

20. UNDERTAKER: L. B. Talloghy ADDRESS: Burley Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED
JUN 30 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 117
Primary Registration District No. 2196
File No. 34506
Registered No. 208

1. PLACE OF DEATH

County of Cassia
City of Burley (No. ....., St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Joseph K. Paris

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male.	White	Single

6. DATE OF BIRTH
Unknown. (Month) (Day) 1853 (Year)

7. AGE
68 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Manager and President Mining Co.
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE
(State or Country) Minn.

10. NAME OF FATHER
J. L. Paris.

11. BIRTHPLACE OF FATHER
(State or Country) Unknown

12. MAIDEN NAME OF MOTHER
"

13. BIRTHPLACE OF MOTHER
(State or Country) "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) L. B. Feeney.
(Address) Burley Ida.

15.
Filed June 22 1921
Dr. J. C. Patterson
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
May (Month) 23 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Hemmorrage of Stomach.

..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) L. B. Feeney. = Coroner = ~~M. D.~~
May 23 1921 (Address) Burley Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Burley Ida.	May 27 1921
20. UNDERTAKER	ADDRESS
L. B. Feeney.	Burley Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34507
Registered No. 515

Registration District No. 117
Primary Registration District No. 2196

RECEIVED
JUN 30 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Cassia
City of Bridge (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Frank Burrowes.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Oct (Month) 7 (Day) 1862 (Year)

7. AGE: 58 Yrs. 7 Mos. 24 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): England.

10. NAME OF FATHER: George Burrowe.

11. BIRTHPLACE OF FATHER (State or Country): England.

12. MAIDEN NAME OF MOTHER: Abigal Brown

13. BIRTHPLACE OF MOTHER (State or Country): England.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Phil Burrowe
(Address) Bridge Ida.

15. Filed June 3 1921 Dr. J. C. Patterson Local Registrar
By ..... D.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 31 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19....., that I last saw h..... alive on ..... 19....., and that death occurred on the date stated above, at 7.30 A.M.
The CAUSE OF DEATH* was as follows:
Cancer of Colon.
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) L. B. Jaeggy-Cassia ~~M. D.~~
19..... (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Sewer Colo. DATE OF BURIAL: June 6 1921

20. UNDERTAKER: L. B. Jaeggy ADDRESS: Burley Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34508

Registered No. 5 x x

1. PLACE OF DEATH.

County of Cassia — Registration District No. 117

City of Burley (No. ..... St.) — Primary Registration District No. 2196

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
JUN 30 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME Mabel Susanna Greco

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. (Month) Jan (Day) 11 (Year) 1892

7. AGE: 29 Yrs. 5 Mos. 7 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Peter S. Greco

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: Sophia C. N. Hansen

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Peter S. Greco
(Address) Burley Ida

15. Filed June 15 1921 Dr. J. W. Patterson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 13 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 11 - 1921, to June 12 1921, that I last saw h alive on June 12 1921, and that death occured on the date stated above, at 9 P M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) 2 Yrs. — mos. — ds.

Contributory (Secondary)

(Duration — yrs. — mos. — ds.

(Signed) H. H. Cooper M. D.

19 (Address) Burley Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rychfield Utah — DATE OF BURIAL: on arrival 1921

20. UNDERTAKER: R. N. Watt — ADDRESS: Burley Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRNE-YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED
JUN 30 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 117
Primary Registration District No. 2196

Pearson.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34509
Registered No. 273

1. PLACE OF DEATH

County of Cassia
City of Burley
If death occurs away from usual residence, give facts called for under special information.

(No. Burley Ave. St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Addie Fehrenbacher Campbell

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Female	White	Married (Write the word.)

6. DATE OF BIRTH: March (Month) 19. (Day) 1876 (Year)

7. AGE: 45 Yrs. 1 Mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kansas.

10. NAME OF FATHER: William Edward Fehrenbacher

11. BIRTHPLACE OF FATHER (State or Country): South Carolina.

12. MAIDEN NAME OF MOTHER: Mary Rogers

13. BIRTHPLACE OF MOTHER (State or Country): England.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) George Irving Campbell.
(Address) Burley Idaho.

15. 2d.
Filed 6-22-21 19.....
Dr. J. C Patterson
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 21. (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 1920, to April 21 1921
that I last saw h.. alive on April 21 1921,
and that death occurred on the date stated above, at 10 A.M.
The CAUSE OF DEATH* was as follows:
Paralysis

(Duration) several Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) J. C. Patterson M. D.
6-22-1921 (Address) Burley, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Burley Idaho.	April 23 1921.
20. UNDERTAKER	ADDRESS
L. L. Simonsen.	Burley Ida.

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cooper.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34511
Registered No. 316

RECEIVED
JUN 30 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 117
Primary Registration District No. 296

County of Cassia
City of Burley (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Margaret Munns

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Female	White	Married

6. DATE OF BIRTH: Jan. (Month) 11th (Day) 1921 (Year)

7. AGE: 19 Yrs. 4 Mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Michigan

10. NAME OF FATHER Mr. McArthur

11. BIRTHPLACE OF FATHER (State or Country) —

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER (State or Country) —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Jean Munns
(Address) Ogden Utah.

15. Filed June 22, 1921 Dr. J. C. Patterson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 25th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 18. 1921, to May 26- 1921, that I last saw her alive on May 26- 1921, and that death occurred on the date stated above, at 3 P. M.
The CAUSE OF DEATH* was as follows:
Pneumonia Embolism
Coming Dangerous Illness

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. A. Cooper M. D.
6/1 1921 (Address) Burley Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Burley Ida.	May 27 1921
20. UNDERTAKER L. B. Jaccoby.	**ADDRESS** Burley Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

34512 XVII

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. [illegible]

Registered No. 75

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No. 12

Primary Registration District No. 3199

County of Cassia

City of Oakley (If outside limits, give township.) St.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
JUL 1 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME Edward Asher Gohorsky

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. April (Month) 3 (Day) 1924 (Year)

7. AGE: ....Yrs....Mos. 7 ds.

IF LESS than 1 day how many.....hrs. or .....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Edward Asher Gohorsky

11. BIRTHPLACE OF FATHER (State or Country) California

12. MAIDEN NAME OF MOTHER Sarah Roe

13. BIRTHPLACE OF MOTHER (State or Country) Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) A. A. Gohorsky

(Address) Oakley Idaho

15. Filed June 20 1924 A. J. Nielson Local Registrar

SVMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 10 (Day) 1924 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 3 1924, to April 10 1924, that I last saw him alive on April 10 1924, and that death occured on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Atelectasis

(Duration) ....Yrs. ....mos. 7 ds.

Contributory (Secondary) .....

(Duration ....Yrs. ....mos. ....ds.

(Signed) A. J. Nielson M. D.

6/20 1924 (Address) Oakley Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Oakley Id. DATE OF BURIAL: April 12 1924

20. UNDERTAKER: K. A. Gohorsky ADDRESS: Oakley Id

1528

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (b) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers,* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, *septicemia,*" "PUERPERAL *peritonitis,*" etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

2 # 6 and death year

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FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 90

Primary Registration District No. 2168

File No. 34514

Registered No. 23

County of Clearwater

City of Orofino (or Village of ....., or Township of ....., St.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED JUL 5 1921 BUREAU OF VITAL STATISTICS

2. FULL NAME Fred Pfeuti

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: ? (Month) (Day) 1 (Year)

7. AGE: about 50 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Switzerland

10. NAME OF FATHER: —

11. BIRTHPLACE OF FATHER (State or Country): — —

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. C. Bullock

(Address) Orofino Idaho

15. Filed June 13 1921

J. M. Tinsley
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Body found June 3-21

About May 26 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....

that I last saw h..... alive on ..... 19.....

and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

By Accident, Coroner & Sheriff Contiguous are ask unable to determine

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. C. Bullock Coroner M. D.

June 17 1921 (Address) Orofino Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Orofino Idaho — DATE OF BURIAL: June 15 1921

20. UNDERTAKER: C. E. Bell and Son — ADDRESS: Orofino Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34515
Registered No. 24

RECEIVED JUL 5 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH. Registration District No. 9
County of Clearwater Primary Registration District No. 2168
City of Orofino, Idaho (If not in city or town give township) St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Henry Morgan Lowell.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: February 2, 1883 or 1884 (Month) (Day) (Year)

7. AGE: About 38 yrs. ~ mos. ~ ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Cook
(b) General nature of industry business or establishment in which employed (or employer): Cooking

9. BIRTHPLACE (State or Country): San Francisco, California

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. W. Atteberry
(Address) Orofino, Idaho.

15. Filed June 4 1921 J. M. Davis Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June Third 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 10 1920 ~~191~~, to June 3rd 1921 ~~191~~, that I last saw him alive on June 2nd 1921 and that death occurred on the date stated above, at 4 00 A. M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Unknown (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) Insanity

(Duration) Unknown yrs. ..... mos. ..... ds.

(Signed) John Lievers M. D.

June 6th 1921 (Address) Orofino, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. 10 mos. 24 ds. In the State about 11 years ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? Unknown
Former or usual residence Clk River, Idaho.

19. PLACE OF BURIAL OR REMOVAL: Grave # 8 Row # 4 Map add. The Northern Lake View Cemetery — DATE OF BURIAL: June 6th 1921

20. UNDERTAKER: J. W. Atteberry — ADDRESS: Orofino Idaho.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34516
Registered No. 27

1. PLACE OF DEATH.
County of Clearwater
City of Orofino, Idaho, (No. ____ St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 90
Primary Registration District No. 2168

RECEIVED
JUL 5 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME Estella A. Rodgers.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married
6. DATE OF BIRTH: August 6th 1887 or 1888 (Month) (Day) (Year)
7. AGE: About 33 yrs. ✓ mos. ✓ ds. IF LESS than 1 day how many ..... hrs. or ..... min.
8. OCCUPATION
(a) Trade, profession or particular kind of work: Teamster
(b) General nature of industry business or establishment in which employed (or employer): General Teaming
9. BIRTHPLACE (State or Country): Missouri
10. NAME OF FATHER: C. P. Rodgers
11. BIRTHPLACE OF FATHER (State or Country): Unknown
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (State or Country): Unknown.
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. W. Atteberry
(Address) Orofino, Idaho.
15. Filed June 6 1921 J. M. Faris Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June Fifth 1921 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from April 30th 1921, to June 5th 1921, that I last saw h.im alive on June 4th 1921, and that death occurred on the date stated above, at 10 A. M.
The CAUSE OF DEATH* was as follows:
Cancer of the Pancreas
Unknown
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Insanity.
(Duration) Unknown yrs. ✓ mos. ..... ds.
(Signed) John W. Stevens M. D.
June 6th 1921 (Address) .....
*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ✓ ✓ 37 mos. ..... ds. In the State 20 yrs. ✓ ✓ mos. ..... ds.
Where was disease contracted, if not at place of death? Unknown.
Former or usual residence Wardner, Idaho.

19. PLACE OF BURIAL OR REMOVAL: Kellogg Ida. DATE OF BURIAL: June 10 1921
20. UNDERTAKER: C. E. Bobo and Son ADDRESS: Orofino

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 90
Primary Registration District No. 2168
File No. 34517
Registered No. 26

1. PLACE OF DEATH

County of Canyon
City of Caldwell (Ward, No. St.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED JUL 5 1921 BUREAU OF VITAL STATISTICS

2. FULL NAME Thos M Johnson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
male	white	married

6. DATE OF BIRTH May (Month) 12 (Day) 80 (Year)

7. AGE 41 Yrs. 0 Mos. 28 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Penn

10. NAME OF FATHER Silas Johnson

11. BIRTHPLACE OF FATHER (State or Country) Penn

12. MAIDEN NAME OF MOTHER Nina Rodabaugh

13. BIRTHPLACE OF MOTHER (State or Country) Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Thos M Johnson
(Address) Caldwell Idaho

15. Filed June 11 1921 J. M. Family Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 10 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 25 1921, to June 10 1921, that I last saw h[illegible] alive on June 10 1921, and that death occurred on the date stated above, at 5 1/2 P.M.
The CAUSE OF DEATH* was as follows:

Multiple Neuritis

(Duration) 2 Yrs. ..... mos. ..... ds.
Contributory (Secondary) Influenza
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Family M. D.
6/11/1921 (Address) Caldwell Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Wilsonian Cemetery Caldwell | DATE OF BURIAL June 13 1921

20. UNDERTAKER Boise Undertaking Co | ADDRESS Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JUL 5 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34518
Registered No. 37

1. PLACE OF DEATH
County of Clearwater
City of Orofino
(Registration District No. 90)
(Primary Registration District No. 2168)
(No. ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Richard Ireland
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Male	White	Married (Write the word.)

6. DATE OF BIRTH
(Month) (Day) 1 (Year)

7. AGE 58 Yrs. ... Mos. ... ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE
(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER
(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J A Crutcher
(Address) Teakean

15. Filed June 16 1921
J M Family
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 16 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ... 19... to ... 19...
that I last saw h... alive on ... 19...
and that death occurred on the date stated above, at 1 A. M.
The CAUSE OF DEATH* was as follows:
Chronic Myocarditis
Brights Disease
(Duration) 8 Yrs. ... mos. ... ds.
Contributory (Secondary)
(Duration) ... yrs. ... mos. ... ds.
(Signed) Earle W Hornaday M. D.
6/16 1921 (Address) Orofino Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: On his own place — DATE OF BURIAL: June 17 1921
20. UNDERTAKER: J A Crutcher — ADDRESS: Teakean Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JUL 5 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Clearwater — Registration District No. 90

City of Orofino — Primary Registration District No. 2168

(No. ..... St.)

File No. 34519

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ralph Carey

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
male	white	Wid.

6. DATE OF BIRTH April 13 1849
(Month) (Day) (Year)

7. AGE 72 Yrs. 2 Mos. 9 ds. — IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Carpenter
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Canada

10. NAME OF FATHER George Carey

11. BIRTHPLACE OF FATHER (State or Country) Eng Canada

12. MAIDEN NAME OF MOTHER Almaria Grey

13. BIRTHPLACE OF MOTHER (State or Country) Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J H Carey
(Address) Lenora Idaho

15. Filed June 22 1921 — J. M. Fairly Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 22 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from — 19..., to — 19...,
that I last saw h... alive on — 19...,
and that death occurred on the date stated above, at 8 A M.
The CAUSE OF DEATH* was as follows:

Strychnine Poisoning
Evidently Suicidal

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary) Bright's Disease

(Duration) ... yrs. ... mos. ...

(Signed) J. M. Fairly M. D.

June 22 1921 (Address) Orofino Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Lenora Idaho — DATE OF BURIAL June 24 1921

20. UNDERTAKER J H Carey — ADDRESS Lenora Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 219

Primary Registration District No. 27

File No. 34521

County of Franklin

City of Preston (Village, St.)

Registered No. 41

If death occurs away from usual residence, give facts called for under special information.

RECEIVED JUL 8 1921 BUREAU OF VITAL STATISTICS

2. FULL NAME Viola Corbridge

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: June (Month) 22 (Day) 1921 (Year)

7. AGE: 0 Yrs. 0 Mos. 0 ds.

IF LESS than 1 day how many 7 hrs. or 5 min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Sylvester Loren Corbridge

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Effie Stephens

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) S. L. Corbridge

(Address) Preston Idaho

15. Filed July 5 1921 Don R. Curtis Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 22 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 22 1921, to June 22 1921, that I last saw h. alive on June 22 1921, and that death occurred on the date stated above, at 11.05 P.M.

The CAUSE OF DEATH* was as follows:

Atelectasis

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Curtis L. Hand M. D.

6/22 1921 (Address) Preston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Preston, Ida. DATE OF BURIAL: June 23 1921

20. UNDERTAKER ADDRESS

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

RECEIVED JUL 8 1921 BUREAU OF VITAL STATISTICS

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2119
Primary Registration District No. 27
File No. 34522
Registered No. 40

1. PLACE OF DEATH.

County of Franklin
City of Preston (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Jemima Dent Bronson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F

4. COLOR OR RACE W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married (Write the word.)

6. DATE OF BIRTH. Nov. (Month) 20 (Day) 1879 (Year)

7. AGE 41 Yrs. 6 Mos. 22 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Salt Lake City Ut

10. NAME OF FATHER George J. Dent

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER Ann Rawlings

13. BIRTHPLACE OF MOTHER (State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Chas C. Bronson
(Address) Preston Idaho

15. Filed June 14 1921 D. A. Quillen Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 6 (Month) 11 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 6-10 1921, to 6-11 1921, that I last saw h[illegible] alive on 6-11 1921, and that death occured on the date stated above, at 8 45 A.M.

The CAUSE OF DEATH* was as follows:
Pernicious Anemia

(Duration) 12 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) A. P. Cutler Jr. M. D.

6-12 1921 (Address) Preston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Fairview Idaho — **DATE OF BURIAL** June 13 1921

20. UNDERTAKER W. A. Skidmore — **ADDRESS** Preston Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BKBS. 24653

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34523
Registered No. 43

RECEIVED JUL 8 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 2119
Primary Registration District No. 27
County of Franklin
City of Riverdale (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Joseph Vail Allen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: June (Month) 15 (Day) 1921 (Year)

7. AGE: 0 Yrs. 0 Mos. 0 ds. IF LESS than 1 day how many 21 hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business or establishment in which employed (or employer) —

9. BIRTHPLACE (State or Country): Riverdale Ida

10. NAME OF FATHER: Joseph Allen

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Susie Vaile

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Joseph Allen
(Address) Riverdale R.F.D. 2 Box ..

15. Filed ..... 19 .....
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 15 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 15 1921, to June 15 1921, that I last saw h.IM. alive on June 15 1921, and that death occurred on the date stated above, at 1 P M.

The CAUSE OF DEATH* was as follows:

Atelectasis

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Breech presentation

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Curtis Blank M. D.
6/16/1921 (Address) Preston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Riverdale Ida — DATE OF BURIAL: June 16 1921

20. UNDERTAKER: W. A. Skidmore — ADDRESS: Preston Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED JUL 8 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH. Registration District No. 2119
County of Franklin Primary Registration District No. 27
City of Riverdale (If outside city limits, give township) St.)
If death occurs away from usual residence, give facts called for under special information.

File No. 34524
Registered No. 42

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary Page

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
F	W.	

6. DATE OF BIRTH. June (Month) 13 (Day) 1921 (Year)

7. AGE ....Yrs....Mos....ds. IF LESS than 1 day how many 6 hrs. or ....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work....
(b) General nature of industry, business, or establishment in which employed (or employer)....

9. BIRTHPLACE (State or Country) Riverdale Idaho.

10. NAME OF FATHER James Irwin Page

11. BIRTHPLACE OF FATHER (State or Country) Dayton Idaho

12. MAIDEN NAME OF MOTHER Anita McCombs

13. BIRTHPLACE OF MOTHER (State or Country) Clarkston Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) James Page
(Address) Preston Idaho

15. Filed July 5 1921 Dora Reeder Local Registrar

SYMS - YORK CO., PTRS. & STNRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 13 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 13 1921, to June 13 1921, that I last saw her alive on June 13 1921, and that death occured on the date stated above, at ....M.

The CAUSE OF DEATH* was as follows:
this was a premature birth 6½ months gestation & died about 4 hours after & left the home
(Duration) ....Yrs. ....mos. ....ds.

Contributory (Secondary) ....
(Duration ....yrs. ....mos. ....ds.

(Signed) Thos. B. Holder M. D.
19.... (Address) Western & via

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death?....
Former or usual residence ....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Dayton	June 14 1921
20. UNDERTAKER W. A. Skidmore	ADDRESS Preston Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

40 block So. (Holder)

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED JUL 2 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

34525

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No.....

Primary Registration District No.....

File No. 7

County of Fremont.

City of Ashton. (No.....St.)

Registered No.....

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Christina Rachel Cunningham

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married.

6. DATE OF BIRTH: November, 2 1857 (Month) (Day) (Year)

7. AGE: 63 Yrs. 7 Mos. 21 21 IF LESS than 1 day how many.....hrs. or.....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah,

10. NAME OF FATHER: Farley

11. BIRTHPLACE OF FATHER (State or Country): England.

12. MAIDEN NAME OF MOTHER: Mary Ellen Reed.

13. BIRTHPLACE OF MOTHER (State or Country): Penn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Willis R. Humpherys
(Address) Parker Idaho.

15. Filed 6-24 1921 C. C. Clawson Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 23 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1 1921, to June 23 1921, that I last saw h.r alive on June 23 1921, and that death occurred on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:
Inflammatory Rheumatism

(Duration) Yrs 2 mos. ds.

Contributory (Secondary) Endocarditis

(Duration) yrs. 1 mos. ds.

(Signed) E. L. Clawson M. D.

June 25 1921 (Address) Ashton Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Marysville Cemetery DATE OF BURIAL: 6 28 1921

20. UNDERTAKER: Lewis Kiser ADDRESS: Ashton Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED JUL 2 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH 34526

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH PRECINCT.

Registration District No.

County of

Registration District No.

File No.

City of MARYSVILLE. (St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME GOOCH.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: FEMALE

4. COLOR OR RACE: WHITE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): M

6. DATE OF BIRTH: APRIL (Month) 1st (Day) 1921 (Year)

7. AGE: ....Yrs. ....Mos. 1 ds. 17

IF LESS than 1 day how many.... hrs. or....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) MARYSVILLE IDAHO.

10. NAME OF FATHER ORALANDA GOOCH

11. BIRTHPLACE OF FATHER (State or Country) WILFORD IDAHO.

12. MAIDEN NAME OF MOTHER GRACE McARTHUR

13. BIRTHPLACE OF MOTHER (State or Country) UTAH.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) ORALALANDO GOOCH?
(Address) MARYSVILLE IDAHO.

15. Filed 6-18-21 Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 17 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 14 1921 to May 17 1921 that I last saw her alive on May 17 1921, and that death occurred on the date stated above, at 6 A. M.
The CAUSE OF DEATH* was as follows:
Whooping Cough

(Duration) ....Yrs. ....mos. ....ds.

Contributory (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) E. P. Hayes M. D.
May 18 1921 (Address) Ashton Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: MARYSVILLE CEMETRY DATE OF BURIAL: May 19 1921

20. UNDERTAKER: None ADDRESS

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34527
Registered No. .....

RECEIVED
JUL 2 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH.
Registration District No. .....
Primary Registration District No. .....
County of Fremont
City of Ashton. (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Milton Colwell.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed,

6. DATE OF BIRTH. June. (Month) 6th (Day) 1847. (Year)

7. AGE: 73 Yrs. 11 Mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country) Illinois.

10. NAME OF FATHER: Prestley Colwell.

11. BIRTHPLACE OF FATHER (State or Country) Ohio.

12. MAIDEN NAME OF MOTHER: Dont Know.

13. BIRTHPLACE OF MOTHER (State or Country) Dontknow.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Lafe Colwell.
(Address) Ashton. Idaho.

15. Filed May 17 1921 — [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 16 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h[illegible] alive on May 16 1921,
and that death occured on the date stated above, at 9 A.M.
The CAUSE OF DEATH* was as follows:
Cerebral congestion
.....
.....
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) [illegible] M. D.
May 16 1921 (Address) Ashton Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: ASHTON. IDAHO. DATE OF BURIAL: 5/13/21 191...

20. UNDERTAKER: Lewis Reser ADDRESS: Ashton Idaho

BYMS - YORK CO., PTRS. & BORS. 24654

FORM V. S. No. 5-25 M. 1-16-13

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 10 2 6 — 34528
Primary Registration District No. 6
File No. 9
Registered No. .....

1. PLACE OF DEATH.
County of Fremont
City of Ashton. (If outside limits of city or village, give township) St.)
If death occurs away from usual residence, give facts called for under special information.

RECEIVED
JUL 2 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME Austin Donald Moore.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. September (Month) 28th (Day) 1916. (Year)

7. AGE: Four Yrs. 7 Mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer)...

9. BIRTHPLACE (State or Country) Ashton Idaho.

10. NAME OF FATHER Laurence Moore.

11. BIRTHPLACE OF FATHER (State or Country) Iowa.

12. MAIDEN NAME OF MOTHER May. Bower sox

13. BIRTHPLACE OF MOTHER (State or Country) Missouri.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Laurence Moore.
(Address) Ashton Idaho.

15. Filed 5/12/ 1921 C.C. Meaken Local Registrar Ashton Idaho.

BYMS - YORK CO., PTRS. & RORS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 11 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5/5 1921, to 5-11 1921, that I last saw h alive on 5/11/1921, and that death occured on the date stated above, at 1:30 A.M.

The CAUSE OF DEATH* was as follows:
Auto intoxication
(Broch.)
(Duration) ..... Yrs. ..... mos. 6 ds.
Contributory (Secondary) Dr. -
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) C. W. Cochran M. D.
5/12 1921 (Address) Ashton Ida -

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?...
Former or usual residence ...

19. PLACE OF BURIAL OR REMOVAL: Ashton Idaho. DATE OF BURIAL: 5/12/ 1921.

20. UNDERTAKER: Lewis Kiser ADDRESS: Ashton Idaho

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

34529

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
JUL 2 1929
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No.
Primary Registration District No.
File No.
Registered No.

County of Fremont.
City of Ashton. (No. St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Alice E. SChultz.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married. (Write the word.)

6. DATE OF BIRTH: December 19. 1903.
(Month) (Day) (Year)

7. AGE: 17 Yrs. 6 Mos. 9 ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ashton Idaho.

10. NAME OF FATHER: George Parrott

11. BIRTHPLACE OF FATHER (State or Country): Dayton Idaho.

12. MAIDEN NAME OF MOTHER: Martha . E. Ward.

13. BIRTHPLACE OF MOTHER (State or Country): Hiram Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): George Parrott
(Address): Ashton Idaho.

15. Filed 6-29 1929 [signature] Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 28 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 28 1929, to June 28 1929
that I last saw h[illegible] alive on June 28 1929
and that death occurred on the date stated above, at 2:55 P.M.

The CAUSE OF DEATH* was as follows:
Peritonitis

(Duration) Yrs. mos. 9 ds.
Contributory (Secondary) Ruptured appendix

(Duration) yrs. mos. ds.

(Signed) [signature] M. D.
June 29 1929 (Address) Ashton Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Marysville Cemetery
DATE OF BURIAL: 6. 29 1929

20. UNDERTAKER: Lewis Kiser
ADDRESS: Ashton Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34530
Registered No.

1. PLACE OF DEATH
Registration District No.
Primary Registration District No. 4
County of Gem
City of Emmett (No. St.)
If death occurs away from usual residence, give facts called for under special information.

RECEIVED JUL 5 1921 BUREAU OF VITAL STATISTICS

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Wesley Knox

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	white	Single

6. DATE OF BIRTH: Sept (Month) 9 (Day) 1841 (Year)

7. AGE: 79 Yrs. 9 Mos. 1 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Mining Prospector
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: James Knox

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Agnes Douglas

13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J Knox
(Address) Emmett Idaho

15. Filed June 4 1921 J. V. Reynolds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 9 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 5 1921 to June 9 1921, that I last saw him alive on June 1 1921, and that death occurred on the date stated above, at 11 A. M.

The CAUSE OF DEATH* was as follows:
Carcinoma of Prostate

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Burton O Clark M. D.
6-13-1921 (Address) Emmett Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Emmett Ida	6/11 1921
20. UNDERTAKER	ADDRESS
O D Bucknum	Emmett Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34531
Registered No.

RECEIVED
JUL 5 1921
BUREAU OF VITAL STATISTICS

Registration District No. 6
Primary Registration District No.
(No. St.)

1. PLACE OF DEATH
County of Gem
City of Emmett
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Babette Wilhelm
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): married

6. DATE OF BIRTH: July (Month) 29 (Day) 1840 (Year)

7. AGE: ....Yrs....Mos....ds.
IF LESS than 1 day how many....hrs. or....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: Johann Freiseimeier

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: unknown

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Herm. Wells
(Address)

15. Filed June 27 1921 J. H. Reynolds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 19 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 15 1921, to June 19 1921 that I last saw her alive on June 15 1921, and that death occurred on the date stated above, at 6 a M.

The CAUSE OF DEATH* was as follows:
Chronic Myocoditis

(Duration) Dewrk Yrs.....mos.....ds.
Contributory (Secondary) Asthma
(Duration) Dewrk Yrs.....mos.....ds.

(Signed) R N Cummings M. D.
6/20 1921 (Address) Emmett

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Emmett Idaho
DATE OF BURIAL: 6/21 1921

20. UNDERTAKER: C. O. Buckmun
ADDRESS: Emmett Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED JUL 5 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34533
Registered No.

Registration District No. 6
Primary Registration District No.

1. PLACE OF DEATH
County of Gem
City of Emmett (No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Juanita Galdos
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Fem	wht	Child (Write the word.)

6. DATE OF BIRTH: May (Month) 18 (Day) 1913 (Year)

7. AGE: 8 Yrs. 1 Mos. 9 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: child
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Sam Goedes

11. BIRTHPLACE OF FATHER (State or Country): Spain

12. MAIDEN NAME OF MOTHER: Josephine Alegria

13. BIRTHPLACE OF MOTHER (State or Country): Spain

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Anastasio Jayo
(Address) Emmett Idaho

15. Filed June 30 1921 J L Reynolds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 27 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 20 1921, to June 26 1921, that I last saw h.s alive on June 26 1921, and that death occurred on the date stated above, at 3 9 M.

The CAUSE OF DEATH* was as follows:
Typhoid Fivers Complicated with Pneumonia
(Duration) Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) J L Reynolds M. D.
6/30 1921 (Address) Emmett Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Emmett Idaho — DATE OF BURIAL: 6/28 1921

20. UNDERTAKER: C D Buckmun — ADDRESS: Emmett Ida

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MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34534
Registered No.

1. PLACE OF DEATH

County of Gem
City of Emmett (Ward) (St.)

If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No. 6

RECEIVED
JUL 5 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME John Charles Phillips

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Child (Write the word.)

6. DATE OF BIRTH: Mar 16 1910 (Month) (Day) (Year)

7. AGE: 11 Yrs. 2 Mos. 22 ds.
IF LESS than 1 day how many..... hrs. or.....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Oklahoma

10. NAME OF FATHER: O. S. Phillips

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Bertha Harsel

13. BIRTHPLACE OF MOTHER (State or Country): Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) O. S. Phillips
(Address) Emmett Idaho

15. Filed 6/10 1921 J. L. Raynolds Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 8 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from not at all, to ..... 19.....
that I last saw h... alive on June 11 1921,
and that death occurred on the date stated above, at 1.30 P M.
The CAUSE OF DEATH* was as follows:
Gun shot wound, which cut the Right subclavian artery. — accidental

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Burton O Clark M. D.
6-10-1921 (Address) Emmett Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Kearney, Mo — DATE OF BURIAL: ..... 19.....

20. UNDERTAKER: O. D. Buckenum — ADDRESS: Emmett Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34535
Registered No.

1. PLACE OF DEATH
County of Gem
City of Emmett
(If outside limits, give township.) (St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No. 4

RECEIVED
JUL 5 1921
BUREAU OF VITAL STATISTICS

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William Myers

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: unknown (Month) (Day) 1 (Year)

7. AGE: 72 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): unknown

10. NAME OF FATHER: "

11. BIRTHPLACE OF FATHER (State or Country): "

12. MAIDEN NAME OF MOTHER: "

13. BIRTHPLACE OF MOTHER (State or Country): "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R N Cummings
(Address) Emmett Ida

15.
Filed June 27 1921
J. L. Reynolds
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar. (Month) 1 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Several months 19 , to Mar 1 1921
that I last saw him alive on Mar 1 1921,
and that death occurred on the date stated above, at M.
The CAUSE OF DEATH* was as follows:
Chronic nephritis

(Duration) Yrs. mos. ds.
Contributory (Secondary) Valvular heart disease
(Duration) Several yrs. mos. ds.

(Signed) R N Cummings M. D.
3/x 1921 (Address) Emmett

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Emmett Idaho	7/3 1921
20. UNDERTAKER	ADDRESS
O D Bucknum	Emmett Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

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FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 21
Primary Registration District No.
File No. 34536
Registered No.

1. PLACE OF DEATH
County of Gooding
City of Hagerman
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sarah Jane Dilatush
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Widow

6. DATE OF BIRTH: Aug. (Month) 25 (Day) 1838 (Year)

7. AGE: 82 Yrs. 6 Mos. 17 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Warren Co. Ohio

10. NAME OF FATHER: Walling Norley

11. BIRTHPLACE OF FATHER (State or Country): Kentucky

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. N. Dilatush
(Address) Hagerman Ida

15.
Filed 19
R. H. Greene
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar. (Month) 12 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 10 1921, to Mar 12 1921, that I last saw her alive on Mar 9th 1921, and that death occurred on the date stated above, at 6:20 A.M.
The CAUSE OF DEATH* was as follows:
Senility -

(Duration) Yrs. 6 mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) J. H. Cromwell M. D.
19 (Address) Gooding Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Hagerman Ida — DATE OF BURIAL: 3/14 1921

20. UNDERTAKER: A. E. Thompson — ADDRESS: Gooding

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34537
Registered No.

RECEIVED JUN 25 1951 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Gooding Registration District No. 21
City of Hagerman Primary Registration District No.
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lyle Thomas Ayers

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
male	white	single

6. DATE OF BIRTH: Oct (Month) 30 (Day) 1904 (Year)

7. AGE: 16 Yrs. 2 Mos. 15 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: School Boy.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Morrow, Ohio

10. NAME OF FATHER: Thomas J. Ayers.

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Ethel Silvers

13. BIRTHPLACE OF MOTHER (State or Country): Morrow, Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ethel Schooler
(Address) Hagerman, Ida.

15. Filed Jan 16 1921 R H Greene Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. (Month) 14 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 28 1920, to Jan 14 1921, that I last saw h 1 alive on Jan 14 1921, and that death occurred on the date stated above, at 10 10 P.M.

The CAUSE OF DEATH* was as follows:

Typhoid fever with hemorrhages

was feeling ill 4 or 5 weeks (Duration) Yrs. mos. ds.

Contributory (Secondary) Hemorrhage

(Duration) Yrs. mos. ds.

(Signed) R H Greene M. D.

Jan 16 1921 (Address) Hagerman

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Hagerman Cemetery DATE OF BURIAL: Jan 16 1921

20. UNDERTAKER: Thompson ADDRESS: Gooding

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

Registration District No. 21

Primary Registration District No. ____

File No. 34538

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registered No. ____

RECEIVED JUN 25 19[illegible]
BUREAU OF VITAL [illegible]

1. PLACE OF DEATH
County of Gooding
City of Hagerman (No. ____ St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ellen Stringer

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Widow

6. DATE OF BIRTH Dec (Month) 21 (Day) 1837 (Year)

7. AGE Yrs. 83 Mos. 1 ds. 14
IF LESS than 1 day how many ____ hrs. or ____ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work aged
(b) General nature of industry, business or establishment in which employed (or employer) ____

9. BIRTHPLACE (State or Country) Nottingham Eng

10. NAME OF FATHER Thomas Watkins

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER Hannah Peach

13. BIRTHPLACE OF MOTHER (State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Bailsford
(Address) Hagerman

15. Filed Feb 4 1921 R H Greene Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 4 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 8 1921, to ____ 19____, that I last saw her alive on Jan 8 1921, and that death occurred on the date stated above, at 8:30 A.M.
The CAUSE OF DEATH* was as follows:

Senility
Feeble 2 or 3 yrs
(Duration) ____ Yrs. ____ mos. ____ ds.
Contributory (Secondary) Valvular heart lesion
(Duration) Don't Know yrs. ____ mos. ____ ds.

(Signed) R H Greene M. D.
Jan 7 1921 (Address) Hagerman

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days
Where was disease contracted if not at place of death? ____
Former or usual residence ____

19. PLACE OF BURIAL OR REMOVAL Hagerman cemetery DATE OF BURIAL Feb 5 1921

20. UNDERTAKER Thompson ADDRESS Gooding

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 21
Primary Registration District No.
File No. 34539
Registered No.

1. PLACE OF DEATH
County of Gooding
City of Wagenman
(No. St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Verna L Wright

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married
6. DATE OF BIRTH: Aug (Month) 16 (Day) 1878 (Year)
7. AGE: 42 Yrs. 4 Mos. 20 ds. IF LESS than 1 day how many hrs. or min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry, business or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Mo
10. NAME OF FATHER: R A Shore
11. BIRTHPLACE OF FATHER (State or Country): N. C.
12. MAIDEN NAME OF MOTHER: Kate Penney
13. BIRTHPLACE OF MOTHER (State or Country): Mo
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W A Shore
(Address) Tuttle
15. Filed Jan 9 1924 R N Greene Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 9 (Day) 1924 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Jan 9 1924, to 19, that I last saw h[illegible] alive on Jan 9 1924, and that death occurred on the date stated above, at 5-10 A.M.
The CAUSE OF DEATH* was as follows:
Goitre
(Duration) 10 Yrs. mos. ds.
Contributory (Secondary) Pregnancy
(Duration) yrs. 7 mos. 7 ds.
(Signed) R N Greene M. D.
Jan 9 1924 (Address) Wagenman

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Gooding — DATE OF BURIAL: Jan 1924
20. UNDERTAKER [illegible] ADDRESS Gooding

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 27
Primary Registration District No.
File No. 34540
Registered No.

1. PLACE OF DEATH
County of Gooding
City of Hagerman
If death occurs away from usual residence, give facts called for under special information.
(No. , St.)
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Maud Josephine Bell

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6. DATE OF BIRTH: June (Month) 13 (Day) 1885 (Year)

7. AGE: 35 Yrs. 6 Mos. 27 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: James R Blackhurst

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Emma James

13. BIRTHPLACE OF MOTHER (State or Country): Ill

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R. P. Bell
(Address) Hagerman Idaho

15. Filed Jan 11 1921 R. W. Greene Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 10 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 31 1920 to Jan 10 1921 that I last saw h[illegible] alive on Jan 10 1921, and that death occurred on the date stated above, at 2:30 A M.

The CAUSE OF DEATH* was as follows:
Chronic Nephritis
Cerebral Hemorrhage

(Duration) Yrs. mos. ds.
Contributory (Secondary) Pregnancy T
(Duration) Yrs. mos. ds.

(Signed) R. W. Greene M. D.
Jan 11 1921 (Address) Hagerman

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Hagerman Idaho	1/11 1921
20. UNDERTAKER	ADDRESS
Melville D Rugg	Twin Falls Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34541
Registered No. .....

1. PLACE OF DEATH.
County of Idaho
City of Kamiah (If not in incorporated limits, give township.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 49
Primary Registration District No. 2429
JUL 9 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME Nonni Ezekiel

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: Ined
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Sing
6. DATE OF BIRTH. ..... (Month) ..... (Day) 1918 (Year)
7. AGE: 3 Yrs. ..... Mos. ..... ds. IF LESS than 1 day how many ..... hrs. or ..... min.
8. OCCUPATION
(a) Trade, profession or particular kind of work: Chied
(b) General nature of industry, business, or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): Idaho
10. NAME OF FATHER: Watkins Ezekiel
11. BIRTHPLACE OF FATHER (State or Country): Idaho
12. MAIDEN NAME OF MOTHER: Daisy Corbett
13. BIRTHPLACE OF MOTHER (State or Country): Idaho
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Watkins Ezekiel
(Address) Kamiah
15. Filed 6/20 1921 C J Johnson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH. June (Month) 20 (Day) 1921 (Year)
17. I HEREBY CERTIFY, That I attended deceased from June 8 1921, to above 1 191..., that I last saw h.. alive on June 19 1921, and that death occured on the date stated above, at 5 36 P.M.
The CAUSE OF DEATH* was as follows:
Sarcoma Pax
.....
.....
.....(Duration) ..... Yrs. ..... mos. 12 ds.
Contributory (Secondary) .....
.....(Duration ..... yrs. ..... mos. ..... ds.
(Signed) C A Bryan M. D.
6/22 1921 (Address) Kamiah

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Ind Cem Nr Kamiah — DATE OF BURIAL: 6/21 1921
20. UNDERTAKER: C J Johnson — ADDRESS: Kamiah

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

EVANS - YORK CO., PTGS. & SOES. 24658

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED JUL 5 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34542

Registered No. .....

1. PLACE OF DEATH. Registration District No. 49

County of Idaho Registration District No. 2428

City of Kendrick (or Village or Township) ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Nina Ezekiel

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: Ind.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1916 (Year)

7. AGE: 5 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): .....

12. MAIDEN NAME OF MOTHER: Nancy Ezekiel

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Watkys Ezekiel
(Address) Kendrick Ida.

15. Filed 6/20 1921 C J Johnson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 20 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 5th 1921, to ..... 191..., that I last saw her alive on June 19th 191..., and that death occured on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:
Lobar Pneumonia
Bronchial Pneumonia

(Duration) ..... Yrs. ..... mos. 15 ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) A. L. Bryan M. D.

6/20 1921 (Address) Kendrick

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Ind Cem No 1. Kendrick — DATE OF BURIAL: 6/21 1921

20. UNDERTAKER: C J Johnson — ADDRESS: Kendrick

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOOKB. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

RECEIVED
JUL 5 1921
BUREAU OF VITAL STATISTICS

Registration District No. 49
Primary Registration District No. 2429

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34543
Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Idaho
City of Kamiah (St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Delia Ezekiel

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: Indian
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow
6. DATE OF BIRTH. ? (Month) ? (Day) 1851 (Year)
7. AGE: about 70 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): Idaho
10. NAME OF FATHER: Albert Ezekiel
11. BIRTHPLACE OF FATHER (State or Country): Idaho
12. MAIDEN NAME OF MOTHER: Alive —
13. BIRTHPLACE OF MOTHER (State or Country): Idaho
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Watkins Ezekiel
(Address) Kamiah Ida
15. Filed 6/20 1921 C J Johnson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 19 (Day) 1921 (Year)
17. I HEREBY CERTIFY, That I attended deceased from June 9 1921, to June 19 1921, that I last saw her alive on June 19 1921, and that death occured on the date stated above, at 7 P M.
The CAUSE OF DEATH* was as follows:
Small Pox
(Duration) ..... Yrs. ..... mos. 10 ds.
Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) J. L. Bryan M. D.
6/20 1921 (Address) Kamiah Ida

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Indl Cem. No 1, Kamiah — DATE OF BURIAL: 6/20 1921
20. UNDERTAKER: C J Johnson — ADDRESS: Kamiah

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34544

Registered No. .....

1. PLACE OF DEATH.

County of Lewis

City of Kamiah

(No. ....., ... St.)

Registration District No. 49

Primary Registration District No. 2728

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Floyd F. Ferguson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. Jan (Month) 18 (Day) 1904 (Year)

7. AGE 12 Yrs. 5 Mos. 25 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: School child

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho. La Fah. Co.

10. NAME OF FATHER: Mole H. Ferguson

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Alma Hollingsworth

13. BIRTHPLACE OF MOTHER (State or Country): Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Molen H Ferguson

(Address) Kamiah Idaho

15. Filed 6/14 1921

C. J. Johnson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 12th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1st 1921, to June ..... 191..., that I last saw h... alive on June 14th 1921, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Lumar Paralysis
Cerebro Spinal Meningitis

(Duration) ..... Yrs. ..... mos. 11 ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) C. F. Ferguson M. D.

6/14 1921 (Address) Kamiah Ida

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Kamiah Cem

DATE OF BURIAL: 6/14 1921

20. UNDERTAKER: C. J. Johnson

ADDRESS: Kamiah Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRNS - YORK CO., PTGS. & ENGS. 24653

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

34545

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
JUL 5 1921
BUREAU OF VITAL STATISTICS

Registration District No. 105
Primary Registration District No. 2183
File No. 8
Registered No.

1. PLACE OF DEATH.
County of Idaho
City of Cottonwood St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Henry Baune
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH: Nov (Month) 15 (Day) 1848 (Year)

7. AGE: 72 yrs. 5 mos. 21 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: Herman Baune

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Anna M Hulsmann

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) William Baune
(Address) Cottonwood Ida

15. Filed May 8 1921 N Bolke
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 6 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 5 1921, to May 6 1921, that I last saw h[illegible] alive on May 5 1921, and that death occurred on the date stated above, at 10a M.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage.

(Duration) ..... yrs. ..... mos. 1 ds.
Contributory (Secondary) none except Chronic Nephritis.
(Duration) Unknown mos. ? ds.
(Signed) Wesley F. Orr M. D.
5/6 1921 (Address) Cottonwood Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Cottonwood Ida
DATE OF BURIAL: 5-9 1921

20. UNDERTAKER: [illegible] Nau
ADDRESS: Cottonwood Ida

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

RECEIVED
JUL 5 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

34546

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 105
Primary Registration District No. 2183
File No. 9
Registered No.

1. PLACE OF DEATH.
County of Idaho
City of Cottonwood (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Alonzo Bernard Bourne

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
male	white	single

6. DATE OF BIRTH
June (Month) 3 (Day) 1921 (Year)

7. AGE
..... yrs. ..... mos. 19 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Infant
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER John Bourne

11. BIRTHPLACE OF FATHER (State or Country) Province Nebraska

12. MAIDEN NAME OF MOTHER Elizabeth Tacks

13. BIRTHPLACE OF MOTHER (State or Country) Texas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Bourne
(Address) Cottonwood Idaho

15.
Filed June 22 1921 H B Blake
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
June (Month) 22 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 20 1921, to June 22 1921, that I last saw him alive on June 22 1921 and that death occurred on the date stated above, at 5-30a M.

The CAUSE OF DEATH* was as follows:
Pneumonia

(Duration) ..... yrs. ..... mos. 3 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J D Steinert M. D.
6-22 1921 (Address) Cottonwood Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: RC Cemetery Cottonwood | DATE OF BURIAL: June 23 1921

20. UNDERTAKER: John Boise | ADDRESS: Cottonwood Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 103
Primary Registration District No. 2181
File No. 34547
Registered No. 14

RECEIVED
JUL 18 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH.
County of Idaho
City of Joe (or) Town of ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Irene M. Hart-Hess

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: 7
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Oct. (Month) 22d (Day) 1867 (Year)

7. AGE: 53 Yrs. 07 Mos. 17 Ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Isabella Co Michigan

10. NAME OF FATHER: Meker Hess.

11. BIRTHPLACE OF FATHER (State or Country): Pennsylvania

12. MAIDEN NAME OF MOTHER: Martha Hamars

13. BIRTHPLACE OF MOTHER (State or Country): Michigan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) W. W. Palmer
(Address) Joe

15. Filed July 1 1921 E S Stockton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 4 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 10 1921, to June 4 1921, that I last saw her alive on May 21 1921, and that death occured on the date stated above, at 6 P. M.
The CAUSE OF DEATH* was as follows:

Carcinoma of bowels

(Duration) 3 Yrs. — mos. — ds.
Contributory (Secondary)
(Duration) — yrs. — mos. — ds.
(Signed) E S Stockton M. D.
6/7 1921 (Address) Grangeville Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Prairie View — DATE OF BURIAL: June 6 1921

20. UNDERTAKER: E S Hancock — ADDRESS: Grangeville

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24858

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34548

1. PLACE OF DEATH.
County of Idaho
City of Grangeville (No. ..... St.)
Registration District No. 103
Primary Registration District No. 1001
Registered No. 12

RECEIVED
JUL 12 1921
BUREAU OF VITAL STATISTICS

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Harld A Zumwalt — Zumwalt

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH. June (Month) 19 (Day) 1921 (Year)
7. AGE ..... Yrs. ..... Mos. ..... ds. IF LESS than 1 day how many ..... hrs. or ..... min.? 8 hrs.
8. OCCUPATION
(a) Trade, profession or particular kind of work... ?
(b) General nature of industry, business, or establishment in which employed (or employer).....
9. BIRTHPLACE (State or Country) Grangeville
10. NAME OF FATHER Robert Zumwalt
11. BIRTHPLACE OF FATHER (State or Country) Washington State
12. MAIDEN NAME OF MOTHER Mary McClelland
13. BIRTHPLACE OF MOTHER (State or Country) Georgia
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Robert Zumwalt
(Address) Grangeville
15. Filed July 1 1921 G S Stockton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 19 (Day) 1921 (Year)
17. I HEREBY CERTIFY, That I attended deceased from June 19 1921, to June 19 1921, that I last saw him alive on June 19 1921, and that death occured on the date stated above, at 11 P M.
The CAUSE OF DEATH* was as follows:
Premature Birth
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration ..... Yrs. ..... mos. ..... ds.
(Signed) B C Hepburn M. D.
6/25 1921 (Address) Grangeville Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Grangeville Cemetery Idaho — DATE OF BURIAL: June 21 1921
20. UNDERTAKER: F S Hancock — ADDRESS: Grangeville

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24853

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34549

Registered No. 16

1. PLACE OF DEATH. RECEIVED

County of Idaho JUL 12 1924 Registration District No. 103

City of Grangeville BUREAU (No. ....., ... St.) Primary Registration District No. 1001

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Clark Joseph Matthews

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. October (Month) 20 (Day) 1919 (Year)

7. AGE: Yrs. 20 Mos. ..... ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Wynona (Winona)

10. NAME OF FATHER Clark Joseph Matthews

11. BIRTHPLACE OF FATHER Arkansaw (State or Country)

12. MAIDEN NAME OF MOTHER Lottie Reeve

13. BIRTHPLACE OF MOTHER Bethany Minnesota (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Lottie Matthews
(Address) Grangeville Idaho

15. Filed July 1 1924 E S Stockton Local Registrar

SYMS - YORK CO., PTRS. & SORS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 20 (Day) 1924 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 14 1924 to June 20 1924, that I last saw him alive on June 19 1924, and that death occured on the date stated above, at 3P M.

The CAUSE OF DEATH* was as follows:
Toxemia from intestinal obstruction

(Duration) ..... Yrs. ..... mos. 12 ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) B Chapman M. D.
6/25 1924 (Address) Grangeville Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Prairie View — DATE OF BURIAL: June 21 1924

20. UNDERTAKER: E S Hancock — ADDRESS: Grangeville

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
JUL 12 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34550
Registered No. 17

Registration District No. 103
Primary Registration District No. 1001

1. PLACE OF DEATH
County of Idaho
City of Grangeville (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George LeRoy Carter
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Oct (Month) 16 (Day) 1918 (Year)

7. AGE: 2 Yrs. 8 Mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: George Carter

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Lelah LeMoss

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) George Carter
(Address) Grangeville

15. Filed July 7 1921 G. S. Stricklin Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 20 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from November 1921, to June 19 1921, that I last saw him alive on June 19 1921, and that death occurred on the date stated above, at 7 A.M.
The CAUSE OF DEATH* was as follows:
Sarcoma of Kidney
(Duration) ..... Yrs. 7 mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) B C Chipman M. D.
7/2 1921 (Address) Grangeville

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Prairie View — DATE OF BURIAL: June 20 1921

20. UNDERTAKER: Chapman — ADDRESS: City

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1916-13

CERTIFICATE OF DEATH.

34551

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 3

Registered No. 81

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Kootenai

City of Harrison (No. St.)

Registration District No. 136

Primary Registration District No. 2204

RECEIVED JUN 25 192 BUREAU OF VITAL STATISTICS STATE

2. FULL NAME Nellie B. Rodaman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH. Aug (Month) 27 (Day) 1897 (Year)

7. AGE: 23 Yrs. 9 Mos. 27 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: John Lawson

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Mary Lawson

13. BIRTHPLACE OF MOTHER (State or Country): Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ralph E Rodaman

(Address) Tekoa Star Rte No 1

15. Filed 6-1 1921 — W M Kinney Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 24 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 21 1921, to May 24 1921, that I last saw her alive on May 23 1921, and that death occured on the date stated above, at 9:30 A.M.

The CAUSE OF DEATH* was as follows:

Hemorrhage

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) W M Kinney M. D.

5-24-1921 (Address) Harrison Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Farmington Wash — DATE OF BURIAL: May 25 1921

20. UNDERTAKER: C. L. Schelund — ADDRESS: Tekoa Wn

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRD - YORK CO., PTRS. & BDRS. 24854

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

34553

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 126

Primary Registration District No. 2204

File No. 5

Registered No. 85

RECEIVED
JUL 10 1924
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH.

County of Kootenai

City of Harrison (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ruth Cooper Connolly

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Harrison Ida

10. NAME OF FATHER John J. Connolly

11. BIRTHPLACE OF FATHER (State or Country) Mass

12. MAIDEN NAME OF MOTHER Ruth Cooper

13. BIRTHPLACE OF MOTHER (State or Country) Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John J. Connolly

(Address) .....

15. Filed 7-1 1924 J. M. Kinney Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 26 (Day) 1924 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191..., that I last saw her alive on June 26 1924 and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Pulmonal foramen ovale

.....

.....

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Kinney M. D.

6-26 1924 (Address) Harrison Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL ..... 191...

20. UNDERTAKER | ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

34554

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
JUL 10 1921
BUREAU OF VITAL STATISTICS

Registration District No. 126
Primary Registration District No. 204
File No. 3
Registered No. 84

1. PLACE OF DEATH.
County of Kootenai
City of Harrison (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Joel Freeman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. 27 January 1869 (Day) (Month) (Year)

7. AGE: 52 Yrs. 4 Mos. 11 Ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Day Laborer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): North Carolina

10. NAME OF FATHER: A. J. Freeman

11. BIRTHPLACE OF FATHER: X (State or Country)

12. MAIDEN NAME OF MOTHER: Nancy Ball

13. BIRTHPLACE OF MOTHER: X (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mary R. C. Freeman
(Address) Harrison, Idaho

15. Filed 7-1 1921 J. W. Freeman Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 7 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 4 1921, to June 7 1921, that I last saw him alive on June 7 1921, and that death occured on the date stated above, at 8:30 A.M.

The CAUSE OF DEATH* was as follows:
Hypostatic Pneumonia
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Arteriosclerosis
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. W. Freeman M. D.
6-8 1921 (Address) Harrison

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL ..... 191...

20. UNDERTAKER: X | ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STNRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

34555

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 126

County of Kootenai Primary Registration District No. 2204 File No. 3

City of Rose Lake, Ida. (No. ..... St.) Registered No. 83

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
JUL 10 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME Mrs. Rosabel Smith

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): widowed

6. DATE OF BIRTH. March (Month) 28 (Day) 1866 (Year)

7. AGE: 55 Yrs. 1 Mos. 15 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): ~~Illinois~~ Ottumwa Iowa

10. NAME OF FATHER: John James Lent.

11. BIRTHPLACE OF FATHER (State or Country): New York State

12. MAIDEN NAME OF MOTHER: Rosabel Lent

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. Bertha A. Langer
(Address) Rose Lake, Ida.

15. Filed 7-1 1921 J. H. Runnoe Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 13 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 12 1921, to June 13 1921, that I last saw her alive on June 13 1921 and that death occured on the date stated above, at 12:38 AM.

The CAUSE OF DEATH* was as follows:
Cerebral hemorrhage, apoplexy.

(Duration) no Yrs. no mos. 1 ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) L. J. Stauffer M. D.
June 15 1921 (Address) Rose Lake, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rose Lake, Ida. DATE OF BURIAL: June 14 1921

20. UNDERTAKER: none employed ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOOKS. 24658

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JUL 10 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH 30 34556

State of Idaho BOARD OF HEALTH Bureau of Vital Statistics

Registration District No. 1051

Primary Registration District No.

File No. 945

Registered No. 945

1. PLACE OF DEATH

County of Kootenai

City of Coeur d'Alene (No. 827, West Garden St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary Barstad

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Oct (Month) (Day) 1884 (Year)

7. AGE: 36 Yrs. 9 Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Home Wife

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Norway

10. NAME OF FATHER: Erick Hanson

11. BIRTHPLACE OF FATHER (State or Country): Norway

12. MAIDEN NAME OF MOTHER: Marie Hanson

13. BIRTHPLACE OF MOTHER (State or Country): Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Henry Barstad

(Address) Coeur d'Alene Ida

15. Filed July 6 1921 D D Brema Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 30 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 24 1921, to June 30 1921, that I last saw h. alive on June 30 1921, and that death occurred on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(Duration) Yrs. mos. 25 ds.

Contributory (Secondary) Influenza

(Duration) yrs. mos. 2 ds.

(Signed) J A Dwyer M. D.

July 6 1921 (Address) Coeur d'Alene Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State 10 yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetery

DATE OF BURIAL: July 8 1921

20. UNDERTAKER: R B Mooney

ADDRESS: Coeur d'Alene Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
JUL 10 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 30
Primary Registration District No. 1031

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34557
Registered No. 944

1. PLACE OF DEATH
County of Kootenai
City of Rathdrum (Or Town, ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mr Max Rothie

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
male	white	single

6. DATE OF BIRTH ..... (Month) ..... (Day) 1 (Year)

7. AGE 75 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Mich.

10. NAME OF FATHER .....

11. BIRTHPLACE OF FATHER (State or Country) Germany

12. MAIDEN NAME OF MOTHER .....

13. BIRTHPLACE OF MOTHER (State or Country) Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs David Morris
(Address) Rathdrum, Ida.

15. Filed July 6 1921 L D Drew Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 27. (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1. 1919 to June 27 1921 that I last saw h[im] alive on June 26 1921 and that death occurred on the date stated above, at 10. A.M.
The CAUSE OF DEATH* was as follows:
Valvular Heart Disease
(Duration) 2 Yrs. ..... mos. ..... ds.
Contributory (Secondary) Hemorrhage
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Frank Weng M. D.
6/28 1921 (Address) Rathdrum, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 6 yrs. 10 mos. 10 days. In the State 20 yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence Coeur d'Alene, Ida.

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Rathdrum	6/29 1921

20. UNDERTAKER P. W. Stone ADDRESS Rathdrum Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED
JUL 10 1921
BUREAU OF VITAL STATISTICS

Form V. S. No. 5. 10M. 6-20-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH — Registration District No. 30
County of Kootenai — Primary Registration District No. 1051
City of Coeur d'Alene (No. Near, Hauser Lake, Idaho St.)
If death occurs away from usual residence, give facts called for under special information.

File No. 31558
Registered No. 943
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Alexander E Miller

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.): Widower

6. DATE OF BIRTH: Jan (Month) 13 (Day) 1864 (Year)

7. AGE: 57 yrs. 5 mos. 13 ds. IF LESS than 1 day how many ..... *hrs. or* ..... *min.*

8. OCCUPATION
(a) Trade, profession or particular kind of work: Clothing Merchant
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ireland

10. NAME OF FATHER: Geo. Miller

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Ann Moore

13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Margaret Miller
(Address) 2129 W Mallon Avenue

15. Filed July 6 1921 A D Drennan Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 26, 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 15 1921, to June 26 1921, that I last saw h[illegible] alive on June 26 1921, 11-10 P M. and that death occurred on the date stated above, at

The CAUSE OF DEATH* was as follows:
Myocarditis with dilatation of left ventricle

(Duration) ..... yrs. Abt mos. a few ds.
Contributory (Secondary) Coronary Sclerosis
(Duration) Unknown yrs. mos. ds.
(Signed) Geo W Libby M. D.
June 29 1921 (Address) Spokane

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Greenwood
DATE OF BURIAL: June 29 1921

20. UNDERTAKER: Turnbull Co
ADDRESS: Spokane

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
JUL 10 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 30

Primary Registration District No. 1051

County of Kootenai

City of Coeur d Alene (No. ....., ... St.)

File No. 34559

Registered No. 792

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George Miller

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	W	—

6. DATE OF BIRTH — (Month) ..... (Day) 1 (Year)

7. AGE about 75 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Lumberman

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Michigan.

10. NAME OF FATHER —

11. BIRTHPLACE OF FATHER (State or Country) —

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER (State or Country) —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs David Morris

(Address) Rathdrum, Idaho

15. Filed July 6 1921 D S Drennan Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH — May (Month) 17 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1915 to May 17 1921 that I last saw him alive on May 16 1921 and that death occurred on the date stated above, at 2 A M.

The CAUSE OF DEATH* was as follows:

Senile Carteriosclerosis

(Duration) 6 Yrs. ..... mos. ..... ds.

Contributory (Secondary) old age

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Frank Ney M. D.

5/20 1921 (Address) Rathdrum Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 7 yrs. ..... mos. ..... days. In the State 20 yrs. ..... mos. ..... days

in Kootenai County hospital (Rathdrum)

Where was disease contracted if not at place of death? .....

Former or usual residence Kootenai County, Idaho

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Rathdrum Ida	20 1921

20. UNDERTAKER — ADDRESS

A. W. Gibson Rathdrum

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JUL 10 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 30
Primary Registration District No. 1051
File No. 34560
Registered No. 941

1. PLACE OF DEATH
County of Kootenai
City of
(No. Swan Lake St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Joseph Bruder

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH
(Month) (Day) (Year)

7. AGE: About 43 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Czechoslovakia

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Bruder
(Address) Meadowmont, Ida.

15.
Filed July 6 1921 D D Tremain
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
June 23 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at 6 P M.
The CAUSE OF DEATH* was as follows:
Accidental Drowning
in Swan Lake

(Duration) Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs mos. ds.

(Signed) R A Rooney Coroner M. D.
6/30 1921 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs mos days. In the State 1 yrs mos days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetery — DATE OF BURIAL: June 30 1921

20. UNDERTAKER: R A Rooney — ADDRESS: Coeur d'Alene

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JUL 1 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34561
Registered No. 940

1. PLACE OF DEATH
County of Kootenai Registration District No. 30
City of Coeur d'Alene (Ward) Lake St.) Registration District No. 1051
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Joseph L. Roy

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH
(Month) (Day) (Year)

7. AGE: 5 Mos. 4 Yrs. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Enarder
(Address) Medonmont Ida

15. Filed July 6, 1921 D D Dreman Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
June (Month) 23 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at 6 P. M.
The CAUSE OF DEATH* was as follows:
accidental Drowning

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) D D Dreman Coroner M. D.
June 30 1921 (Address) Coeur d'Alene Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. 3 mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetery
DATE OF BURIAL: June 30 1921

20. UNDERTAKER: W B Mooney
ADDRESS: Coeur d'Alene Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JUL 10 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 30

Primary Registration District No. 1051

(No. 811 Lake Side ave St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34562

Registered No. 939

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Kootenai

City of Coeur d'Alene

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Riley

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Jan (Month) 7 (Day) 1838 (Year)

7. AGE: 83 Yrs. 5 Mos. 17 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Home Wife

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ireland

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) James Riley

(Address) Coeur d'Alene Ida

15. Filed July 6 1921 D. D. Dreman Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 19 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 15 1921, to June 19 1921 that I last saw h.. alive on June 17 1921 and that death occurred on the date stated above, at 7 P M.

The CAUSE OF DEATH* was as follows:

Angina Pectoris.

(Duration) 2 Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John O'Wood M. D.

June 22 1921 (Address) Coeur d'Alene Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State 14 yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: St Thomas Cem — DATE OF BURIAL: June 21 1921

20. UNDERTAKER: R B Mooney — ADDRESS: Coeur d'Alene Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED JUL 10 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34563
Registered No. 938

1. PLACE OF DEATH.
Registration District No. 30
Primary Registration District No. 1051
County of Kootenai
City of Coeur d'Alene (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Carroll L. Skeel
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Mar

6. DATE OF BIRTH. Aug (Month) 15 (Day) 1869 (Year)

7. AGE: 51 Yrs. 9 Mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Post Master & Merchant
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wis

10. NAME OF FATHER: Nathan L. Skeel

11. BIRTHPLACE OF FATHER (State or Country): Pen

12. MAIDEN NAME OF MOTHER: Elizabeth Lucas

13. BIRTHPLACE OF MOTHER (State or Country): N. Y

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Margaret Skeel
(Address) Bay View Ida

15. Filed July 6 1921 D.D. Penna Local Registrar

SYMS - YORK CO., PTRS. & SOBS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 10. (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 1920 to May 10 1921, that I last saw h— alive on May 5. 1921, and that death occured on the date stated above, at 9:00 A.M.
The CAUSE OF DEATH* was as follows:
Pulmonary Hemorrhage
(Duration) 2 months Yrs. mos. ds.
Contributory (Secondary) Pulmonary tuberculosis
(Duration 1 yrs. 2 mos. ds.
(Signed) Frank L. Keane M. D.
5/14 1921 (Address) Rathdrum Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Athol Idaho | DATE OF BURIAL: May 13 1921

20. UNDERTAKER: C. W. Stone | ADDRESS: Rathdrum Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
JUL 10 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 30

County of ..... Primary Registration District No. 1651

File No. 34564

City of ..... (No. ....., ... St.)

Registered No. 937

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Donald Reed

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): S

6. DATE OF BIRTH: Dec (Month) 17 (Day) 1919 (Year)

7. AGE: 1 Yrs. 8 Mos. 24 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Coeur D. Alene

10. NAME OF FATHER: R. H. Reed

11. BIRTHPLACE OF FATHER (State or Country): Ill

12. MAIDEN NAME OF MOTHER: Myrtle Whitney

13. BIRTHPLACE OF MOTHER (State or Country): N. Y.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Lizzie DeWald

(Address) 605 7th St Coeur D Alene

15. Filed July 6 1921 D D Drenna Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 11 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 11 1921, to June 11 1921, that I last saw h..... alive on ..... 19....., and that death occurred on the date stated above, at ..... P M.

The CAUSE OF DEATH* was as follows:

Drowning accidental

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. H. Koelsch M. D.

19..... (Address) Coeur d Alene Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetery Coeur D Alene | DATE OF BURIAL: June 13 1921

20. UNDERTAKER: C. W. Stone Rathdrum Ida | ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
JUL 10 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 30
Primary Registration District No. 1057
File No. 34565
Registered No. 936

1. PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene (No. 924, 5th St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Roses

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: single (Write the word.)

6. DATE OF BIRTH: 5 (Month) 28 (Day) 1921 (Year)

7. AGE: ..... Yrs. ..... Mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Theador Roses.

11. BIRTHPLACE OF FATHER (State or Country): Dis.

12. MAIDEN NAME OF MOTHER: Ed A. May Herman

13. BIRTHPLACE OF MOTHER (State or Country): Ont.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Theador Roses
(Address) 923 Front C d A

15. Filed July 6 1921 D D Drema Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 4 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 28 1921, to June 4 1921 that I last saw h~~er~~ alive on June 3 1921, and that death occurred on the date stated above, at 6 A.M.

The CAUSE OF DEATH* was as follows:
Premature Births

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Mrs. P Wagner by Midwife M.D.
Jun 4 1921 (Address) Gibbs Bay P Kirkin Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: St. Thomas. Cem. C D Alene | DATE OF BURIAL: 6-5 1921

20. UNDERTAKER: C Cassedy | ADDRESS: C D Alene

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
JUL 10 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 30
Primary Registration District No. 1057
File No. 34566
Registered No. 935

1. PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene (No. 1007, 2nd St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James D. Stone
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Sept 8 1877 (Month) (Day) (Year)

7. AGE: 43 Yrs. 8 Mos. 23 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Deliveryman
(b) General nature of industry, business or establishment in which employed (or employer): Folsom Bro Grocery

9. BIRTHPLACE (State or Country): Minn

10. NAME OF FATHER: Jo Stone

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs J. D. Stone
(Address) Coeur d'Alene Ida

15. Filed July 6. 1921 D D Dreman Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 1 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..., to ..... 19...
that I last saw h... alive on ..... 19...,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Angina Pectoris
Story to Myocardial degeneration
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) D. D. Dreman M. D.
6/2 1921 (Address) Coeur d Alene Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State 35 yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetery — DATE OF BURIAL: June 8 1921

20. UNDERTAKER: R B Mooney — ADDRESS: Coeur d'Alene Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
JUL 10 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 30
Primary Registration District No. 1051
File No. 34567
Registered No. 934

1. PLACE OF DEATH
County of Kootenai
City of Coeur d' Alene (No. 831-7th St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mrs Ragna K. Amundsen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F	W	Widow

6. DATE OF BIRTH: April (Month) 30 (Day) 1866 (Year)

7. AGE: 55 Yrs. 1 Mos. 12 ds. IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House Wife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Norway

10. NAME OF FATHER: Nils Olsen

11. BIRTHPLACE OF FATHER (State or Country): Norway

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R. Amundsen
(Address) 831 7th Coeur D. Alene

15. Filed July 6, 1921 Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 12 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 6 1921, to June 12 1921, that I last saw her alive on June 10 1921, and that death occurred on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:
Nephritis (Interstitial)
(Duration) Yrs. 18 mos. ds.
Contributory (Secondary) Organic Heart Trouble
(Duration) yrs. mos. ds.

(Signed) W. H. Hoedemaker M. D.
6/12 1921 (Address) Coeur d'Alene Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF ~~BURIAL~~ OR REMOVAL: Park River N.D.
DATE OF BURIAL: 6/12 1921
20. UNDERTAKER: C. Cassedy
ADDRESS: Coeur d'Alene

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED JUL 8 1921 BUREAU OF VITAL STATISTICS

Registration District No. 64
Primary Registration District No. 2744
File No. 3456
Registered No.

1. PLACE OF DEATH
County of Latah
City of Troy (St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Olof Samuel Hjort

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: November 25 1905 (Month) (Day) (Year)

7. AGE: 15 Yrs. 6 Mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER: Carl G. Hjort

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Bertha Johnson

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Carl G. Hjort
(Address) Troy Idaho

15. Filed June 11 1921 Lucy M. Pickard Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 9th 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 9 1921 to ..... 19.....
that I last saw him alive on ..... 19.....
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
fracture ribs [illegible]
[illegible] to [illegible]
(Duration) instant Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) [illegible] M. D.
6/10 1921 (Address) Troy Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Troy Idaho. DATE OF BURIAL: 6/11 1921

20. UNDERTAKER: Lee Price ADDRESS Moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
JUL 9 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Latah — Registration District No. 61
City of Moscow — Primary Registration District No. 1011
(No. St.)
If death occurs away from usual residence, give facts called for under special information.

File No. 34569
Registered No. 35

2. FULL NAME Mary M. Westover

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widowed

6. DATE OF BIRTH: Mar 8 1840 (Month) (Day) (Year)

7. AGE: 80 Yrs. 6 Mos. 24 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business or establishment in which employed (or employer): With Children

9. BIRTHPLACE (State or Country): Canada.

10. NAME OF FATHER — Havens.

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Z

13. BIRTHPLACE OF MOTHER (State or Country): Maine

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) .....
(Address) .....

15. Filed June 5 19.. N. H Carothers Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 6 19 21 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 1 19 21, to June 6 19 21, that I last saw h.. alive on May 31 19 21, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary): Acute Arteriosclerosis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. N. Clarke M. D.

19.. (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Moscow	June 19 21
20. UNDERTAKER	ADDRESS
[illegible]	[illegible]

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 61
Primary Registration District No. 1011
File No. 34570
Registered No. 3A

RECEIVED
JUL 9 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Latah
City of Moscow (or Village or Township) (St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Alvin G. Raisz
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH: June 19 1913 (Month) (Day) (Year)

7. AGE: 7 Yrs. 11 Mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: John L. Raisz

11. BIRTHPLACE OF FATHER (State or Country): Norway

12. MAIDEN NAME OF MOTHER: Dorthy Olsen

13. BIRTHPLACE OF MOTHER (State or Country): Minn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): John L. Raisz
(Address): Moscow

15. Filed June 11 1921 W. H. Carruthers, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 9 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1 1921, to June 9 1921
that I last saw h[illegible] alive on June 9 1921
and that death occurred on the date stated above, at 10 P M.
The CAUSE OF DEATH* was as follows:

Typhoid Fever
(Duration) Yrs. 1 mos. 3 ds.
Contributory (Secondary)
(Duration) yrs. 00 mos. ds.

(Signed) H. C. Willis M. D.
6/11 1921 (Address) Moscow, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Moscow Cem
DATE OF BURIAL: 6/12 1921
20. UNDERTAKER: [illegible]
ADDRESS: Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 61
Primary Registration District No. 1011
File No. 34571
Registered No. 582

RECEIVED
JUL 9 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Latah
City of Moscow (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Marjory Eileen Smith

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: March (Month) 4 (Day) 1920 (Year)

7. AGE: 1 Yrs. 4 Mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Moscow, Idaho

10. NAME OF FATHER Percifer Earl Smith

11. BIRTHPLACE OF FATHER (State or Country) Idaho

12. MAIDEN NAME OF MOTHER Myrtle Hegsted

13. BIRTHPLACE OF MOTHER (State or Country) Washington

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) P. E. Smith
(Address) Moscow

15. Filed 6/15 1921 W. H. Carithers Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 14 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 10 1921, to June 14 1921, that I last saw h.. alive on June 13 1921, and that death occurred on the date stated above, at 2:30 P.M.

The CAUSE OF DEATH* was as follows:

Whooping Cough.

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas. L. Fortune M. D.

6/15/ 1921 (Address) Moscow, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Moscow — DATE OF BURIAL: 6/15 1921

20. UNDERTAKER: Hill Price — ADDRESS: Moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34572
Registered No. 33

Registration District No. 61
Primary Registration District No. 1011

BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Latah
City of Moscow (If outside city limits, give township) St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Victor Kostalek

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widowed

6. DATE OF BIRTH: June 5 1849 (Month) (Day) (Year)

7. AGE: 71 Yrs. Mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Tailor
(b) General nature of industry, business or establishment in which employed (or employer): Retired

9. BIRTHPLACE (State or Country): Bohemia

10. NAME OF FATHER: Vaclav Kostalek

11. BIRTHPLACE OF FATHER (State or Country): Bohemia

12. MAIDEN NAME OF MOTHER: Not Known to him

13. BIRTHPLACE OF MOTHER (State or Country): Bohemia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. D. Kostalek
(Address) Moscow Ida

15. Filed June 14 1921 W. H. Carithers Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 13 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 16 1921 to June 13 1921 that I last saw h.. alive on June 3 1921, and that death occurred on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary): Prostatitis.

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas. L. Fitzman M. D.

6/14 1921 (Address) Moscow Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Milwaukee, Ore. DATE OF BURIAL ..... 19....

20. UNDERTAKER: Gill ADDRESS Moscow

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34573

Registered No. 31

Registration District No. 61

Primary Registration District No. 1011

RECEIVED
JUL 9 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Latah

City of Moscow (No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Infant Dreelin

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: W Luth

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH: June 17 (Month) (Day) 1921 (Year)

7. AGE: ....Yrs....Mos....ds.

IF LESS than 1 day how many 1 hrs. or 20 min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work....

(b) General nature of industry, business or establishment in which employed (or employer)....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Patrick H Dreelin

11. BIRTHPLACE OF FATHER (State or Country) Washington

12. MAIDEN NAME OF MOTHER Elizabeth E Horvath

13. BIRTHPLACE OF MOTHER (State or Country) Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Patrick H Dreelin

(Address) Moscow Ida

15. Filed 6/18 19.... N H Carithers Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 17 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 17 1921 to June 17 1921 that I last saw h.im alive on June 17 1921 and that death occurred on the date stated above, at 12:40 M.

The CAUSE OF DEATH* was as follows:

Premature birth Sixth month

(Duration) ....Yrs....mos....ds.

Contributory (Secondary)....

(Duration) ....yrs....mos....ds.

(Signed) Chas. L. Fortune M. D.

6/18 1921 (Address) Moscow, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death....yrs....mos....days. In the State....yrs....mos....days

Where was disease contracted if not at place of death?....

Former or usual residence....

19. PLACE OF BURIAL OR REMOVAL: Moscow | DATE OF BURIAL: 6/18 1921

20. UNDERTAKER: Glen Bruce | ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
JUL 9 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
Registration District No. 101
County of Latah
Primary Registration District No. 1011
City of Moscow, (St.)
File No. 34574
Registered No. 30
If death occurs away from usual residence, give facts called for under special information.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary Ellen Daubenspeck

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Married

6. DATE OF BIRTH October 26 1860
(Month) (Day) (Year)

7. AGE 60 Yrs. 8 Mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) West Virginia

10. NAME OF FATHER John Haven

11. BIRTHPLACE OF FATHER (State or Country) Pennsylvania

12. MAIDEN NAME OF MOTHER Nancy Elizabeth Balston

13. BIRTHPLACE OF MOTHER (State or Country) Pennsylvania

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. W. Daubenspeck
(Address) Moscow, Idaho.

15. Filed 6/28 1921 W. H. Laviithers
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 27 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 9th 1921, to June 27 1921, that I last saw her alive on June 27 1921, and that death occurred on the date stated above, at 12:10 P.M.
The CAUSE OF DEATH* was as follows:

Carcinoma of cecum

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas. L. Gritman M. D.
6/28 1921 (Address) Moscow, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. 5 mos. 18 days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Moscow — DATE OF BURIAL 6/29 1921

20. UNDERTAKER Ellis Nee — ADDRESS Moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Latah — Registration District No. 61

City of Moscow — Primary Registration District No. 1011

(No. ... St.)

File No. 34575

Registered No. 29

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

RECEIVED JUL 9 1921 BUREAU OF VITAL STATISTICS STATE OF IDAHO

2. FULL NAME Adam Eutsler

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	White	Married

6. DATE OF BIRTH — Feb (Month) 11 (Day) 1871 (Year)

7. AGE — 50 Yrs. 3 Mos. 18 ds. — IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: Henry G Eutsler

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Etta Berthalf

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Henry G Eutsler
(Address) Moscow

15. Filed May 31 1921 W. H. Gaither Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH — May (Month) 29 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 27 1921 to May 29 1921 that I last saw h[illegible] alive on May 29 1921 and that death occurred on the date stated above, at 7:30 P. M.

The CAUSE OF DEATH* was as follows:
Valvular Leakage of Heart

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary): Pulmonary Tubercul[osis]

(Duration) 2 yrs. ... mos. ... ds.

(Signed) W M Mayfield M. D.

5/31 1921 (Address) Moscow

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Moscow — DATE OF BURIAL: 5/31 1921

20. UNDERTAKER: [illegible] — ADDRESS: Moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Lemhi — Registration District No. 42 41

City of Leadore — Primary Registration District No. 2153 2116 — File No. 34577

(If not in incorporated limits, give township, St.) — Registered No. 9

If death occurs away from usual residence, give facts called for under special information.

JUN 25 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME John Wesley Yearian

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: March (Month) 25th (Day) 1858 (Year)

7. AGE: 63 Yrs. 1 Mos. 10 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Merchant & Mining
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): St. Johns Ill.

10. NAME OF FATHER: George Yearian

11. BIRTHPLACE OF FATHER (State or Country): Mansfield Ohio

12. MAIDEN NAME OF MOTHER: Abigail Frost

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. N. Friday.
(Address) Leadore Idaho

15. Filed 5/6/ 1921 — I. B. Keller — Local Registrar
6-24-21 — M. K. Givens

STEWS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 4 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from — 19..., to — 19..., that I last saw him alive on May 3rd 1921, and that death occurred on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:
Shock - due to fall of dirt & rock while mining in tunnel. death was instantaneous.
— (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary): none
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Irvin B. Keller M. D.
5/6/ 1921 (Address) Leadore, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Yearian Cemetery — DATE OF BURIAL: 5-6" 1921

20. UNDERTAKER: John C. Doebler — ADDRESS: Salmon Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 41

Primary Registration District No. 2116

File No. 34578

County of Lemhi

City of Salmon (If not in incorporated limits, give township.) St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

JUN 1921
BUREAU OF VITAL STATISTICS

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Floyd Dougherty

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Oct 3rd (Month) (Day) 1882 (Year)

7. AGE: 38 Yrs. 7 Mos. 18 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Day Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): On Public Highway.

9. BIRTHPLACE (State or Country): Montana

10. NAME OF FATHER: David Dougherty

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Ida Bash

13. BIRTHPLACE OF MOTHER (State or Country): Oregon.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Gladys Dougherty
(Address) Salmon Ida

15. Filed 6-10 1921 M. V. Greene Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 21st (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occured on the date stated above, at 10 A. M.
The CAUSE OF DEATH* was as follows: Shot in
Head with 32 revolver
Self inflicted
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) Wm C Tockle Coroner M. D.
5-22" 1921 (Address) Salmon Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Salmon Cemetery — DATE OF BURIAL: 5-22" 1921

20. UNDERTAKER: W C Tockle — ADDRESS: Salmon Ida

N. B.—Every item of information should be carefully supplied. AGE should be accurately stated. Exact statement should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

EVANS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34579
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

RECEIVED
JUN 25 1921
BUREAU OF VITAL STATISTICS

Registration District No. 41
Primary Registration District No. 2116

1. PLACE OF DEATH
County of Lemhi
City of Spring Mountain (If outside limits of city or village, write the word "Country") St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Johnson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH. Not known (Month) (Day) 1 (Year)
7. AGE: about 35 Yrs. ..... Mos. ..... ds. IF LESS than 1 day how many .... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Quartz Miner
(b) General nature of industry, business, or establishment in which employed (or employer) .....
9. BIRTHPLACE (State or Country): Sweeden
10. NAME OF FATHER: Not known
11. BIRTHPLACE OF FATHER (State or Country): Not known
12. MAIDEN NAME OF MOTHER: " "
13. BIRTHPLACE OF MOTHER (State or Country): " "
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wm C Jacobs
(Address) Johnson Ida.
15. Filed 6-10 1921. M. N. Greene Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 2nd 1921 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from ..... 191..... to .....191...
that I last saw h.....alive on .....191....
and that death occurred on the date stated above, at ....A....M.
The CAUSE OF DEATH* was as follows:
Gun shot wound in head, Self inflicted.
.....(Duration) ..... Yrs..... mos. ..... ds.
Contributory (Secondary) .....
.....(Duration) ..... Yrs..... mos. ..... ds.
(Signed) Wm C Jacobs Coroner
5-4" 1921. (Address) Johnson Ida.
*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Spring Mountain Cemetery — DATE OF BURIAL: 5-4" 1921
20. UNDERTAKER: Wm C Jacobs — ADDRESS: Johnson Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

34580

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED JUN 25 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Lemhi — Registration District No. 42 41

City of Leadore (No. ..... St.) — Primary Registration District No. 2153 2116

File No. 10

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Robert DeVance

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Not known (Month) (Day) ..... (Year)

7. AGE: 48 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Rancher

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Texas

10. NAME OF FATHER: Robert DeVance

11. BIRTHPLACE OF FATHER (State or Country): France

12. MAIDEN NAME OF MOTHER: Adelaide Spencer

13. BIRTHPLACE OF MOTHER (State or Country): Texas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Louise B. Connely

(Address) 365 E-57 St Chicago Ill

15. Filed 5/9/1921 — Irvin B. Keller Local Registrar

6-10-21 M. D. Lemhi

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 8th (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 29th 1921, to May 7th 1921 that I last saw him alive on May 7th 1921, and that death occurred on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) — Yrs. 9 mos. — ds.

Contributory (Secondary) none

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Irvin B. Keller M. D.

5/9 1921 (Address) Leadore, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Leadore Cemetery — DATE OF BURIAL: 5-10-21

20. UNDERTAKER: W. C. Voelte — ADDRESS: Salmon Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34581
Registered No.

RECEIVED
JUN 25 1921
BUREAU OF VITAL STATISTICS

Registration District No. 41
Subregistration District No. 2116

1. PLACE OF DEATH
County of Lemhi
City of Black Bird Ida (If outside limits, give township) St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Thomas Mahoney

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Divorced

6. DATE OF BIRTH: Not known (Month) (Day) 1 (Year)

7. AGE: about 60 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ireland

10. NAME OF FATHER: Not known

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Not known

13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. C. Freeman
(Address) Salmon Idaho

15. Filed 6/10 1921 W. D. Greene Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 2nd (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..., to ..... 19...
that I last saw h... alive on ..... 19...,
and that death occurred on the date stated above, at 12:30 P.M.
The CAUSE OF DEATH* was as follows:
Natural
Causes, due to Brain fever

(Duration) Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) W. C. Doole, Coroner M. D.
6-2" 1921 (Address) Salmon Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Salmon Cemetery — DATE OF BURIAL: 6-4" 1921

20. UNDERTAKER: W. C. Doole — ADDRESS: Salmon Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34582

1. PLACE OF DEATH

County of Lemhi — Registration District No. 41

City of Salmon — Primary Registration District No. 416 — (No. ..... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

RECEIVED JUN 25 1921 BUREAU OF VITAL STATISTICS

2. FULL NAME Mrs Josephine Steele

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem.

4. COLOR OR RACE: English

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married.

6. DATE OF BIRTH: April (Month) 20 (Day) 1857 (Year)

7. AGE: 64 Yrs. 2 Mos. 17 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Mother & Wife.
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Concord, N. H.

10. NAME OF FATHER: Joe. -Clark.

11. BIRTHPLACE OF FATHER (State or Country): Concord, New Hampshire

12. MAIDEN NAME OF MOTHER: Mother borned. Concord N.H.

13. BIRTHPLACE OF MOTHER (State or Country): Milinda Foot.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Annie Cooper
(Address) Carmen Idaho

15. Filed 6/10 1921 M. D. Greene Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 6" 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1921, to June 6 1921, that I last saw h[illegible] alive on June 7 1921, and that death occurred on the date stated above, at 1 H. M.

The CAUSE OF DEATH* was as follows:

Pneumonia - bronchial

Chronic (Duration) 2 yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas F Hanson M. D.

June 7 1921 (Address) Salmon

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Sunset Cemetery — DATE OF BURIAL: 6-8" 1921

20. UNDERTAKER: [illegible] — ADDRESS: Salmon Idaho

N. B.—Every item of information should be carefully supplied. AGE and OCCUPATION is very important. See instructions on back of certificate. Exact statement of in plain terms, so that it may be properly classified. WRITE PLAINLY, WITH UNFADING INK. THIS IS A PERMANENT RECORD MARGIN [illegible] OR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 4
Primary Registration District No. 2116
File No. 34583
Registered No.

1. PLACE OF DEATH
County of Lemhi
City of Salmon (If outside limits, give township) St.)
If death occurs away from usual residence, give facts called for under special information.

RECEIVED JUN 25 1921 BUREAU OF VITAL STATISTICS

2. FULL NAME James L Cheney Infant
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.):

6. DATE OF BIRTH: May 6th 1921 (Month) (Day) (Year)

7. AGE: Yrs. Mos. 15 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: James M. Cheney

11. BIRTHPLACE OF FATHER (State or Country): Montana

12. MAIDEN NAME OF MOTHER: Marie Labaie

13. BIRTHPLACE OF MOTHER (State or Country): North Dakota

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): James M Cheney
(Address): Baker Ida

15.
Filed 6/10 1921 M. D. Greene Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 21st 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 16 1921, to May 21 1921, that I last saw h. alive on May 21 1921, and that death occurred on the date stated above, at 1 P M.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) Yrs. mos. 5 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Chas F Hamman M. D.

June 7 1921 (Address) Salmon

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Salmon Cemetery
DATE OF BURIAL: 5-23 1921

20. UNDERTAKER: Wm C Doebler
ADDRESS: Salmon Ida

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JUL 5 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 30
Primary Registration District No. 2129
File No. 34584
Registered No. 7

1. PLACE OF DEATH
County of Lewis
City of Craigmont (or Village or Township) St.)
If death occurs away from usual residence give facts called for under special information.

2. FULL NAME Sterling N. Bruce

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Male	White	Married (Write the word.)

6. DATE OF BIRTH: Feb (Month) 17 (Day) 1850 (Year)

7. AGE: 71 Yrs. 3 Mos. 24 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Massachusetts

10. NAME OF FATHER: George Bruce

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Fidelia Hollenbeck

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mary I Buttrey
(Address) Craigmont Idaho

15. Filed 6/12 1921 F C Daniels Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 10 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apl 12 1920, to June 10 1921, that I last saw h[illegible] alive on June 9 1921, and that death occurred on the date stated above, at 1.45 P.M.
The CAUSE OF DEATH* was as follows:

Cerebral apoplexy.
(Duration) ..... Yrs. ..... mos. 3 ds.
Contributory (Secondary) Chronic Interstitial nephritis
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F C Daniels M. D.
6/13 1921 (Address) Craigmont Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Craigmont Cemetery	6/13 1921
20. UNDERTAKER	ADDRESS
Craigmont Hdw & Furn Co	Craigmont

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34587
Registered No. 6

1. PLACE OF DEATH.
County of Lewis
City of Morrow (No. ..... St.)
Registration District No. V
Primary Registration District No. 2129.
If death occurs away from usual residence, give facts called for under special information.

RECEIVED
JUN 4 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME Mary Anne Norton

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married
6. DATE OF BIRTH. Sept. (Month) 12, (Day) 1857 (Year)
7. AGE: 63 Yrs. 8 Mos. 2 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Missouri
10. NAME OF FATHER: Christian Strohm
11. BIRTHPLACE OF FATHER (State or Country): Switzerland
12. MAIDEN NAME OF MOTHER: Harriet Farley
13. BIRTHPLACE OF MOTHER (State or Country): Missouri
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) A. Norton
(Address) Morrow
15. Filed 6/23 1921 P. E. Dwelle Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 14, (Day) 1921 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Oct. 14, 1920, to May 14, 1921, that I last saw her alive on Dec. 27, 1920 and that death occured on the date stated above, at 6:00 P.M.
The CAUSE OF DEATH* was as follows:
Nephritis, Chronic.
(Duration) 4+ Yrs. mos. ds.
Contributory (Secondary)
(Duration yrs. mos. ds.
(Signed) J. J. Warby M. D.
6/6 1921 (Address) Reserved

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Westlawn Cem Co
DATE OF BURIAL: 6/6 1921
20. UNDERTAKER: Mrs. Jobe
ADDRESS: Craigmont Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34588

Registered No. .....

RECEIVED
JUL 8 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH.

Registration District No. 100

Primary Registration District No. 2178

County of Madison

City of ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Regina Heinz

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. August (Month) 28 (Day) 1862 (Year)

7. AGE: 58 Yrs. 9 Mos. 17 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): At home

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: Michael Heinz

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Elizabeth Karpf

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mayor Nash

(Address) Rexburg, Ida.

15. Filed 6/16 1921

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 6 (Month) 15 (Day) 21 191 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 6-10 1921, to 6-13-21 191, that I last saw her alive on 6-13-21 191, and that death occured on the date stated above, at 1 P. M.

The CAUSE OF DEATH* was as follows:

Pernicious anemia

(Duration) few Yrs. mos. ds.

Contributory (Secondary) Mal nutrition

(Duration) yrs. few mos. ds.

6/16 1921 (Signed) Lorin F. Rich M. D.

(Address) Rexburg Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rexburg, Ida. DATE OF BURIAL: June 18 1921

20. UNDERTAKER: David R. Young ADDRESS: Rexburg I

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SVMS - YORK CO., PTRS. & SORS. 24854

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34589

Registered No.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

RECEIVED
JUL 8 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 100

Primary Registration District No. 2178

County of Madison

City of Rexburg (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Clifton Hawkes

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: June (Month) 11 (Day) 1921 (Year)

7. AGE: — yrs. — mos. 3 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Rexburg Ida

10. NAME OF FATHER: Bryant Hawkes

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Evelyn Horton

13. BIRTHPLACE OF MOTHER (State or Country): Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Bryant Hawkes
(Address): Rexburg Ida

15. Filed 6/28 1921 G. E. Cope
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 6 (Month) 15 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 6-11-21 191 , to 6-15-21 191 , that I last saw h[illegible] alive on 6-15-21 191 , and that death occurred on the date stated above, at 5 P M.

The CAUSE OF DEATH* was as follows:
Sinus thrombosis

(Duration) yrs. mos. 3 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

6/15 1921 (Signed) Lorne F. Rich M. D.
(Address) Rexburg Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Sugar City Cemetery — DATE OF BURIAL: June 15 1921

20. UNDERTAKER: Rexburg Furniture Co — ADDRESS: Rexburg Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34590
Registered No. .....

1. PLACE OF DEATH.
County of Madison
City of Rexburg. (St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 100
Primary Registration District No. 2178

RECEIVED
JUL 8 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME Homer Dale Moore

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: "hite
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH. December 17 1920 (Month) (Day) (Year)
7. AGE: .. Yrs. 6 Mos. 1 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country) Idaho
10. NAME OF FATHER: William H. Moore
11. BIRTHPLACE OF FATHER (State or Country) Utah
12. MAIDEN NAME OF MOTHER: Mary Ellen Neeley
13. BIRTHPLACE OF MOTHER (State or Country) Idaho
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) D W Smith
(Address) Rexburg Ida
15. Filed 6/19 1921 G G Eske Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 18, (Day) 1921. (Year)
17. I HEREBY CERTIFY, That I attended deceased from June 15 1921, to June 18 1921, that I last saw him alive on June 18 1921, and that death occured on the date stated above, at 11 P.M.
The CAUSE OF DEATH* was as follows:
Lobar Pneumonia
(Duration) ... Yrs. ... mos. 8 ds.
Contributory (Secondary)
(Duration ... Yrs. ... mos. ... ds.
(Signed) D W Martin M. D.
June 20 1921 (Address) Rexburg, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Burton, Idaho — DATE OF BURIAL: June 20 1921
20. UNDERTAKER: David Young — ADDRESS: Rexburg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24654

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

RECEIVED
JUL 8 1921
BUREAU OF VITAL STATISTICS

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 100
Primary Registration District No. 2178
File No. 34592
Registered No.

1. PLACE OF DEATH.
County of Madison
City of Rexburg (or St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ernest L. Smith

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	W	Bale

6. DATE OF BIRTH: June (Month) 24 (Day) 1921 (Year)

7. AGE: ..... yrs. ..... mos. 1 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Bale
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Rexburg

10. NAME OF FATHER: E. L. Smith

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Evangeline Jones

13. BIRTHPLACE OF MOTHER (State or Country): Rexburg

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E L Smith
(Address) R 3.

15. Filed 6/27 1921 G. W. Teske Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 6 (Month) 26 (Day) 21 (Year) 191

17. I HEREBY CERTIFY, That I attended deceased from 6-24-21 191, to 6-26-21 191, that I last saw h IM alive on 6-26-21 191, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Intestinal obstruction
Congenital

(Duration) ..... yrs. ..... mos. 2 ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

6/26 1921 (Signed) Lorin A Rich M. D.
(Address) Rexburg Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Porter Regan	6/27 1921

20. UNDERTAKER	ADDRESS
J Ryan	Rexburg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

GYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED JUL 5 192 BUREAU OF STATISTICS

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 92 — 34595

County of Nez Perce — Primary Registration District No. 2170 — File No. 5

City of Agatha, ... St.) — Registered No. 23

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Frank Fields

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	White	single

6. DATE OF BIRTH. Apr (Month) 7 (Day) 1854 (Year)

7. AGE 67 Yrs. 2 Mos. 14 ds. — IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work... farm labor
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Oregon

10. NAME OF FATHER Thos Fields

11. BIRTHPLACE OF FATHER (State or Country) —

12. MAIDEN NAME OF MOTHER Rebecca Ripps

13. BIRTHPLACE OF MOTHER (State or Country) —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) E. Aldrich
(Address) Orofino Ida

15. Filed 6 - 24 1921 — E.E. Watts, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 6 (Month) 23 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ~ 191~, to ~ 191~, that I last saw him alive on ~ 191~, and that death occured on the date stated above, at 11-00 a.m.

The CAUSE OF DEATH* was as follows:
Apoplexy
instant death
(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) E.E. Watts M. D.
6-24 1921 (Address) Gifford

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Gifford — DATE OF BURIAL: 6-25 1921

20. UNDERTAKER P.T. Adamson (each) — ADDRESS Gifford

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & STRS. 24658

FORM V. S. No. 5-25 M. 1-16-18

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Shoshone — RECEIVED — Registration District No. 92 — 3459

City of Kellogg — JUL 5 — Primary Registration District No. 2170

(No. ... St.) — BUREAU OF VITAL STATISTICS — File No. 5

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Abraham L Staley — Registered No. 22

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH. April 4 (Month) June (Day) 15 1861 (Year)

7. AGE 60 Yrs. 2 Mos. 11 ds. — IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work... Farmer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Ohio

10. NAME OF FATHER Wm H Staley

11. BIRTHPLACE OF FATHER (State or Country) Ohio

12. MAIDEN NAME OF MOTHER Lilla Babcock

13. BIRTHPLACE OF MOTHER (State or Country) Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) E R Staley
(Address) Reubens Idaho

15. Filed 6-26 1921 — E. E. Watts, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 15 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at 6 00 M.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
..... (Duration) ..... Yrs. ..... mos. 30 min. ds.
Contributory (Secondary)
..... (Duration ..... yrs. ..... mos. ..... ds.
(Signed) E.E. Watts M. D.
6/16/1921 (Address) Clifford

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Cook Cem — DATE OF BURIAL 6-17 1921

20. UNDERTAKER H E Goddard — ADDRESS Clifford

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRNE - YORK CO., PTRS. & STRS. 24653

FORM V. S. No. 5-A—25 M. 1-19.

34597

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED JUL 2 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 136

County of Owyhee Primary Registration District No. Homedale

City of Homedale (or Township) St.)

File No.

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William Lemon Thompson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male | 4. COLOR OR RACE: white | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: July (Month) 18 (Day) 1854 (Year)

7. AGE: 66 Yrs. 11 Mos. 24 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Andrew Thompson

11. BIRTHPLACE OF FATHER (State or Country): Ohio.

12. MAIDEN NAME OF MOTHER: Elizabeth Willis

13. BIRTHPLACE OF MOTHER (State or Country): Ohio.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Jos E. Thompson
(Address): Homedale, Idaho

15. Filed July 1 1921 S. Hopper Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 12 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 12 1921, to June 12 1921, that I last saw him alive on June 13 1921, and that death occurred on the date stated above, at 10-a M.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

(Duration) unknown ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Simeon Hopper M. D.

19..... (Address) Homedale Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill. | DATE OF BURIAL: 6-14 1921

20. UNDERTAKER: E. V. Peckham | ADDRESS: Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY; PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

34598

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
JUL 12 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Oneida — Registration District No. 26

City of Ridgedale Ida (No. ..... St.) — Primary Registration District No. 2069

File No. .....

Registered No. 21

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Alfred C. Nilsen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: October 24 (Month) (Day) 1884 (Year)

7. AGE: 36 Yrs. 7 Mos. 10 ds.

IF LESS than 1 day: how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer.

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Draper Utah

10. NAME OF FATHER: Peter A. Nilsen

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: Olevia Jensen

13. BIRTHPLACE OF MOTHER (State or Country): Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ernest E Thomas

(Address) Ridgedale Ida

15. Filed June 9 1921 — P. M. Mauer M. D. Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 4 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 19.. to June 19..,

that I last saw h. alive on June 4 1921,

and that death occurred on the date stated above, at 1 P. M.

The CAUSE OF DEATH* was as follows:

Hit by Lightning

Instantly

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. — ds.

(Signed) J. M. Kerns, M. D.

6/4 1921 (Address) Malad Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Draper, Utah — DATE OF BURIAL ..... 19..

20. UNDERTAKER: Wm. P. Horne — ADDRESS Tremonton, Ut.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

RECEIVED

JUL 15 1927

BUREAU OF STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34599
Registered No. 22

1. PLACE OF DEATH. County of Owyhee; City of Murtaugh (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. .....
Registration District No. .....

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William Richards

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	White	Widowed

6. DATE OF BIRTH: July (Month) 20 (Day) 1827 (Year)

7. AGE: 93 yrs. 10 mos. 9 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) Farming

9. BIRTHPLACE (State or Country) Wales

10. NAME OF FATHER William Richards

11. BIRTHPLACE OF FATHER (State or Country) Wales

12. MAIDEN NAME OF MOTHER Harriett Jones

13. BIRTHPLACE OF MOTHER (State or Country) Wales

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E E Richards
(Address) .....

15.
Filed ..... 191...
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June (Month) 7 (Day) 1927 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1 1927, to June 9 1927, that I last saw him alive on June 8 1927, and that death occurred on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:
Senile Gangrene
.....
.....
.....
(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J F Alton M.D.
6-11-1927 (Address) Malad Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Malad Idaho	June 12 1927

20. UNDERTAKER: J Jay Benson — ADDRESS: Malad Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

GYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

34600

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Owyhee RECEIVED JUL 12 1921 Registration District No. 74

City of Grand View (No. ....., ... St.) Primary Registration District No. 2151

File No. 1

Registered No. 1

If death occurs away from usual residence, give facts called for under special information.

BUREAU OF VITAL STATISTICS

2. FULL NAME Jean Marie Ornsby.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
female	white	Single

6. DATE OF BIRTH: June (Month) 11 (Day) 1921 (Year)

7. AGE: 0 Yrs. 0 Mos. 10 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Owyhee Co. Idaho.

10. NAME OF FATHER: Child born out of wedlock

11. BIRTHPLACE OF FATHER (State or Country): ✓

12. MAIDEN NAME OF MOTHER: Irene Ornsby

13. BIRTHPLACE OF MOTHER (State or Country): Iowa.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Wm. Ornsby

(Address) Grand View.

15. Filed June 21 1921 W J Eskenbeck Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 21 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from this date only to June 21 1921 that I last saw her alive on Jun 21 1921, and that death occurred on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:

Starvation

(Duration) ✓ Yrs. ✓ mos. 10 ds.

Contributory (Secondary) Poorly developed infant

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Wm. J. Eskenbeck M. D.

June 1921 (Address) grand View Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: grand View Cemetery — DATE OF BURIAL: June 22 1921

20. UNDERTAKER: none — ADDRESS: ✓

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FOR [redacted] RECEIVED JUL 1 1921 BUREAU OF VITAL STATISTICS

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH Registration District No. 4
County of Payette Primary Registration District No. 1008
City of Payette (No. ..... St.)
File No. 34601
Registered No. 21

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lee O Connerly

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6. DATE OF BIRTH: Feb (Month) 22 (Day) 1876 (Year)

7. AGE: 45 Yrs. 3 Mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ind.

10. NAME OF FATHER: William Connerly

11. BIRTHPLACE OF FATHER (State or Country): Ind

12. MAIDEN NAME OF MOTHER: Mary Hest

13. BIRTHPLACE OF MOTHER (State or Country): Ind

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) B. R. Wilts
(Address) Payette

15. Filed June 3 1921 J C Woodward Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 30 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I ~~attended deceased from~~ ..... 19..... to ..... 19.....
that I last saw h— alive on May 29 1921,
and that death occurred on the date stated above, at 10:00 A.M.
The CAUSE OF DEATH* was as follows:
Heart failure. deceased found dead with no indications other than above stated
— (Duration) — Yrs. — mos. — ds.
Contributory (Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Will Wells. J.P. acting coroner M. D.
19..... (Address) Payette Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Payette Ida	May 31 1921
20. UNDERTAKER	ADDRESS
J Alden Payette Ida	

SUNS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
JUL 1 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 4
Primary Registration District No. 1008
File No. 34602
Registered No. 29

1. PLACE OF DEATH
County of Payette
City of Payette (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Zola A Brannock.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Married

6. DATE OF BIRTH: June 16 (Month) 898 (Day) (Year)

7. AGE: 22 Yrs. 11 Mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Texas

10. NAME OF FATHER: John Pierce

11. BIRTHPLACE OF FATHER (State or Country): Texas

12. MAIDEN NAME OF MOTHER: Hannah Yount

13. BIRTHPLACE OF MOTHER (State or Country): Ala

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Hannah A Pearce
(Address) Payette

15. Filed June 4 1921 J. B. Woodward Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 26 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 15 1921, to May 26 1921, that I last saw h.. alive on May 26 1921, and that death occurred on the date stated above, at 1 P. M.
The CAUSE OF DEATH* was as follows:
Tubercular Peritonitis
(Duration) 1 Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) J R Woodward M. D.
6/1 1921 (Address) Payette Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Payette Ida	May 28 1921
20. UNDERTAKER	ADDRESS
E. Nadeau	Payette Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JUL 1 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Payette — Registration District No. 4
City of Payette (No. ..... St.) — Primary Registration District No. 1008.
File No. 34603
Registered No. 23
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Margaret Godfrey
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widowed

6. DATE OF BIRTH: Apr (Month) 28 (Day) 1848 (Year)

7. AGE: 73 Yrs. 1 Mos. 24 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ireland

10. NAME OF FATHER: Timothy Mainey

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Anastasia Lyon

13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) .....
(Address) Mrs Marion Hamby Payette Idaho

15. Filed June 23 1921 J. C. Woodward Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 22 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 9 1921, to June 22 1921, that I last saw her alive on June 21 1921, and that death occurred on the date stated above, at 7:30 P.M.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
(Duration) Yrs. About mos. 3 / ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) O. H. Hoag M. D.
6/23/1921 (Address) Payette Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Payette Ida — DATE OF BURIAL: 6-24 1921

20. UNDERTAKER: D. Nelson — ADDRESS: Payette Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
JUL 1 1921
BUREAU OF VITAL STATISTICS

Registration District No. 4
Primary Registration District No. 1008
File No. 34604
Registered No. 24

1. PLACE OF DEATH
County of Payette
City of Payette (If outside limits, give township) (No. St.)
If death occurred away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Hendrix Jackson James

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Dec (Month) 2 (Day) 1915 (Year)

7. AGE: 5 Yrs. 7 Mos. 21 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Walter James

11. BIRTHPLACE OF FATHER (State or Country) Ill.

12. MAIDEN NAME OF MOTHER Alma A Smith

13. BIRTHPLACE OF MOTHER (State or Country) Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Walter James
(Address) Payette Idaho

15. Filed June 23 1921 J. O. Woodward Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 23 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from January 1920, to June 23 1921, that I last saw him alive on June 23 1921, and that death occurred on the date stated above, at 8⁰⁰ P.M.

The CAUSE OF DEATH* was as follows:
Convulsion — Epileptic
(Duration) about two hours yrs. mos. ds.
Contributory (Secondary) Jacksonian Epilepsy
(Duration) 3½ yrs. mos. ds.

(Signed) O. F. Avery M. D.
6/24/1921 (Address) Payette, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Payette Idaho — DATE OF BURIAL: June 24 1921

20. UNDERTAKER: Blum & Landon — ADDRESS: Payette Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34606
Registered No. 26

1. PLACE OF DEATH

RECEIVED
JUL 1 1921
BUREAU OF VITAL STATISTICS

Registration District No. 4
Primary Registration District No. 1008

County of Ada
City of Ontario (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elmer Ellsworth Jarvis

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widowed

6. DATE OF BIRTH: Oct. (Month) 26 (Day) 1861 (Year)

7. AGE: 59 Yrs. 8 Mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ill.

10. NAME OF FATHER: Alvin S Jarvis

11. BIRTHPLACE OF FATHER (State or Country): Penn.

12. MAIDEN NAME OF MOTHER: Hannah Young

13. BIRTHPLACE OF MOTHER (State or Country): [illegible]

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Homer S Jarvis
(Address) Parma Idaho

15. Filed June 29 1921 J C Woodward Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 28 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 27 1921, to June 28 1921, that I last saw h[illegible] alive on June 28 1921, and that death occurred on the date stated above, at 5:30 P.M.

The CAUSE OF DEATH* was as follows:

Tetanus of Jaw Trismus Sulcatimus
(Duration) ..... Yrs. ..... mos. 2 ds.
Contributory (Secondary) Peritonitis
(Duration) ..... yrs. ..... mos. / ds.

(Signed) J. A. McNamee M. D.
6-29 1921 (Address) Payette Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Payette Idaho
DATE OF BURIAL: June 29 1921

20. UNDERTAKER: Glenn C Landon
ADDRESS: Payette Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Payette — Registration District No. 4

City of Payette — Primary Registration District No. 1008

(No. ..... St.)

File No. 34607

Registered No. 27

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

RECEIVED JUL 1 1921 BUREAU OF VITAL STATISTICS

2. FULL NAME Nat Heaney

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. ~~SINGLE~~, MARRIED, WIDOWED OR ~~DIVORCED~~: widowed (Write the word.)

6. DATE OF BIRTH: Nov 9 1845 (Month) (Day) (Year)

7. AGE: 75 Yrs. 7 Mos. 16 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Nova Scotia

10. NAME OF FATHER: Wm Henry

11. BIRTHPLACE OF FATHER (State or Country): Nova Scotia

12. MAIDEN NAME OF MOTHER: Don't Know

13. BIRTHPLACE OF MOTHER (State or Country): Nova Scotia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Ray Barron

(Address) Payette

15. Filed June 30 1921 J C Woodward Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 25 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 20 1921, to June 25 1921 that I last saw him alive on June 20 1921, and that death occurred on the date stated above, at 8:00 P.M.

The CAUSE OF DEATH* was as follows:

Endocarditis — (Mitral insufficiency)

(Duration) Indefinite yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) O. H. Avery M. D.

6/28/1921 (Address) Payette, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Payette Idaho — DATE OF BURIAL: June 25 1921

20. UNDERTAKER: Glenn C Landon — ADDRESS: Payette Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

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FORM V. S. No. 5-25 M. 1-19.

RECEIVED
JUL 2 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34608

1. PLACE OF DEATH
County of Payette
City of Fruitland
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No.
(No. , St.)

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Virginia Gorman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: widow (Write the word.)

6. DATE OF BIRTH: Oct (Month) 10 (Day) 1850 (Year)

7. AGE: 70 Yrs. 8 Mos. 18 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Vig

10. NAME OF FATHER: James Elliott

11. BIRTHPLACE OF FATHER (State or Country): Vig

12. MAIDEN NAME OF MOTHER: Amelia Litton

13. BIRTHPLACE OF MOTHER (State or Country): Vig

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. L. Shipp
(Address) Fruitland Ida

15. Filed June 30 1921 C. C. Paxton Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 29 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ——— 19—, to ——— 19—, that I last saw h— alive on ——— 19—, and that death occurred on the date stated above, at about 7 P.M.

The CAUSE OF DEATH* was as follows:
Drowned

(Duration) — Yrs. — mos. — ds.
Contributory (Secondary)
— (Duration) — yrs. — mos. — ds.

(Signed) C. C. Paxton M. D.
6-29 1921 (Address) Fruitland Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence Clio Iowa

19. PLACE OF BURIAL OR REMOVAL: Clio Iowa — DATE OF BURIAL: July 3 1921

20. UNDERTAKER: Glenn C Landon — ADDRESS: Payette Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED JUL 8 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 25 — 34609

Primary Registration District No. 2072

File No. 3

Registered No. 129

County of Power

City of Rockland (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Meta Sibyl Walker

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWER OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. not known (Month) (Day) (Year)

7. AGE: 16 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Rockland, Idaho

10. NAME OF FATHER: M.E.Walker

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Lara Walker

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) M E Walker

(Address) Rockland, Idaho

15. Filed 7-1 1921 R. F. Nott Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 27 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from October 1920, to June 1921, that I last saw her alive on June 1921, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Hypertrophy of heart

(Duration) Many yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) V G Fegan M. D.

6/27 1921 (Address) American Falls, Idaho

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rockland, Idaho — DATE OF BURIAL: June 28 1921

20. UNDERTAKER: A.W.Davis — ADDRESS: American Falls, I

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24853

FORM V. S. No. 5-12 M. 6-15-17.

RECEIVED JUL 8 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 25

Primary Registration District No. 2072

34610

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3
Registered No. 128
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Power
City of American Falls (If not in incorporated limits, give township) St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Maria Isaak

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH. March (Month) 10 (Day) 1846 (Year)

7. AGE: 74 Yrs. 2 Mos. 25 ds.
IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): South Russia

10. NAME OF FATHER: Christ Schuler

11. BIRTHPLACE OF FATHER (State or Country): South Russia

12. MAIDEN NAME OF MOTHER: Not Known

13. BIRTHPLACE OF MOTHER (State or Country): South Russia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John D. Isaak
(Address) American Falls, Idaho

15. Filed 6-7 1921 R. J. Nott Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 5 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 2 1921 to June 4 1921
that I last saw h[illegible] alive on June 4 1921
and that death occurred on the date stated above, at .... M.

The CAUSE OF DEATH* was as follows:
Pneumonia
(Duration) .... Yrs. .... mos. .... ds.
Contributory (Secondary)
(Duration) .... Yrs. .... mos. .... ds.

(Signed) W. G. Sizer M. D.
6/6 1921 (Address) American Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the ,State....yrs....mos....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Am Falls
DATE OF BURIAL: June 6/21

20. UNDERTAKER [illegible] AM Falls ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED JUL 11 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH.

34611

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 1

Registered No. 6

1. PLACE OF DEATH.

County of Shoshone

City of Avery (If outside limits of city or village, give township.) St.)

Registration District No. 2400

Subdistrict, Registration District No.

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary J. Dewey

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. October (Month) 9 (Day) 1845 (Year)

7. AGE 76 Yrs. 5 Mos. 11 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Housewife

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Vermont, U.S.A

10. NAME OF FATHER John Fanning

11. BIRTHPLACE OF FATHER Vermont, U.S.A (State or Country)

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER Vermont, U.S.A (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Geo. Williams c/o

(Address) Avery, Idaho

15.

Filed May 20 1921 C Bruny Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 20 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 14 1921, to May 20 1921, that I last saw h.. alive on May 20 1921, and that death occured on the date stated above, at 6.55 AM.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... Yrs. ..... mos. 6 ds.

Contributory (Secondary) Chronic Nephritis

(Duration 7 yrs. ..... mos. ..... ds.

(Signed) C Bruny M. D.

May 20 1921 (Address) Avery Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Spokane, Wash

DATE OF BURIAL ..... 191..

20. UNDERTAKER

ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

8Y96 - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

34612 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
JUL 12 1921
BUREAU OF VITAL STATISTICS

Registration District No. 16
Primary Registration District No. 1016
File No.
Registered No. 11

1. PLACE OF DEATH.
County of Lincoln
City of Shoshone
(If death occurs away from usual residence, give facts called for under special information.)
No. ..... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Katheryn Virginia Redmon

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. June 6 1921 (Month) (Day) (Year)

7. AGE ..... Yrs. 21 Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work... Infant
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Richfield

10. NAME OF FATHER Raymond W. Redmon

11. BIRTHPLACE OF FATHER (State or Country) Colorado

12. MAIDEN NAME OF MOTHER Kathryn C. Miller

13. BIRTHPLACE OF MOTHER (State or Country) Colorado

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) .....
(Address) .....

15. Filed June 27 1921 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 27 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 23 1921, to June 27 1921, that I last saw her alive on June 26 1921, and that death occured on the date stated above, at 7 a M.

The CAUSE OF DEATH* was as follows:
Gastro-enteritis

(Duration) ..... Yrs. ..... mos. 20 ds.
Contributory (Secondary) No
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) ..... M. D.
June 27 1921 (Address) Shoshone Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos. 3 days. In the State.....yrs.....mos. 21 days
Where was disease contracted if not at place of death? Richfield Ida.
Former or usual residence Richfield Ida.

19. PLACE OF BURIAL OR REMOVAL: Richfield — DATE OF BURIAL: 6-28 1921

20. UNDERTAKER: D. F. Thurman — ADDRESS: Shoshone

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Exact statement should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED
JUL 12 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 3401

Registered No. 10

1. PLACE OF DEATH. Registration District No. 16
County of Lincoln Primary Registration District No. 1016
City of Shoshone (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME George M. Stoner

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed
6. DATE OF BIRTH. April (Month) 18 (Day) 1861 (Year)
7. AGE: 60 Yrs. 7 Mos. 28 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Iowa
10. NAME OF FATHER: Mark Stoner
11. BIRTHPLACE OF FATHER (State or Country): Penn.
12. MAIDEN NAME OF MOTHER: Madden
13. BIRTHPLACE OF MOTHER (State or Country): Penn
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Harry Stoner
(Address) Shoshone
15.
Filed ..... 191.....
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 17 (Day) 1921 (Year)
17. I HEREBY CERTIFY, That I attended deceased from June 5 1921, to June 17 1921, that I last saw h[illegible] alive on June 17 1921, and that death occured on the date stated above, at 8 P M.
The CAUSE OF DEATH* was as follows:
Spotted Fever
(Duration) ..... Yrs. ..... mos. 12 ds.
Contributory (Secondary) Exposure to Tick
(Duration) ..... Yrs. ..... mos. ..... ds.
(Signed) [illegible] M. D.
June 18 1921 (Address) Shoshone Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. 12 days. In the State. 17 yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? Fort Mojie Dam
Former or usual residence Shoshone Ida

19. PLACE OF BURIAL OR REMOVAL: Shoshone
DATE OF BURIAL: June 19 1921
20. UNDERTAKER: O J Brennan
ADDRESS: Shoshone

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOOKS. 24858

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED JUL 1 BUREAU OF STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 77

Primary Registration District No. 2176

File No. 34614

Registered No. One

1. PLACE OF DEATH

County of Teton

City of Valview, Idaho (No. ....., St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Dale Vaughan Callahan

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH: February (Month) 13 (Day) 1919 (Year)

7. AGE: 2 Yrs. 3 Mos. 29 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business or establishment in which employed (or employer): "

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: L. R. Callahan.

11. BIRTHPLACE OF FATHER (State or Country): Arkansas.

12. MAIDEN NAME OF MOTHER: Myrtle Vaughan

13. BIRTHPLACE OF MOTHER (State or Country): Miss

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) L R Callahan
(Address) Letonia Idaho.

15. Filed June 21 1921 Martha Marker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 12 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Accidental Drowning.

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Niles Pearson, Coroner M. D.

6/13 1921 (Address) Driggs, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Letonia Ida	6/14 1921

20. UNDERTAKER	ADDRESS
W J King	Driggs Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED AUG 5 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34615

Registered No. 50

1. PLACE OF DEATH

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 8

Primary Registration District No. 2004

No. S. W. Corner Fairground St.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME J. M. Laing

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M.	W.	Married

6. DATE OF BIRTH: Feb 8 1842
(Month) (Day) (Year)

7. AGE: 79 Yrs. 4 Mos. 24 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mich.

10. NAME OF FATHER: Isaac Laing

11. BIRTHPLACE OF FATHER (State or Country): N. Y.

12. MAIDEN NAME OF MOTHER: Bird

13. BIRTHPLACE OF MOTHER (State or Country): N. Y.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wm McBratney
(Address) Boise, Idaho.

15. Filed July 2 19 21 R. H. Pratt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July 1 — 1921
(Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 23d 1921, to July 1st 1921 that I last saw h. m. alive on June 30th 1921, and that death occurred on the date stated above, at 5 A. M.

The CAUSE OF DEATH* was as follows:
Tumor of Cerebellum of
seven years standing

(Duration) 7 Yrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) A. Blanman M. D.
7/2/21 19 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. ~~LENGTH~~ OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cem. DATE OF BURIAL: 7/3/21 19

20. UNDERTAKER: W. McBratney ADDRESS: Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-25 M. 1-19.

RECEIVED AUG 5 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 8
Primary Registration District No. 8004
File No. 34016
Registered No. 51

1. PLACE OF DEATH
County of Valley
City of McCall
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Paul Bryant Hinckley
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.):

6. DATE OF BIRTH: October (Month) 8 (Day) 1900 (Year)

7. AGE: 20 Yrs. 9 Mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Provo Utah

10. NAME OF FATHER: Edwin S. Hinckley

11. BIRTHPLACE OF FATHER (State or Country): Millard Co Utah

12. MAIDEN NAME OF MOTHER: Addie Henry

13. BIRTHPLACE OF MOTHER (State or Country): Fillmore Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Edwin S Hinckley
(Address) Box 41 Ogden Utah

15. Filed Aug 6 1921 R. H. Pratt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 4th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 25 1921, to 4 P.M. July 4th 1921, that I last saw h[illegible] alive on July 4th 1921, and that death occurred on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:
Spotted Fever.
Had been sick a few days before I saw him (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Frederick K Lyons M. D.
July 5 1921 (Address) McCall-Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence Removed

19. PLACE OF BURIAL OR REMOVAL: Provo Utah
DATE OF BURIAL: 8 5 1921

20. UNDERTAKER: Schreiber & Hildenbrand
ADDRESS: Boise

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34617
Registered No. 57

RECEIVED
AUG 5 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 8
Primary Registration District No. 1 Ward 4
County of Ada
City of Boise
(If outside city limits or village, write the word "rural")
No. Collister Station St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John E. Worley

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH: Dec (Month) 5 (Day) 1869 (Year)

7. AGE: 51 Yrs. 7 Mos. 1 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Carpenter
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): U. S.

10. NAME OF FATHER: C. G. Worley

11. BIRTHPLACE OF FATHER (State or Country): U. S.

12. MAIDEN NAME OF MOTHER: Ella Freeman

13. BIRTHPLACE OF MOTHER (State or Country): U. S.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) William N. Worley
(Address) Denver Colo.

15. Filed July 9 19 21 — R. N. Pratt, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 6 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 1, 1921, to July 6 1921 that I last saw h.... alive on July 6 1921, and that death occurred on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:
Venous Thrombosis
(Duration) ... Yrs. ... mos. 1 ds.
Contributory (Secondary) Sciatic Rheumatism
(Duration) 1 yrs. ... mos. ... ds.

(Signed) R. S. French M. D.
July 9 1921 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Morris Hill Cemetery	7/10 1921
20. UNDERTAKER	ADDRESS
Schreiber & Heidenfelder	Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
AUG 5 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No.

County of Ada

Primary Registration District No.

File No. 34618

City of /

(No.) 3 Miles West of Boise

Registered No. 53

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James Popham

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6. DATE OF BIRTH: (Month) (Day) 1836 (Year)

7. AGE: 85 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Miner

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Unknown

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Clyde Summers

(Address) Boise Ida

15. Filed July 21 1921 R. H. Paul Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 19 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1917 to July 19 1921, that I last saw him alive on July 17 1921, and that death occurred on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis and Senility

(Duration) Yrs. mos. ds.

Contributory (Secondary) Chronic Myocarditis

(Duration) 2 yrs. 6 mos. ds.

(Signed) T. N. Bratton M. D.

July 19 1921 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: July 22 1921

20. UNDERTAKER: Summers & Pfost — ADDRESS: Boise Ida

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34619

Registered No. 55

1. PLACE OF DEATH

RECEIVED
AUG 5 1921
BUREAU OF VITAL STATISTICS

Registration District No. 8

Primary Registration District No. 8004

County of Ada

City of Boise (No. U.S.P.H.S.Hospital #52 St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Vivian F. Mallett

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: January 6, 1895 (Month) (Day) 1 (Year)

7. AGE: 26 Yrs. 6 Mos. 14 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Returned Soldier

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ontario, Oregon

10. NAME OF FATHER: C. W. Mallett

11. BIRTHPLACE OF FATHER (State or Country): Maine

12. MAIDEN NAME OF MOTHER: Mary Merritt

13. BIRTHPLACE OF MOTHER (State or Country): California

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) William McBratney

(Address) Boise, Idaho.

15. Filed July 21 1921

Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July 20, 1921. (Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 10 1921 to July 20 1921 that I last saw him alive on July 20 1921, and that death occurred on the date stated above, at 3-a M.

The CAUSE OF DEATH* was as follows:

T.B. abscesses - multiple

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Surgical shock

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W.H. Allen M. D.

July 21 1921 (Address) U.S.P.H.S. Hosp.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Ontario, Oregon

DATE OF BURIAL: 7/22/21

20. UNDERTAKER: William McBratney

ADDRESS: Boise Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED AUG 5 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Tallman

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34620

Registered No. 526

1. PLACE OF DEATH

Registration District No.

County of Ada

Primary Registration District No.

City of

(No. 6 Miles East of Boise St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Alice Gertrude Walker

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word:)
F	White	Married

6. DATE OF BIRTH: June (Month) 3 (Day) 1892 (Year)

7. AGE: 29 Yrs. 1 Mo. 26 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mich

10. NAME OF FATHER: E. J. Probert

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Belle Stevens

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. L. Walker
(Address) Barber Idaho

15. Filed July 30 1921 R. H. Rad Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 29 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 2 1921, to July 29 1921, that I last saw her alive on July 26 1921, and that death occurred on the date stated above, at 9 P M.

The CAUSE OF DEATH* was as follows:

Cancer of ovary

(Duration) 2 Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) M. K. Tallman M. D.

7/30 1921 (Address) Boise Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Morris Hill Cemetery DATE OF BURIAL July 31 1921

20. UNDERTAKER Summers & Wells ADDRESS Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED AUG 5 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

94021

1. PLACE OF DEATH

County of Ada — Registration District No. 5

City of Boise — Primary Registration District No. 11 (St. Luke's Hospital St.)

File No.

Registered No. 189

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Warren T. Simmons.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White.	Married.

6. DATE OF BIRTH 1884 (Month) 1 (Day) (Year)

7. AGE 37 Yrs. — Mos. — ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Cattleman

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Dont Know

10. NAME OF FATHER "

11. BIRTHPLACE OF FATHER (State or Country) "

12. MAIDEN NAME OF MOTHER "

13. BIRTHPLACE OF MOTHER (State or Country) "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm McBratney

(Address) Boise Idaho

15. Filed July 1 1921 R. N. Pratt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 1 — 1921 (Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 30 1921, to July 1 1921, that I last saw h. alive on July 1 1921, and that death occurred on the date stated above, at 11a M.

The CAUSE OF DEATH* was as follows:

Cerebral Concussion
Automobile accident

(Duration) Yrs. mos. 2 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) James T. Stewart M. D.

7/1 1921 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Emmett Idaho	7/2/21

20. UNDERTAKER W McBratney — ADDRESS Boise Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 9402

Registered No. 190

1. **PLACE OF DEATH**

County of Ada

City of Boise (St. Alphonsus Hospital)

If death occurs away from usual residence, give facts called for under special information.

Registration District No. .....

Primary Registration District No. 1326

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. **FULL NAME** Jesse Elmer Marsh

RECEIVED
AUG 5 1921
BUREAU OF VITAL STATISTICS

PERSONAL AND STATISTICAL PARTICULARS

3. **SEX** Male.

4. **COLOR OR RACE** White

5. **SINGLE, MARRIED, WIDOWED OR DIVORCED** Married (Write the word.)

6. **DATE OF BIRTH** May 14, 1888
(Month) (Day) (Year)

7. **AGE** 33 Yrs. 1 Mos. 16 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. **OCCUPATION**
(a) Trade, profession or particular kind of work Mechanic.
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. **BIRTHPLACE** (State or Country) Washington

10. **NAME OF FATHER** David Marsh.

11. **BIRTHPLACE OF FATHER** (State or Country) Ind

12. **MAIDEN NAME OF MOTHER** Nancy Tillery

13. **BIRTHPLACE OF MOTHER** (State or Country) Tenn

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**
(Informant) Wm McBratney
(Address) Boise Idaho.

15. Filed July 2 1921 R. H. Pratt Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH** June 29 - 1921
(Month) (Day) (Year)

17. **I HEREBY CERTIFY, That I attended deceased from** 6/29 1921 to 6/29 1921
that I last saw h[illegible] alive on 6/29 1921
and that death occurred on the date stated above, at 1 P. M.
The **CAUSE OF DEATH*** was as follows:
Runaway accident
Causing Internal abdominal injuries & fracture
left thigh (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Shock
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Ralph Fall M. D.
6/30/21 (Address) Boise, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. **PLACE OF BURIAL OR REMOVAL** Morris Hill Cem. — **DATE OF BURIAL** 7/2 1921

20. **UNDERTAKER** W McBratney — **ADDRESS** Boise Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
AUG 5 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Ada — Registration District No. 2

City of Boise (No. 1913 Bannock St.) — Primary Registration District No. 1004

File No. 34622

Registered No. 791

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elizabeth J. Kendall

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widow (Write the word.)

6. DATE OF BIRTH: Apr 27 (Month) (Day) 1857 (Year)

7. AGE: 64 Yrs. 2 Mos. 7 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): England.

10. NAME OF FATHER: Nicholas Saundry.

11. BIRTHPLACE OF FATHER (State or Country): England.

12. MAIDEN NAME OF MOTHER: Fannie Bond.

13. BIRTHPLACE OF MOTHER (State or Country): England.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Lillie M. Kendall

(Address) .....

15. Filed July 5 1921 — R. H. Pratt, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July 4 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 15 1921, to July 4 1921, that I last saw her alive on July 4 1921, and that death occurred on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) ..... Yrs. ..... mos. 19 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) P P French M.D.

July 5 1921 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: July 6 1921

20. UNDERTAKER: Summers & Nels. — ADDRESS: Boise Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED AUG 5 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34624
Registered No. 1921

1. PLACE OF DEATH

Registration District No. 2

Primary Registration District No. 1004

County of Ada

City of Boise (If outside limits, give township) 410 State St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Walter Scott Alford

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: (Month) (Day) 1854 (Year)

7. AGE: 67 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Sawyer

(b) General nature of industry, business or establishment in which employed (or employer): Sawmilling

9. BIRTHPLACE (State or Country): Kansas

10. NAME OF FATHER: James Alford

11. BIRTHPLACE OF FATHER (State or Country): not known

12. MAIDEN NAME OF MOTHER: Harriet Stafford

13. BIRTHPLACE OF MOTHER (State or Country): Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs V. F. Thornley

(Address) 907 Ada

15. Filed July 5 1921 R. N. Pratt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 4th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 15, 1921, to July 4 1921 that I last saw him alive on July 2 1921 and that death occurred on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(Duration) 3 Yrs. ..... mos. ..... ds.

Contributory (Secondary) Angina Pectoris

(Duration) ..... yrs. 3 mos. ..... ds.

(Signed) M. H. Dallman M. D.

7/5 1921 (Address) Boise, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence Oregon.

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 7/6 1921

20. UNDERTAKER: Ackreiter & Sidenfaden — ADDRESS: Boise, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED AUG 5 1921 BUREAU OF VITAL STATISTICS

(Springer)

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Ada
City of Boise
Registration District No. 2
Primary Registration District No. [illegible]
(No. St Lukes Hospital St.)
File No. 34625
Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Vida R. Gossen.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: White.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (or widowed)

6. DATE OF BIRTH: Sep 21 (Month) 1885 (Day) (Year)

7. AGE: 35 Yrs. 9 Mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At home
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Chris Meltvedt.

11. BIRTHPLACE OF FATHER (State or Country): Norway.

12. MAIDEN NAME OF MOTHER: Susanna Jacobsen

13. BIRTHPLACE OF MOTHER (State or Country): Norway.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Lewis Gossen
(Address) Boise Idaho

15. Filed July 6 1921 R. H. Pratt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July 2 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 10 1921 to July 2nd 1921 that I last saw h[illegible] alive on July 2nd 1921, and that death occurred on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

Strepto Coccus Pneumonia

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. S. Springer M. D.

7-8 1921 (Address) Boise Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cem — DATE OF BURIAL: July 6 1921

20. UNDERTAKER: Summers & Cobb. — ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. Age should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED AUG 5 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2

Primary Registration District No. 1066

File No. 34627

Registered No. 196

1. PLACE OF DEATH

County of Ada

City of Boise (No. 212 Jefferson St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Infant Benton

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: July (Month) 8 (Day) 1921 (Year)

7. AGE: ....Yrs. ....Mos. ....ds.

IF LESS than 1 day how many 4 hrs. or ....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business or establishment in which employed (or employer): ....

9. BIRTHPLACE (State or Country): Boise Idaho

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Hadee Benton

13. BIRTHPLACE OF MOTHER (State or Country): Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Clyde E Summers

(Address) Boise Idaho

15. Filed July 9 1921 — A. V. Bath, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 8 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 8 1921 to July 8 1921 that I last saw h. alive on July 8 1921 and that death occurred on the date stated above, at 10 A. M.

The CAUSE OF DEATH* was as follows:

Premature Birth - (6 1/2 Month)

....(Duration) ....Yrs. ....mos. ....ds.

Contributory (Secondary) ....

....(Duration) ....yrs. ....mos. ....ds.

(Signed) John Baeck M. D.

July 9 1921 (Address) Boise Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs. ....mos. ....days. In the State ....yrs. ....mos. ....days

Where was disease contracted if not at place of death? ....

Former or usual residence ....

19. PLACE OF BURIAL OR REMOVAL: County Cemetery — DATE OF BURIAL: July 9 1921

20. UNDERTAKER: Summers & Fred's — ADDRESS: Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34628

Registered No. 197

RECEIVED
AUG 5 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Ada — Registration District No. 2

City of Boise — Primary Registration District No. 1004

(No. 410 Bannock St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lusia Yribar

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, ~~MARRIED, WIDOWED OR DIVORCED~~ (Write the word.): Single

6. DATE OF BIRTH: Aug (Month) 10th (Day) 1918 (Year)

7. AGE: 2 Yrs. 11 Mos. 2 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Boise, Idaho.

10. NAME OF FATHER: Juan Yribar

11. BIRTHPLACE OF FATHER (State or Country): Spain

12. MAIDEN NAME OF MOTHER: Epifisa Asostegui

13. BIRTHPLACE OF MOTHER (State or Country): Spain

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Juan Yribar

(Address) 410 Bannock St

15. Filed July 23 1921 — R. V. Pratt, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 12th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 19 1921, to July 12 1921, that I last saw h[illegible] alive on July 12 1921, and that death occurred on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Burns & arm

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.

..... 19..... (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence Boise, Idaho

19. PLACE OF BURIAL OR REMOVAL: St Johns Cemetery — DATE OF BURIAL: 7/14 1921

20. UNDERTAKER: Schreiber & Sidenfaden, Boise, Coulter — ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-A--25 M. 1-19.

RECEIVED
AUG 5 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34629
Registered No. 198

1. PLACE OF DEATH
County of Ada Registration District No. 2
City of Boise Primary Registration District No. 1004
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Alta M Whiteley

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6. DATE OF BIRTH: Aug. (Month) 11 (Day) 1906 (Year)

7. AGE: 15 Yrs. 11 Mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: School Girl
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Meridian Idaho

10. NAME OF FATHER: Amon Whiteley

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Meda Turner

13. BIRTHPLACE OF MOTHER (State or Country): Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Fred Adams
(Address) Meridian Idaho

15. Filed July 14 1921 — R. V. Pratt, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 14 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 7 1921, to July 14 1921
that I last saw h..... alive on ..... 19....., and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Auto-intoxication

(Duration) ..... Yrs. ..... mos. 6 ds.
Contributory (Secondary) Family elimination
(Duration) ..... yrs. 5 or 6 mos. ..... ds.

(Signed) [illegible] M. D.
7-14 1921 (Address) Boise, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Meridian Cemetery — DATE OF BURIAL ..... 19.....
20. UNDERTAKER: W. B. Waters — ADDRESS Meridian Id.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34630
Registered No. 199

RECEIVED
AUG 5 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
Registration District No. 2
Primary Registration District No. 11004
County of Ada
City of Boise (If not in incorporated city or village give township) (Street and No. of hospital, St. Alphonsus Hospital St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Minnie Priest Linton
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widow (Write the word.)

6. DATE OF BIRTH: — — 1867 (Month) (Day) (Year)

7. AGE: 54 Yrs. — Mos. — ds.
IF LESS than 1 day how many ____ hrs. or ____ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Saleswoman.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): N. H.

10. NAME OF FATHER: Priest

11. BIRTHPLACE OF FATHER (State or Country): Don't Know

12. MAIDEN NAME OF MOTHER: "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. McBratney
(Address) Boise, Idaho.

15. Filed July 14 1921 R. H. Pratt Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July 13 - 1921. (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 11 1921 to July 13 1921 that I ~~last saw her alive~~ did not see her 19____, and that death occurred on the date stated above, at ____ M.

The CAUSE OF DEATH* was as follows:
Chronic Nephritis
(Duration) 3 Yrs. ____ mos. ____ ds.
Contributory (Secondary) General Anasarca
(Duration) ____ yrs. ____ mos. 30 ds.

(Signed) T. N. Braxton M. D.
7/13/21 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Masonic Cemetery — DATE OF BURIAL: 7/14 1921

20. UNDERTAKER: W. McBratney — ADDRESS: Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34632
Registered No. 201

RECEIVED
AUG 5 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Ada Registration District No. 2
City of Boise Primary Registration District No. 1004
(If outside limits, give township) No. Hurtt Apts. St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Joseph Pinkham

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
M.	White	Widower (or widow)

6. DATE OF BIRTH
Dec 15 1833
(Month) (Day) (Year)

7. AGE
87 Yrs. 6 Mos. 28 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business or establishment in which employed (or employer) —

9. BIRTHPLACE
(State or Country) Canada

10. NAME OF FATHER Ebenezer Pinkham

11. BIRTHPLACE OF FATHER
(State or Country) New Brunswick

12. MAIDEN NAME OF MOTHER Rachel B. Brickle

13. BIRTHPLACE OF MOTHER
(State or Country) New Hampshire

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Harry Webb.
(Address) Boise Idaho.

15.
Filed July 16 1921 R. N. Pratt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
July 13 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1918, to July 13 1921, that I last saw h.im alive on July 13 1921, and that death occurred on the date stated above, at 1:30 P.M.
The CAUSE OF DEATH* was as follows:

Senility

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. W. Smith M. D.
7/14/1921 (Address) Boise, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Morris Hill Cemetery	July 15 1921
20. UNDERTAKER	ADDRESS
Summers & Webb.	Boise Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34633
Registered No. 202

RECEIVED
AUG 5 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. .....
Primary Registration District No. 4

County of Ada
City of Boise (If outside limits, give township) No. 1507 Euclid St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Donald Eugene Shuman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: July (Month) 17 (Day) 1921 (Year)

7. AGE: ____ Yrs. ____ Mos. ____ ds.
IF LESS than 1 day how many 3 hrs. or ____ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Boise Ida.

10. NAME OF FATHER: Addison Shuman

11. BIRTHPLACE OF FATHER (State or Country): Neb.

12. MAIDEN NAME OF MOTHER: Tacy Bentley

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A. Addison Shuman
(Address)

15. Filed July 18 1921 — R. H. Pratt, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 17 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 17 1921, to July 17 1921, that I last saw h[illegible] alive on July 17 1921, and that death occurred on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:
Pulmonary atelectasis

(Duration) ____ Yrs. ____ mos. 1 hour
Contributory (Secondary) Asphyxiation
(Duration) ____ yrs. ____ mos. ½ hour

(Signed) T. N. Brayton M. D.
July 18 1921 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 7/18 1921

20. UNDERTAKER: Schreiber & Redemsden — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED AUG 5 1921 BUREAU OF VITAL STATISTICS

Registration District No. 2
Primary Registration District No. 1004
File No. 34634
Registered No. 204

1. PLACE OF DEATH
County of Ada
City of Boise (If outside limits, give township) No. Pacific Hotel St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elizabeth Oughtretree
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH: March 24 1849 (Month) (Day) (Year)

7. AGE: 72 Yrs. 3 Mos. 24 ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER: Alexander C. Sliter

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Julia Lawrence

13. BIRTHPLACE OF MOTHER (State or Country): New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Belle C. Parke
(Address) 2924 Parkinell Berkeley Cal.

15. Filed July 18 1921 R. H. Coad Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July 15 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 12 1921 to July 15 1921, that I last saw h[illegible] alive on [illegible] 1921, and that death occurred on the date stated above, at [illegible] M.

The CAUSE OF DEATH* was as follows:
Cancer of stomach
(Duration) 3 Yrs. mos. ds.
Contributory (Secondary) Chronic nephritis
(Duration) 10 yrs. mos. ds.

(Signed) M. F. Sullivan M. D.
7/18 1921 (Address) Boise Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: July 18 1921
20. UNDERTAKER: Summers & Trefz — ADDRESS: Boise Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED AUG 5 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34635

Registered No. 205

1. PLACE OF DEATH

Registration District No. .....

County of Ada

Primary Registration District No. .....

City of Boise (No. 1207 W. Washington St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ella Hunter Perky

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F	White	married

6. DATE OF BIRTH: Feb (Month) 6 (Day) 1870 (Year)

7. AGE: 51 Yrs. 5 Mos. 11 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: at Home
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ohio.

10. NAME OF FATHER: John A. Hunter.

11. BIRTHPLACE OF FATHER (State or Country): Ohio.

12. MAIDEN NAME OF MOTHER: Martha Bailey.

13. BIRTHPLACE OF MOTHER (State or Country): Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Kirtland D. Perky.
(Address) 1207 West Washington St.

15. Filed July 19 1921 R. H. Pratt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 17 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 10 1921, to July 17 1921, that I last saw h.e alive on July 12 1921, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Dilatation of Heart
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Malignant Tumor
..... (Duration) 6 mos. yrs. ..... mos. ..... ds.

(Signed) John Boeck M. D.
7-18 1921 (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Morris Hill Cemetery	July 20 1921

20. UNDERTAKER	ADDRESS
Summers & Kreps	Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED AUG 5 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34636
Registered No. 207

1. **PLACE OF DEATH**

County of Ada Registration District No. 2

Primary Registration District No. 1

City of Boise (If not in incorporated limits, give township.) 309 Vermont St.)

If death occurs away from usual residence, give facts called for under special information.

2. **FULL NAME** Annie Laurie Johns

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
F.	W.	Single (Write the word.)

6. **DATE OF BIRTH** July 19, 1921
(Month) (Day) (Year)

7. **AGE** ~~Yrs.~~ Mos. 3 ds.

IF LESS than 1 day how many ~~hrs.~~ or ~~min.~~?

8. **OCCUPATION**

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business or establishment in which employed (or employer)

9. **BIRTHPLACE** (State or Country) Boise Ida

10. **NAME OF FATHER** David D. Johns

11. **BIRTHPLACE OF FATHER** (State or Country) Neb

12. **MAIDEN NAME OF MOTHER** Ruby Ithia Jessee

13. **BIRTHPLACE OF MOTHER** (State or Country) Oregon

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**

(Informant) Wm McBratney

(Address) Boise Ida

15. Filed July 21 1921 A. R. Craft Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH** July 21, 1921
(Month) (Day) (Year)

17. **I HEREBY CERTIFY, That I attended deceased from** ..... 19..... to ..... 19.....

that I last saw h..... alive on ..... 19.....,

and that death occurred on the date stated above, at ..... M.

The **CAUSE OF DEATH*** was as follows:

Prematurity - 6½ mos.

(Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) B. W. Mather M. D.

7/21/21 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Meridian Cemetery	7/22 19 21
20. UNDERTAKER W. McBratney	**ADDRESS** Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-25 M. 1-19.

RECEIVED AUG 5 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34637
Registered No. 208

1. PLACE OF DEATH
County of Ada Registration District No. 2
City of Boise Primary Registration District No. 2254
(No. 2922 Tessegnue St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Carrie Wilkinson
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.): Widow

6. DATE OF BIRTH: July (Month) 16 (Day) 1844 (Year)

7. AGE: 77 Yrs. 02 Mos. ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Isaac Toland

11. BIRTHPLACE OF FATHER (State or Country): Maryland

12. MAIDEN NAME OF MOTHER: Adeliza Lewis

13. BIRTHPLACE OF MOTHER (State or Country): Penn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Emma Wilkinson
(Address) Boise Idaho

15. Filed July 21 1921 R. H. Pratt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 7 (Month) 19 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1 1921, to July 19 1921
that I last saw h.. alive on July 19 1921
and that death occurred on the date stated above, at 6 P. M.
The CAUSE OF DEATH* was as follows:
Valvular Heart Disease
(Duration) Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) H. Worthington M. D.
7/30 1921 (Address) Boise

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: July 21 1921

20. UNDERTAKER: Summers & Webb — ADDRESS: Boise Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED
AUG 5 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34638
Registered No. 209

1. PLACE OF DEATH
County of Ada — Registration District No. 2
City of Boise (No. 719 no 12 — St.) — Primary Registration District No. 4 Ward 4

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Annie Beardsley Taylor

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widow

6. DATE OF BIRTH: July 21, 1853
(Month) (Day) (Year)

7. AGE: 67 Yrs. 11 Mos. 28 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: Edward Beardsley

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Ann Bowman

13. BIRTHPLACE OF MOTHER (State or Country): England.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Edith F Taylor
(Address): Boise Idaho.

15. Filed July 22 1921 — R W Pratt, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July 20 — 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 20 1921, to July 20 1921, that I last saw h— alive on — 19—, and that death occurred on the date stated above, at — M.

The CAUSE OF DEATH* was as follows:
Probably Organic Heart disease

(Duration) — Yrs. — mos. — ds.

Contributory (Secondary)
(Duration) ... yrs. ... mos. ... ds.

(Signed) J. R Newman M. D.
7/22/21 (Address) Boise Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Spokane - Wash. — DATE OF BURIAL 19...

20. UNDERTAKER: Wm Straney — ADDRESS: Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34639
Registered No. 310

RECEIVED
AUG 5 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Ada Registration District No. 2
City of Boise (If outside limits of city or village, write the name of township.) 417 N. 9th St.) Primary Registration District No. 1004
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Francis Henry Hinkley
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Nov. (Month) 30 (Day) 1882 (Year)

7. AGE: 38 Yrs. 7 Mos. 23 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Steam fitter
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Paradise Valley Nev

10. NAME OF FATHER: C. W. Hinkley

11. BIRTHPLACE OF FATHER (State or Country): Ill

12. MAIDEN NAME OF MOTHER: Catherine T. Skane

13. BIRTHPLACE OF MOTHER (State or Country): N. York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. Schreiber
(Address) Boise

15. Filed July 23 1921 R. H. Pratt Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 23 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 21 1921, to July 23 1921, that I last saw him alive on July 23 1921, and that death occurred on the date stated above, at 3-30 P.M.

The CAUSE OF DEATH* was as follows:
Syphilis of Central Nervous System
Syphilitic Aortitis

(Duration) 2 Yrs. ? mos. ? ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Harold W Stone M. D.
July 23 1921 (Address) 410 Overland Bldg.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: St Johns Cemetery — DATE OF BURIAL: 7/23 1921

20. UNDERTAKER: Schreiber & Sederholm — ADDRESS: Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED AUG 5 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34640
Registered No. 211

1. PLACE OF DEATH
County of Ada Registration District No. 2
City of Boise Primary Registration District No. 1004
(No. 11 Latah Ave St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Donald Ivan Hapson
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Feb (Month) 9 (Day) 1921 (Year)

7. AGE: ~ Yrs. 5 Mos. 14 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Boise Ida

10. NAME OF FATHER: C. A. Hapson

11. BIRTHPLACE OF FATHER (State or Country): Neb.

12. MAIDEN NAME OF MOTHER: Nonna Maxon

13. BIRTHPLACE OF MOTHER (State or Country): Ver.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C A Hapson
(Address) 205 S 16th

15. Filed July 25 1921 — R. N. Foote, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 25 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 24 1921, to July 25 1921, that I last saw him alive on July 24 1921, and that death occurred on the date stated above, at 5a M.

The CAUSE OF DEATH* was as follows:
Acute gastro-enteritis —

(Duration) ..... Yrs. ..... mos. 12 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. Earl Keil M. D.
7/28/21 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 7/27 1921

20. UNDERTAKER: Schreiber & Sidenfaden — ADDRESS: Boise Ida

Hill

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

Taylor,

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 3461T

Registered No. 212

RECEIVED
AUG 5 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 2

Primary Registration District No. 4004

County of Ada

City of Boise (No. 1 Fourth Apartments St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Gaspah Rosenberger

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F	White	Widow

6. DATE OF BIRTH: Sept 4 (Month) (Day) 1828 (Year)

7. AGE: 92 Yrs. 10 Mos. 21 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Indiana

10. NAME OF FATHER: William Griest

11. BIRTHPLACE OF FATHER (State or Country): N. C.

12. MAIDEN NAME OF MOTHER: Lydia Miller

13. BIRTHPLACE OF MOTHER (State or Country): N. C.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Lydiann Hadley.
(Address) Boise Idaho.

15. Filed July 27 1921 R. N. Peat Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 25 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 23 1921, to July 25 1921, that I last saw her alive on July 25 1921, and that death occurred on the date stated above, at 7 P M.

The CAUSE OF DEATH* was as follows:

Senility

(Duration) 10 Yrs. mos. ds.

Contributory (Secondary) Cerebro Colitis

(Duration) yrs. mos. 3 ds.

(Signed) F. M. Braxton M. D.

July 27 1921 (Address) Boise Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery | DATE OF BURIAL: July 28 1921

20. UNDERTAKER: Summers & Kirby | ADDRESS: Boise Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

Parke

FORM V. S. No. 5-25 M. 1-19.

RECEIVED AUG 5 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH — Registration District No. 2

County of Ada — Primary Registration District No. 1004

City of Boise — 1318 N. 16 St.) — File No. 34642

If death occurs away from usual residence, give facts called for under special information. — Registered No. 214

2. FULL NAME Orlow M. Harris

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1860 (Year)

7. AGE: 61 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: John Harris

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown Chapin

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R. J. Burns
(Address) Boise Idaho

15. Filed July 28 1921 — O. H. Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 27 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 20 1921, to July 27 1921, that I last saw h.... alive on July 27 1921, and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) ..... Yrs. ..... mos. 14 ds.

Contributory (Secondary): Nephritis

(Duration) ..... 1 yrs. ..... mos. ..... ds.

(Signed) O. H. Parker M. D.

7/27 1921 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: July 29 1921

20. UNDERTAKER: Summers & Trebs — ADDRESS: Boise Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATIONERY CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34643
Registered No. 215

RECEIVED
AUG 5 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
Registration District No. 2
Primary Registration District No. 1004
County of Ada
City of (If outside limits, give 3 Miles West of Boise St.) Soldiers Home.
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John W. Dickens

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married.

6. DATE OF BIRTH: (Month) (Day) 1843. (Year)

7. AGE: 78 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Veteran Civil War
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Unknown

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Clyde E. Summers
(Address) Boise Idaho

15. Filed July 29 1921 R. W. Pratt Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 28 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1 1920 to July 28 1921
that I last saw him alive on July 1 1921,
and that death occurred on the date stated above, at 4:00 P.M.
The CAUSE OF DEATH* was as follows:
Senility

(Duration) Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) Roscoe C Ward M. D.
7/29 1921 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: July 30 1921
20. UNDERTAKER: Summers & Krebs. — ADDRESS: Boise Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
AUG 5 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004

File No. 34644
Registered No. 216

1. PLACE OF DEATH

County of Ada
City of Boise (No. 410, State St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William R. Gibson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): M

6. DATE OF BIRTH: About 1852 (Month) (Day) (Year)

7. AGE: About 69 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Cal.

10. NAME OF FATHER: ?

11. BIRTHPLACE OF FATHER (State or Country): ?

12. MAIDEN NAME OF MOTHER: ?

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A Schreiber
(Address) Boise

15. Filed July 30 1921 R. N. Pratt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 19 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 13 19.., to July 19 1920 that I last saw h alive on July 15 1920 and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) Yrs. 5 mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Jno. L. Hart M. D.

19.. (Address) Boise Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Ada Co. Ida. DATE OF BURIAL: 7/30 1921

20. UNDERTAKER: Schreiber & Sedgwick ADDRESS: Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED AUG 5 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 2

County of Ada — Registration District No. 1004

City of Boise (No. 309 Vermont St. St.)

File No. 3465

Registered No. 217

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Frank Vanderson Johns

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M.	W.	Single

6. DATE OF BIRTH: July (Month) 19 (Day) 1921 (Year)

7. AGE: ___ Yrs. ___ Mos. 12 Ds. IF LESS than 1 day how many ___ hrs. or ___ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Boise Idaho.

10. NAME OF FATHER: David Johns.

11. BIRTHPLACE OF FATHER (State or Country): Neb

12. MAIDEN NAME OF MOTHER: Ruby Jessee

13. BIRTHPLACE OF MOTHER (State or Country): Oregon.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wm McBratney
(Address) Boise. Idaho

15. Filed July 31 1921 R. T. Pratt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 31 (Day) 1921 (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from July 27 1921, to July 31 1921, that I last saw him alive on July 30 1921, and that death occurred on the date stated above, at 8:40 A.M.,
The CAUSE OF DEATH* was as follows:
Premature & Malnutrition.

(Duration) ___ Yrs. ___ mos. ___ ds.
Contributory (Secondary) Premature
(Duration) ___ yrs. ___ mos. ___ ds.

(Signed) C. L. Sutton M. D.
7/31/21 (Address) Boise, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ___ yrs. ___ mos. ___ days. In the State ___ yrs. ___ mos. ___ days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Meridian Cemetery	7/31/19 21
20. UNDERTAKER: Wm McBratney	ADDRESS: Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

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FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34641
Registered No.

1. PLACE OF DEATH
County Ada
City or Village Eagle
(If outside city limits or hours away from residence, give facts called for under special information.)

Registration District No.
Primary Registration District No.
(No. , St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mrs Julyna Masters

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: July (Month) 8 (Day) 1847 (Year)

7. AGE: 74 Yrs. 1 Mos. 4 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Jackson C. Ohio

10. NAME OF FATHER: Wey Dudley

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER: Julyna Dudley

13. BIRTHPLACE OF MOTHER (State or Country): Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. J. Barber
(Address) Meridian R. F. D. No 1.

15. Filed Aug 12 1921 Frederick L. Lewis Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August (Month) 11 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 10 1921, to Aug 6 1921, that I last saw h. 3. alive on July 15 1921, and that death occurred on the date stated above, at 10 P. M.
The CAUSE OF DEATH* was as follows:
Carcinoma of Uterus
(Duration) 2 Yrs. 6 mos. ds.
Contributory (Secondary) Carcinoma of Uterus
(Duration) 2 yrs. 6 mos. ds.
(Signed) George Hall M. D.
Aug 11 1921 (Address) Eagle Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Joplin — DATE OF BURIAL: Aug 13 1921
20. UNDERTAKER: W. Bratney — ADDRESS: Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions

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Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34647

RECEIVED
JUL 5 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH. Registration District No. .....
Primary Registration District No. .....
County of Adams
City of New Meadows (St.)
If death occurs away from usual residence, give facts called for under special information.

Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Frances Theodosia Shiefer

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Single

6. DATE OF BIRTH
May (Month) 2 (Day) 1921 (Year)

7. AGE
— yrs. — mos. 14 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Babe
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) New Meadows, Idaho

10. NAME OF FATHER Frederick Sayler Shiefer

11. BIRTHPLACE OF FATHER (State or Country) Warren Idaho

12. MAIDEN NAME OF MOTHER Edna Martin

13. BIRTHPLACE OF MOTHER (State or Country) Wyoming.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. A. J. Dean
(Address) New Meadows

15.
Filed May 21 1921 W. H. Dean
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
May (Month) 15 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 14 1921, to May 15 1921
that I last saw her alive on May 15 1921
and that death occurred on the date stated above, at 8:15 P. M.

The CAUSE OF DEATH* was as follows:
Mal-nutrition.
2.
.....
(Duration) ..... yrs. ..... mos. 1 ds.
Contributory (Secondary) Slightly premature in birth
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) W. H. DeLongpre M. D.
19 (Address) New Meadows Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
New Meadows Cemetery	May 16 1921
20. UNDERTAKER	ADDRESS
	New Meadows Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SVMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34648

RECEIVED
JUL 5 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Adams
City of Tamarack (Registration District No. ..... Primary Registration District No. ..... St.)
Registered No. .....
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Annetta Jane Wilson
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Nov (Month) 9 (Day) 1837 (Year)

7. AGE: 83 Yrs. 4 Mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mo.

10. NAME OF FATHER: Edwin Ryle

11. BIRTHPLACE OF FATHER (State or Country): — —

12. MAIDEN NAME OF MOTHER: — —

13. BIRTHPLACE OF MOTHER (State or Country): — —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Price Wilson
(Address) Tamarack, Idaho

15. Filed May 31 1921 — W M Brown, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 14 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..., to Feb 15 1921
that I last saw h..... alive on 19 21,
and that death occurred on the date stated above, at 3 P. M.
The CAUSE OF DEATH* was as follows:
General decline incident to old age
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) W M Brown M. D.
3/30 1921 (Address) Council

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Council — DATE OF BURIAL: Mar 15 1921

20. UNDERTAKER — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34649

Registered No.

1. PLACE OF DEATH

County of Bannock

City of Chesterfield (No. St.)

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 84

Primary Registration District No. 2161

RECEIVED
AUG 10 1921
BUREAU OF VITAL STATISTICS

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME James M. Gooch

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
male	white	single

6. DATE OF BIRTH: Aug 3 (Month) 1875 (Day) (Year)

7. AGE: 46 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Cattleman

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Richmond Utah

10. NAME OF FATHER: John O. Gooch

11. BIRTHPLACE OF FATHER (State or Country): Mass.

12. MAIDEN NAME OF MOTHER: Louise Arbon

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Gooch Brother

(Address) Chesterfield

15. Filed 8-1-21 19

Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July 23, 1921 (Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from July 23, 1921 to 19, that I last saw him alive on July 23, 1921 19, and that death occurred on the date stated above, at 5 A M.

The CAUSE OF DEATH* was as follows:

Pneumonia (double lobar)

(Duration) Yrs. mos. 3 ds.

Contributory (Secondary) Carcinoma of the bladder

(Duration) 7 yrs. mos. ds.

(Signed) Walter L. Bach M. D.

7-24 19 21 (Address) Bancroft

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Chesterfield	7-24-21 19
20. UNDERTAKER	ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

34650

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 4 B

Registered No. 3619

1. PLACE OF DEATH

County of Bannock

City of Pocatello

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2

Primary Registration District No. 241

(No. Gregory 10 Pocatello St.)

RECEIVED AUG 10 1921 BUREAU OF VITAL STATISTICS

2. FULL NAME Jutaro Mataicki

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: Japanese

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: September 3 (Month) (Day) 91 (Year)

7. AGE: 29 Yrs. 10 Mos. 14 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Japan

10. NAME OF FATHER: Kayomon Kurasaki

11. BIRTHPLACE OF FATHER (State or Country): Japan

12. MAIDEN NAME OF MOTHER: Okuno

13. BIRTHPLACE OF MOTHER (State or Country): Yokohama Japan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Otto Mataicki

(Address) Pocatello House.

15. Filed 7/18 1921

J. H. Young
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 17 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1 1921, to July 17 1921, that I last saw h[illegible] alive on July 16 1921, and that death occurred on the date stated above, at 1.30 P.M.

The CAUSE OF DEATH* was as follows:

Exophthalmic goiter

(Duration) Yrs. 5 mos. ds.

Contributory (Secondary) Toxaemia

(Duration) yrs. mos. ds.

(Signed) Hamner C. Davis M. D.

7/18 1921 (Address) Pocatello

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain View Cem. DATE OF BURIAL: July 19 1921

20. UNDERTAKER: Schumacher & Hall ADDRESS: Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-A—25 M. 1-19 Rev

CERTIFICATE OF DEATH

34651

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 72

Registered No. 3227

RECEIVED
AUG 10 1921
BUREAU OF VITAL STATISTICS

Registration District No.

Primary Registration District No. 2141

1. PLACE OF DEATH

County of Blaine

City of American Falls Ida (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Angelina De Julis

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: July (Month) 8 (Day) 1921 (Year)

7. AGE: — Yrs. — Mos. 8 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Blaine Idaho

10. NAME OF FATHER: Rocco De Julis

11. BIRTHPLACE OF FATHER (State or Country): Italy

12. MAIDEN NAME OF MOTHER: Mary Dicenzo

13. BIRTHPLACE OF MOTHER (State or Country): Italy

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Rocco DeJulis

(Address) American Falls Ida

15. Filed July 25 1921

J H Young
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 23 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....

that I last saw h..... alive on ..... 19.....,

and that death occurred on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

Enteri Colitis

.....(Duration) .....Yrs.....mos.....ds.

Contributory (Secondary)

.....(Duration) .....yrs.....mos.....ds.

(Signed) C. F. Schultz M. D.

July 23 1921 (Address) American Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? Yes

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mt View Cem. DATE OF BURIAL: July 24 1921

20. UNDERTAKER: A. L. McClain ADDRESS: Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

34652

Registration District No. 28
Primary Registration District No. 2161
File No. 42
Registered No. 3628

RECEIVED
AUG 10 1921
BUREAU OF VITAL

1. PLACE OF DEATH

County of Bannock
City of Pocatello
(No. 339 So 3rd ave St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Dorothy Gilberta Monhart

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6. DATE OF BIRTH: Aug (Month) 9 (Day) 1918 (Year)

7. AGE: 2 Yrs. 11 Mos. 25 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Salt Lake City Ut

10. NAME OF FATHER: Albert J Monhart

11. BIRTHPLACE OF FATHER (State or Country): Wyoming

12. MAIDEN NAME OF MOTHER: Mary Sullivan

13. BIRTHPLACE OF MOTHER (State or Country): Colorado

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Albert J Monhart
(Address) 339 So 3rd ave

15. Filed July 29 1921 ..... Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 25 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 28 1921, to July 28 1921
that I last saw her alive on July 28 1921
and that death occurred on the date stated above, at 12 15 P M.

The CAUSE OF DEATH* was as follows:

Abscess Ear

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.
July 29 1921 (Address) Pocatello Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 1 yrs. 6 mos. ..... days. In the State 1 yrs. 6 mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence Salt Lake City Ut

19. PLACE OF BURIAL OR REMOVAL: Mt View Cem | DATE OF BURIAL: July 31 1921

20. UNDERTAKER: H. L. McHan | ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V.S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho 34653
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 28
Primary Registration District No. 2161
File No. 42
Registered No. 3629

1. PLACE OF DEATH
County of Lemhi
City of Tyhee
(No. Rauch Avenue St.)
If death occurs away from usual residence, give facts called for under special information.

AUG 10 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME Mrs. C. M. Andreason

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6. DATE OF BIRTH: Aug (Month) 3 (Day) 1874 (Year)

7. AGE: 47 Yrs. 11 Mos. 27 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Denmark.

10. NAME OF FATHER: Christopher Nielsen

11. BIRTHPLACE OF FATHER (State or Country): Denmark.

12. MAIDEN NAME OF MOTHER: ✓

13. BIRTHPLACE OF MOTHER (State or Country): Denmark.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. M. Andreason
(Address) Tyhee Idaho

15. Filed 7/30 1921 J. H. Young (Local Registrar)

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 30 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1920 to July 29 1921
that I last saw her alive on May 10
and that death occurred on the date stated above, at
The CAUSE OF DEATH* was as follows:
Carcinoma Gall [illegible]
Operated Dec. 1920

(Duration) 1 Yrs. — mos.
Contributory (Secondary) Recurrent Cancer
(Duration) ..... yrs. One mos.

(Signed) W. F. Howard
7/30 1921 (Address) Pocatello, Ida.

*State the Disease Causing Death; or in deaths from Violent [illegible] (1) Means of Injury; and (2) whether Accidental, Suicidal or [illegible]

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Scipio Utah | DATE OF [illegible]

20. UNDERTAKER: W. T. Trader

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

34654

Registration District No. RECEIVED 28
Primary Registration District No. AUG 10 1921 2141
BUREAU OF VITAL STATISTICS

File No. 42
Registered No. 3625

1. PLACE OF DEATH
County of Bannock
City of Pocatello
(No. Lyons Bet 5th & 6th St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs Peter Rasmussen
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the words): Married

6. DATE OF BIRTH: Sept 17 1845 (Month) (Day) (Year)

7. AGE: 75 Yrs. 10 Mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Jewelsburg Iowa

10. NAME OF FATHER: James Harwood

11. BIRTHPLACE OF FATHER (State or Country): /

12. MAIDEN NAME OF MOTHER: Maryann Morrison

13. BIRTHPLACE OF MOTHER (State or Country): /

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) D. H. Davidson
(Address) 219 Depot Bld Pocatello

15. Filed 7/23 1921 J. Manning Local Registrar

STEWART-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July 22 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 15 1921 to July 22 1921 that I last saw her alive on July 22 1921 and that death occurred on the date stated above, at 3.15 P.M.

The CAUSE OF DEATH* was as follows:
Fracture of the hip.
(Duration) ..... Yrs. ..... mos. 7 ds.
Contributory (Secondary) Pleurisy
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) A. W. Lyons M. D.
July 22 1921 (Address) Pocatello Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Spencer Ida. DATE OF BURIAL: 7/24 1921

20. UNDERTAKER: P. P. Tracey ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

34655

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 42

Registered No. 3626

1. PLACE OF DEATH

County of Bannock Registration District No. 28

City of Pocatello Primary Registration District No. [illegible] 7/16/21

(No. 204 East [illegible] St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James [illegible]

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	Colored	Married

6. DATE OF BIRTH ..... (Month) ..... (Day) 1866 (Year)

7. AGE 61 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) [illegible]

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

Not Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm Landers

(Address) Pocatello

15. Filed 7/23 1921 J. F. Young Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 21 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....

that I last saw h... alive on ..... 19.....

and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Dysentery Alcohol

Poisoning

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) S. S. Ferguson M. D.

7-21-1921 (Address) Pocatello Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: New Cemetery DATE OF BURIAL: 7/24 1921

20. UNDERTAKER: W. L. Procter ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 1-25 M. 1-19.

34656

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

CERTIFICATE OF DEATH

RECEIVED
AUG 10 1921
BUREAU OF VITAL STATISTICS

Registration District No. 28
Primary Registration District No. 2141
File No. 42
Registered No. 3624

1. PLACE OF DEATH
County of Bannock
City of Pocatello
(No. Main St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Pastue Raymond McGaugh

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Aug (Month) 26 (Day) 1890 (Year)

7. AGE: 30 Yrs. 11 Mos. 21 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Chauffeur
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Springdale Ark.

10. NAME OF FATHER: J. McGaugh

11. BIRTHPLACE OF FATHER (State or Country): Tenn

12. MAIDEN NAME OF MOTHER: Mattie Finch

13. BIRTHPLACE OF MOTHER (State or Country): Tenn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. J. Eversole
(Address) 1543 Taft ave

15.
Filed Aug 2 1921
Local Registrar

SUNS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 17th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 17th, 1921, to July 17th, 1921, that I last saw him alive on July 17th, 1921, and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Strychnine poisoning
Suicidal
(Duration) hours Yrs. mos. ds.

Contributory (Secondary): none
(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.
July 17 1921 (Address) Pocatello, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: City Cemetery
DATE OF BURIAL: July 22 1921

20. UNDERTAKER: W. B. Walker
ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

34657

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 42

Registered No. 3422

RECEIVED
JUL 30 1921
BUREAU OF VITAL STATISTICS

Registration District No. 28

Primary Registration District No. 2167

1. PLACE OF DEATH

County of Bannock

City of Pocatello

(No. 1421 Yellowstone Ave. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME. Lena Drake

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Sept. (Month) 30 (Day) 1902 (Year)

7. AGE: 18 Yrs. 10 Mos. 21 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: School Girl

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Cordell Okla

10. NAME OF FATHER: Henry Drake

11. BIRTHPLACE OF FATHER (State or Country): No. Russia

12. MAIDEN NAME OF MOTHER: Anna Buller

13. BIRTHPLACE OF MOTHER (State or Country): No Russia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Henry Drake

(Address) Aberdeen Ida

15. Filed 7/21 1921

Local Registrar

SUNS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 21 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 18 1921 to July 21 1921 that I last saw her alive on July 21 1921, and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Typhoid Pneumonia

Cardiac.

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Operation

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

July 21 1921 (Address) Pocatello Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Aberdeen Ida — DATE OF BURIAL: 7/21 1921

20. UNDERTAKER: H. H. Tracker — ADDRESS: Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

RECEIVED AUG 10 1921 BUREAU OF VITAL STATISTICS

Registration District No. 28 — 34658

Primary Registration District No. 2141

File No. 42

Registered No. 3623

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bannock

City of Pocatello

(No. 942 Alameda Ave. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Bruno Falotto

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Italian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: (Month) (Day) 1/14 (Year)

7. AGE: 7 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wallace Ida

10. NAME OF FATHER: D. J. Falotto

11. BIRTHPLACE OF FATHER (State or Country): Italy

12. MAIDEN NAME OF MOTHER: Mary Arittzo

13. BIRTHPLACE OF MOTHER (State or Country): Italy

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) L. P. Alfard

(Address) 342 Pocatello

15. Filed 1/22 1921

J. P. Young
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 20 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 20th 1921 to July 20 1921 that I last saw him alive on July 20 1921, and that death occurred on the date stated above, at 5P P.M.

The CAUSE OF DEATH* was as follows:

Scarlet Fever

(Duration) Yrs. mos. 4 ds.

Contributory (Secondary): None

(Duration) yrs. mos. ds.

(Signed) A. W. Lyman M. D.

July 21 1921 (Address) Pocatello

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Pocatello Cemetery DATE OF BURIAL: 7/24 1921

20. UNDERTAKER: J. B. Frazier ADDRESS: Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

28 34659

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bannock

City of Pocatello

Registration District No. 2141

Primary Registration District No.

(No. 442 East Hayden St.)

File No. 42

Registered No. 3624

RECEIVED
AUG 10 1921
BUREAU OF VITAL STATISTICS

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Pedro Veldez

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	Mexican	Married

6. DATE OF BIRTH: June (Month) 24 (Day) 1887 (Year)

7. AGE: 34 Yrs. - Mos. 18 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Machinist

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mexico

10. NAME OF FATHER: Pedro Veldez

11. BIRTHPLACE OF FATHER (State or Country): Mexico

12. MAIDEN NAME OF MOTHER: Lorenza Sera

13. BIRTHPLACE OF MOTHER (State or Country): Mexico

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Pedro Veldez Jr

(Address) Pocatello

15. Filed 8/12 19 21

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 12 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from * 19 , to * 19

that I last saw h* alive on * 19 ,

and that death occurred on the date stated above, at 2 A. M.

The CAUSE OF DEATH* was as follows:

Gun Shot Wound

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) S. D. Ferguson Coroner

7/12/21 (Address) Pocatello

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mt View Cemetery

DATE OF BURIAL: 7/21/21 19

20. UNDERTAKER: Will T. WALKER

ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

RECEIVED AUG 10 1921 VITAL STATISTICS

28 34660

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bannock

City of POCATELLO, IDAHO

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 10

Primary Registration District No. 214

(No. Pocatello General Hospital Street)

File No. 42

Registered No. 3428

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Noamo Kader

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: married

6. DATE OF BIRTH: September 24 (Month) (Day) 1871 (Year)

7. AGE: 49 Yrs. 9 Mos. 25 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Section foreman

(b) General nature of industry, business or establishment in which employed (or employer): O S L R R

9. BIRTHPLACE (State or Country): Kentucky

10. NAME OF FATHER: George Kader

11. BIRTHPLACE OF FATHER (State or Country): Kentucky

12. MAIDEN NAME OF MOTHER: Sallie Powell

13. BIRTHPLACE OF MOTHER (State or Country): Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Walter Banning

(Address) Jerome Idaho

15. Filed July 19 1921

Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 19 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 15 1921 to July 19 1921 that I last saw h. alive on 7-19 1921 and that death occurred on the date stated above, at 4 a M.

The CAUSE OF DEATH* was as follows:

Septic meningitis

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

..... (Duration) ..... yrs. ..... mos. 4 ds.

(Signed) [signature] M. D.

7/19 1921 (Address) POCATELLO, IDAHO

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. 4 days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence Jerome Idaho

19. PLACE OF BURIAL OR REMOVAL: Shoshone Idaho — DATE OF BURIAL: July 19 1921

20. UNDERTAKER: H. L. McHAN — ADDRESS: POCATELLO, IDAHO

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

34661

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 28
Primary Registration District No. 2161
File No. 42
Registered No. 3618

RECEIVED
AUG 6 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Bannock
City of Pocatello
(No. Tyhee Apts St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Roy Conley

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single
6. DATE OF BIRTH: June 6 1894 (Month) (Day) (Year)
7. AGE: 27 Yrs. 1 Mos. 8 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: manager Postal Telegraph Pocatello
(b) General nature of industry, business or establishment in which employed (or employer): Idaho.
9. BIRTHPLACE (State or Country): Georgia
10. NAME OF FATHER: B. J. Conley
11. BIRTHPLACE OF FATHER (State or Country): unknown
12. MAIDEN NAME OF MOTHER: unknown
13. BIRTHPLACE OF MOTHER (State or Country): unknown
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John P. Weston
(Address) 442 S. Arthur
15. Filed 7/6 21 J. Young. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July 14th 1921 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Gun Shot Wound
(Suicidal)
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) S. D. Ferguson Coroner M. D.
7-16-1921 (Address) Pocatello Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Cornelia Georgia — DATE OF BURIAL: July 20 1921
20. UNDERTAKER: Schumacher & Hall — ADDRESS: Pocatello Idaho

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

34662 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bannock — Registration District No. 28

City of Pocatello — Primary Registration District No. 216 — (No. ... St.) — Ward ... — File No. 42

If death occurs away from usual residence, give facts called for under special information.

RECEIVED JUL 20 1921 BUREAU OF VITAL STATISTICS

Name of Hospital or Institution: St Anthony Hospital — Registered No. 361

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME: Mrs Gertrude Dwyer

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6. DATE OF BIRTH: June 6th 1880 (Month) (Day) (Year)

7. AGE: 41 Yrs. 1 Mos. 7 ds. — IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Colorado.

10. NAME OF FATHER: John Cooney

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Bridget Byrne

13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs James Daley
(Address) Pocatello Idaho

15. Filed 7/16 1921 — J. Young, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July 15th 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from January 19 19, to July 15th 1921, that I last saw h-er alive on July 15th 1921, and that death occurred on the date stated above, at 3:00 P.M.

The CAUSE OF DEATH* was as follows:

Hypophisis Cyst.

(Duration) Unknown yrs. ... mos. ... ds.

Contributory (Secondary) Dr. Pine Thrombosis

(Duration) 2 yrs. ... mos. ... ds.

(Signed) W. A. Wright M. D.

7/16 1921 (Address) Pocatello, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain View — DATE OF BURIAL: July 18 1921

20. UNDERTAKER: Chamberlain Hoag — ADDRESS: Pocatello Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

34663

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 26
Primary Registration District No. 2141
File No. 42
Registered No. 3616

RECEIVED
AUG 10 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Bannock
City of Pocatello
(No. 2 Deagle Hosp St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William Martin Deming

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Divorced
6. DATE OF BIRTH: March 17 1875 (Month) (Day) (Year)
7. AGE: 46 Yrs. 3 Mos. 24 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Blacksmith
(b) General nature of industry, business or establishment in which employed (or employer): O.S.L. Shops
9. BIRTHPLACE (State or Country): West Virginia
10. NAME OF FATHER: John Deming
11. BIRTHPLACE OF FATHER (State or Country): Not Known
12. MAIDEN NAME OF MOTHER: Thebe Cochran
13. BIRTHPLACE OF MOTHER (State or Country): Not Known
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Son Floyd E. Deming
(Address) Ft. Hall, Ida.
15. Filed July 12 1921 J. Young Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 11 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 11 1921, to July 11 1921
that I last saw him alive on July 11 1921
and that death occurred on the date stated above, at 11:40 A.M.

The CAUSE OF DEATH* was as follows:
Angina Pectoris

(Duration) ..... Yrs. ..... mos. 2 hrs. ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. A. Rothers M. D.
July 1924 (Address) Pocatello, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 1 hour yrs. ..... mos. ..... days. In the State 14 yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence West Virginia

19. PLACE OF BURIAL OR REMOVAL: Mt View Cem. Pocatello Ida. DATE OF BURIAL: July 13 1921

20. UNDERTAKER: H. L. McHan ADDRESS: Pocatello Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

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SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

34664

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 25

Primary Registration District No. 1

File No. 7

Registered No. 364

1. PLACE OF DEATH
County of Bannock
City of Pocatello
If death occurs away from usual residence, give facts called for under special information.

(No. [redacted] Hospital St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME [illegible] Burke [illegible]

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AUG 10 1921
BUREAU OF VITAL STATISTICS

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widow (Write the word.)

6. DATE OF BIRTH: March (Month) 15 (Day) 1864 (Year)

7. AGE: 57 Yrs. 3 Mos. 16 ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer): None

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER: Southerlind

11. BIRTHPLACE OF FATHER (State or Country): Sweeden

12. MAIDEN NAME OF MOTHER: Not known

13. BIRTHPLACE OF MOTHER (State or Country): Sweeden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) L A Burke
(Address) 1153 No. Garfield Pocatello Ida.

15. Filed 7/2 1921 J W Hansen Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 1st (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 27 1921, to July 1st 1921, that I last saw h[illegible] alive on July 1st 1921, and that death occurred on the date stated above, at 11 00 M.

The CAUSE OF DEATH* was as follows:
Appoplexy

(Duration) — Yrs. — mos. 15 ds.

Contributory (Secondary)
(Duration) — yrs. — mos. — ds.

(Signed) J W Hansen M. D.
7/2 1921 (Address) Pocatello

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death — yrs. — mos. 8 days. In the State — yrs. — mos. 8 days
Where was disease contracted if not at place of death? Paralyzed
Former or usual residence Pampa. S Dak.

19. PLACE OF BURIAL OR REMOVAL: Burial | DATE OF BURIAL: 7/3 1921

20. UNDERTAKER: J. I. Tracker ADDRESS Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

34665

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 28

Primary Registration District No. 2141

File No. 42

Registered No. 3618

1. PLACE OF DEATH

County of Bannock

City of Pocatello

(No. Kane Building St.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
AUG 10 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME Infant Son Geo Manos

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH: July (Month) 7 (Day) 1921 (Year)

7. AGE: ....Yrs....Mos. 8 ds. IF LESS than 1 day how many....hrs. or....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Pocatello

10. NAME OF FATHER: Geo Manos

11. BIRTHPLACE OF FATHER (State or Country): Greece

12. MAIDEN NAME OF MOTHER: Ella Meacham

13. BIRTHPLACE OF MOTHER (State or Country): Malad Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Geo Manos
(Address) Pocatello

15. Filed 7/11 1921

Local Registrar

SUNS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 10 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 7 1921, to JULY 10 1921, that I last saw him alive on July 10 1921, and that death occurred on the date stated above, at 9.15PM

The CAUSE OF DEATH* was as follows:
Premature Birth
Convulsions.

(Duration) ....Yrs....mos. 3 ds.

Contributory (Secondary)
(Duration) ....yrs....mos....ds.

(Signed) C Ray M. D.
7/11 1921 (Address) Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Mt View Cemetery	7/11/21

20. UNDERTAKER	ADDRESS
Will T. Walker	Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

34666

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

Registration District No. 52 RECEIVED
Primary Registration District No. JAN 16 1922
BUREAU OF VITAL STATISTICS

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.
Registered No.

1. PLACE OF DEATH.
County of Bear Lake
City of Montpelier
(No. ,)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Edith Williams

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	married

6. DATE OF BIRTH
1 (Month) 1 (Day) (Year)

7. AGE
34 yrs. mos. ds.
IF LESS than 1 day how many hrs. or mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer) —

9. BIRTHPLACE (State or Country) U. S.

10. NAME OF FATHER John Martin

11. BIRTHPLACE OF FATHER (State or Country) Wales

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country) Wales

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. F. Swyon
(Address) Montpelier Ida.

15. Filed 8-1- 1921 W. H. Rees Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
3. (Month) 2. (Day) 1922 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feby 3rd 1921, to Mch 2nd 1921, that I last saw her alive on Mch 2 1921 and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:
Softening of the Brain
Cause unknown

(Duration) — yrs. 1 mos. — ds.

Contributory (Secondary) Nothing

(Duration) — yrs. — mos. — ds.

(Signed) E. F. Swyon M. D.
3-3-1921 (Address) Montpelier Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ...yrs...mos...days. In the State ...yrs...mos...days.
Where was disease contracted if not at place of death? —
Former or usual residence —

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Montpelier Ida	Mch 5th 1922

20. UNDERTAKER	ADDRESS
F. M. Williams	Montpelier Ida

CLAIMS stating cause of DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5—20M.1-16-12

CERTIFICATE OF DEATH

RECEIVED AUG 10 BUREAU OF VITAL STATISTICS

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 52

Primary Registration District No. 2126

File No. 34667

County of Oneida

City of Malad (No. ..... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary Bee

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH: 12 (Month) 15th (Day) 1866 (Year)

7. AGE: 55 yrs. 7 mos. 22 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry business, or dstablishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): U.S.

10. NAME OF FATHER: John Haddock

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Margaret Penman

13. BIRTHPLACE OF MOTHER (State or Country): Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Bee
(Address) Blomington Ida

15. Filed 8-1-1921 J. H. Thurey Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 5 (Month) — 7 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from No physician 191.., to — 191.., that I last saw h alive on — 191.., and that death occurred on the date stated above, at 2 35 M.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

(Duration) — yrs. — mos. 2 ds.

Contributory (Secondary) Espelesy

(Duration) 28 yrs. — mos. — ds.

(Signed) No physician M. D.

19.... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Blomington Ida — DATE OF BURIAL: May 9th 1921

20. UNDERTAKER: None — ADDRESS: —

Bishop, Hart — Blomington Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34669
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

Registration District No. 52
Primary Registration District No. 2136
(No. ....., ... St.)

RECEIVED
AUG 10 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Bear Lake
City of Montpelier
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs. Ella Bruce

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female.

4. COLOR OR RACE White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.) Single

6. DATE OF BIRTH. July (Month) 6 (Day) 1904 (Year)

7. AGE 16 Yrs. 10 Mos. 21 ds. IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work At School
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Wyoming

10. NAME OF FATHER James H Bruce

11. BIRTHPLACE OF FATHER (State or Country) Scotland

12. MAIDEN NAME OF MOTHER Annie Clark

13. BIRTHPLACE OF MOTHER (State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R. H. Bruce
(Address) Smoot Wyo.

15. Filed 8-1-21 .....
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 27 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 27" 1921 to May 27" 1921 that I last saw her alive on May 27" 1921 and that death occurred on the date stated above, at 10.30 P. M.

The CAUSE OF DEATH* was as follows:
Typhoid Pneumonia
.....
.....
.....
(Duration) — Yrs. — mos. 22 ds.

Contributory (Secondary) .....
(Duration) — Yrs. — mos. — ds.

(Signed) G. F. Guyon M. D.
5-28-1921. (Address) Emerald Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the ,State....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Smoot Wyoming — **DATE OF BURIAL** May 30 1921

20. UNDERTAKER F. M. Williams — **ADDRESS** Montpelier Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34670
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

Registration District No. 532
Primary Registration District No. 2136

RECEIVED
AUG 10 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Bear Lake
City of Montpelier
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Alfred J. Wells

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): Infant
6. DATE OF BIRTH: May (Month) 29 (Day) 1921 (Year)
7. AGE: ....Yrs....Mos. 1 ds. IF LESS than 1 day how many .... hrs. or .... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): Idaho
10. NAME OF FATHER: Alfred J. Wells
11. BIRTHPLACE OF FATHER (State or Country): Utah
12. MAIDEN NAME OF MOTHER: Mary Mullen
13. BIRTHPLACE OF MOTHER (State or Country): Utah
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Alfred J. Wells
(Address) Montpelier Ida
15. Filed 8-1-1921 W W Heusy Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 30 (Day) 1921 (Year)
17. I HEREBY CERTIFY, That I attended deceased from May 29 1921 to May 29 1921
that I last saw him alive on May 29 1921
and that death occurred on the date stated above, at 5 P.M.
The CAUSE OF DEATH* was as follows:
Premature Foramen Ovale
(Blue Baby)
.....(Duration) .... Yrs. .... mos. .... ds.
Contributory (Secondary) .....
.....(Duration) .... Yrs. .... mos. .... ds.
(Signed) W W Heusy M. D.
5-30 1921 (Address) Montpelier

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Montpelier DATE OF BURIAL: May 32 1921
20. UNDERTAKER: F M Williams ADDRESS: Montpelier Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 52
Primary Registration District No. 2136
File No. 34671
Registered No.

RECEIVED
AUG 10 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH.
County of Bear Lake
City of Dingle Ida
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sarah Clayton

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Widowed

6. DATE OF BIRTH: 3 (Month) 28 (Day) 1834 (Year)

7. AGE: 87 yrs. 2 mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: John Nicholls

11. BIRTHPLACE OF FATHER (State or Country): U. S.

12. MAIDEN NAME OF MOTHER: Not Known

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H. A. Dayton
(Address) Dingle Ida

15. Filed 8-1-21 by H. H. Young Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 6 (Month) 3 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 26th 1921, to June 3rd 1921, that I last saw her alive on June 3 1921, and that death occurred on the date stated above, at 12.10 P.M.

The CAUSE OF DEATH* was as follows:
Senility

(Duration) ... yrs. ... mos. ... ds.

Contributory
(Secondary)
(Duration) ... yrs. ... mos. ... ds.

(Signed) E. F. Lyon M. D.
6-7 1921 (Address) Montpelier Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Dingle Ida | DATE OF BURIAL: June 5th 1921

20. UNDERTAKER: F. M. Williams | ADDRESS: Montpelier Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYNS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
AUG 10 1921
BUREAU OF VITAL STATISTICS

Registration District No. 53
Primary Registration District No. 2136
File No. 34672
Registered No.

1. PLACE OF DEATH
County of Bear Lake
City of Montpelier
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ray Bissegger

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Infant

6. DATE OF BIRTH: June 13 (Month) (Day) 1921 (Year)

7. AGE: ..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or 10 min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business or establishment in which employed (or employer): Son

9. BIRTHPLACE (State or Country): Montpelier Ida

10. NAME OF FATHER: Lyle Bissegger

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Josephine Dayton

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Lyle Bissegger
(Address) Montpelier Ida

15. Filed 8-1-1921 [illegible] Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 13 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 13 1921, to June 13 1921, that I last saw him alive on June 13 1921, and that death occurred on the date stated above, at 4:40 M.
The CAUSE OF DEATH* was as follows: Marasmus
Was Child born about 10 Weeks ago Premature.
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Acute Pneumonia
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Geo Cushley M. D.
6-13-1921 (Address) Montpelier

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Wardboro Ida — DATE OF BURIAL: 6-15-1921

20. UNDERTAKER: Albert Dimick — ADDRESS: Montpelier

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34674

Registration District No. 32
Primary Registration District No. 3130

1. PLACE OF DEATH
County of Bear Lake
City of Montpelier
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME David Follick

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Male	White	Married. (Write the word.)

6. DATE OF BIRTH
December 31th 1840
(Month) (Day) (Year)

7. AGE
80 Yrs. 6 Mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Contractor
(b) General nature of industry, business or establishment in which employed (or employer) Farmer.

9. BIRTHPLACE
(State or Country) Iowa, Fremont Co.

10. NAME OF FATHER George Alexander Follick

11. BIRTHPLACE OF FATHER
(State or Country) Canada.

12. MAIDEN NAME OF MOTHER
Nancy Porter

13. BIRTHPLACE OF MOTHER
(State or Country) Canada.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Isabella Dayton
(Address) Montpelier Idaho

15. Filed 8-1-1921 N. H. Reuey
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 2, 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 24 1921, to July 2, 1921.
that I last saw him alive on " " 1921,
and that death occurred on the date stated above, at 7 A. M.
The CAUSE OF DEATH* was as follows:

" Flux "

(Duration) Yrs. mos. 14 ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) Elmer E. Stinchfield M. D.
7/4 1921 (Address) Montpelier

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence Montpelier.

19. PLACE OF BURIAL OR REMOVAL Montpelier, Ida. DATE OF BURIAL July 5 1921

20. UNDERTAKER F. M. Williams ADDRESS Montpelier, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK. THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
AUG 10 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Bear Lake
City of Montpelier
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 52
Primary Registration District No. 2136
(No. ... St.)

File No. 34675
Registered No. ...
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME George Augustus Robinson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Aug 20th 1848 (Month) (Day) (Year)

7. AGE: 72 Yrs. 10 Mos. 26 ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Janitor - School
(b) General nature of industry, business or establishment in which employed (or employer): ...

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: George M. Robinson

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Matilda Ford

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) George A. Robinson
(Address) Montpelier Ida
July 19 1921

15. Filed 8-1-1921
N. K. Kerry
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July 16th 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 16 1921, to July 16 1921, that I last saw h[im] alive on July 16 1921 and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
(Apoplexy)
(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary) ...
(Duration) ... yrs. ... mos. ... ds.

(Signed) N. K. Kerry M. D.
(Address) Montpelier Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death? ...
Former or usual residence ...

19. PLACE OF BURIAL OR REMOVAL: Montpelier Ida — DATE OF BURIAL: 7-19 1921

20. UNDERTAKER: F. M. Williams — ADDRESS: Montpelier Ida

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

3467 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Bear Lake
City of Bloomington
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 63
Primary Registration District No.
(No. , St.)
File No. 9
Registered No.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

RECEIVED
AUG 15 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME Sarah Ann Findlay

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Jan. (Month) 25 (Day) 1860 (Year)

7. AGE: 60 Yrs. 6 Mos. 26 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry, business or establishment in which employed (or employer): 1

9. BIRTHPLACE (State or Country): Salt Lake City Utah

10. NAME OF FATHER: John Nebeker

11. BIRTHPLACE OF FATHER (State or Country): Delaware

12. MAIDEN NAME OF MOTHER: Mary Woodcock

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Alma Findlay
(Address) Bloomington Ida

15.
Filed July 20 1921 Mrs. J. S. Skinner Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 19 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....,
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Heart Trouble Dropsy
Cardio-Vascular Renal Disease
(Duration) 1 Yrs. 2 mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) C. O. Moore M. D.
July 20 1921 (Address) Paris Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Bloomington
DATE OF BURIAL: July 21 1921
20. UNDERTAKER: Bishop A. A. Hart
ADDRESS: Bloomington

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

34677 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 63
Primary Registration District No.
(No. St.)
File No. 8
Registered No.

1. PLACE OF DEATH.
County of Bear Lake
City of Paris
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Favre

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. ~~SINGLE~~, ~~MARRIED~~, WIDOWED ~~OR DIVORCED~~. (Write the word.): Widowed
6. DATE OF BIRTH. Aug (Month) 15 (Day) 1844 (Year)
7. AGE: 76 Yrs. 11 Mos. 15 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Soldier
(b) General nature of industry, business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country) Switzerland
10. NAME OF FATHER Not Known
11. BIRTHPLACE OF FATHER (State or Country) Switzerland
12. MAIDEN NAME OF MOTHER Not Known
13. BIRTHPLACE OF MOTHER (State or Country) Switzerland
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Simon Favre
(Address) Paris Idaho
15. Filed July 18 1921 Mrs. J. L. Skinner Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 16 (Day) 1921 (Year)
17. I HEREBY CERTIFY, That I attended deceased from July 10 1921, to July 16 1921, that I last saw h. alive on July 15 1921 and that death occured on the date stated above, at 7 30 P.M.
The CAUSE OF DEATH* was as follows:
Apoplexy - Hemorrhage into Cerebrum
(Duration) Yrs. mos. 5 ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) C. O. Moore M. D.
July 16 1921 (Address) Paris Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Paris — DATE OF BURIAL: July 18 1921
20. UNDERTAKER: Bishop Gowe — ADDRESS: Paris

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BORS. 24654

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

34678

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bear Lake.

City of Paris.

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 53

Primary Registration District No.

(No. RECEIVED St.)

AUG 15 1921

BUREAU OF VITAL STATISTICS

File No. 7

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Van Wilks.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single. (Write the word.)

6. DATE OF BIRTH: April (Month) 9 (Day) 1921. (Year)

7. AGE: Yrs. 3 Mos. 4 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Baby.

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Paris Ida.

10. NAME OF FATHER: John Wilks.

11. BIRTHPLACE OF FATHER (State or Country): Wyo.

12. MAIDEN NAME OF MOTHER: Mabel. Wallentine

13. BIRTHPLACE OF MOTHER (State or Country): Paris. Ida.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John. H. Wilks

(Address) Paris

15. Filed July 13 1921 Mrs. J. S. Skinner Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 13 (Day) 1921. (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 10 1921, to July 18 1921, that I last saw him alive on July 12 1921, and that death occurred on the date stated above, at 4:20 A.M.

The CAUSE OF DEATH* was as follows:

Pneumonia & Bowel Trouble.

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. Dalton M. D.

7/13/21 (Address) Paris.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Paris. DATE OF BURIAL: 7-16-1921

20. UNDERTAKER: Bishop Bros. ADDRESS: Paris Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

34679

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
AUG 15 1921
BUREAU OF VITAL STATISTICS

Registration District No. 53
Primary Registration District No.
(No.)

File No. 11
Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Bear Lake
~~City~~ Village of Lanark

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Frederick W Passey.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. Married (Write the word.)

6. DATE OF BIRTH. November 1st 1875 (Month) (Day) (Year)

7. AGE 46 Yrs. 8 Mos. 24 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Farmer

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER John P. Passey

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER Elizabeth Clifton

13. BIRTHPLACE OF MOTHER (State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ezra Passey

(Address) Paris Idaho

15.

Filed Aug 5 1921 Mrs. J. S. Wanner Local Registrar

SYMS - YORK CO., PTRS. & BOOS. 24854

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 24 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1 1921, to July 16 1921, that I last saw h alive on July 16 1921, and that death occured on the date stated above, at 7 30 P.M.

The CAUSE OF DEATH* was as follows:

Cardio - Renal - Vascular Disease

(Duration) 3 Yrs. 2 mos. ds.

Contributory (Secondary)

(Duration yrs. mos. ds.

(Signed) C. O. Moore M. D.

Aug 6 1921 (Address) Paris Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Paris Idaho

DATE OF BURIAL July 26 1921

20. UNDERTAKER Bishop Lowe.

ADDRESS Paris Idaho

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34680
Registered No. .....

RECEIVED JUL 5 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH. Registration District No. .....
Primary Registration District No. 5-5-
County of Bear Lake
City of Fish Haven (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Wesley K. Stock

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. March (Month) 21st (Day) 1900 (Year)

7. AGE: 21 Yrs. 3 Mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): State of Idaho.

10. NAME OF FATHER: J. W. E. Stock

11. BIRTHPLACE OF FATHER (State or Country): South Africa

12. MAIDEN NAME OF MOTHER: Clara V. Olsen.

13. BIRTHPLACE OF MOTHER (State or Country): Sweden.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. W. E. Stock
(Address) Fish Haven, Idaho

15. Filed July 5 1921 John Mattie Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 23rd (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Accidental by runaway team
instant death

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
..... 19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Fish Haven Idaho — DATE OF BURIAL: June 26th 1921

20. UNDERTAKER: F. M. Williams — ADDRESS: Montpelier Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 46

County of Benewah RECEIVED

Primary Registration District No. 2123

File No. 34681

City of DeSmet JUL 20 1921 No. ..... St.)

Registered No. 5

If death occurs away from usual residence, give facts called for under special information.

BUREAU OF VITAL STATISTICS

2. FULL NAME Mary A. Bennett.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH. June (Month) 11 (Day) 1841 (Year)

7. AGE: 87 Yrs. — Mos. 5 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Indiana, Noble Co.

10. NAME OF FATHER (Last name not known): Johnson

11. BIRTHPLACE OF FATHER (State or Country): Virginia

12. MAIDEN NAME OF MOTHER: Rhoda Johnson

13. BIRTHPLACE OF MOTHER (State or Country): Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. Bennett
(Address) Worley, Ida.

15. Filed July 17 1921 — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 16 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 24th 1921, to June 8th 1921, that I last saw her alive on June 8th 1921, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Chronic Rheumatism,

(Duration) 20 Yrs. — mos. — ds.

Contributory (Secondary) Dislocation of Hip Joint

(Duration 20 yrs. — mos. — ds.

(Signed) J. J. Herrington M. D.

19..... (Address) Worley Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Worley, Idaho — DATE OF BURIAL: June 18 1921

20. UNDERTAKER: H. G. Jaeger — ADDRESS: Plummer,

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SVMS - YORK CO. PTRS. & BOOKS. 24658

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 92

Primary Registration District No. 2049

File No. 34682

Registered No. 23

County of Benewah

City of St Maries (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
AUG 5 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME Jacob Stautenburgh

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED: Widowed (Write the word.)

6. DATE OF BIRTH: June (Month) 21 (Day) 1838 (Year)

7. AGE: 83 Yrs. 1 Mos. 5 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER: Jacob Stautenburgh

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER: Sarah Lewis

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) B. L. Stautenburgh

(Address) St Maries

15. Filed July 26 1921

H E Hurst
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 26 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 25 1921, to July 26 1921, that I last saw him alive on July 25 1921, and that death occurred on the date stated above, at 3.30 P.M.

The CAUSE OF DEATH* was as follows:

General Anasarca

(Duration) 1 Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A D Platt M. D.

July 27 1921 (Address) St Maries, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Woodlawn

DATE OF BURIAL: 7/27 1921

20. UNDERTAKER: H E Hurst & Co

ADDRESS: St Maries

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED AUG 5 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34683

Registered No. 32

1. PLACE OF DEATH

Registration District No. 32

County of Shoshone Registration District No. 2049

City of St Joe (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Richard Bishop

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	white	single

6. DATE OF BIRTH: Sept (Month) 10 (Day) 1863 (Year)

7. AGE: 57 Yrs. 11 Mos. 1 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: farmer
(b) General nature of industry, business or establishment in which employed (or employer): small Ranch

9. BIRTHPLACE (State or Country): Wisconsin

10. NAME OF FATHER: Gabriel Bishop

11. BIRTHPLACE OF FATHER (State or Country): American Born

12. MAIDEN NAME OF MOTHER: not known

13. BIRTHPLACE OF MOTHER (State or Country): not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs W. F. Buchholtz
(Address) Spokane Wn.

15. Filed July 13 1921 H E Hamel Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 11 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 12 1921 to [illegible] 19..., that I last saw h[illegible] alive on [illegible] 19..., and that death occurred on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Sun-stroke

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) heat Exaustion

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H C. Alcorn M. D.

7/12 1921 (Address) St Maries Ida. Coroner Benewah Co

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Spokane Wash	7-13 1921
20. UNDERTAKER	**ADDRESS**
Turnbull Und Co	St Maries Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
AUG 5 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34684

Registered No. 31

1. PLACE OF DEATH

Registration District No. 32

County of Benewah Primary Registration District No. 2049

City of St. Maries (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Emma Parker

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Dec (Month) 5 (Day) 1861 (Year)

7. AGE: 59 Yrs. 6 Mos. 25 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Kentucky

10. NAME OF FATHER: George Bryant

11. BIRTHPLACE OF FATHER (State or Country): .....

12. MAIDEN NAME OF MOTHER: Lyda Paugton

13. BIRTHPLACE OF MOTHER (State or Country): .....

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Beatrice Lee

(Address) Lewiston Idaho

15. Filed July 4 1921 H E Hunt Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 3 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 22 1921, to July 3 1921, that I last saw h.. alive on July 3 1921, and that death occurred on the date stated above, at 11:30 P.M.

The CAUSE OF DEATH* was as follows:

Myocardial failure

(Duration) ..... yrs. ..... mos. 1 ds.

Contributory (Secondary) Chronic Intestinal Appendicitis

(Duration) ..... yrs. ..... mos. 4 ds.

(Signed) L D Connaghe, M. D.

1/5 1921 (Address) St Maries

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Woodlawn — DATE OF BURIAL: 7/6 1921

20. UNDERTAKER: H E Hunt Co — ADDRESS: St Maries

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34685

Registered No. 24

RECEIVED JUN 3 1921

1. PLACE OF DEATH

Registration District No. 32

Primary Registration District No. 2049

County of Benewah

City of St. Maries (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Fred Benare

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Male	White	single (Write the word.)

6. DATE OF BIRTH: Sept (Month) 20 (Day) 1863 (Year)

7. AGE: 57 Yrs. 8 Mos. 12 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Common Labarer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Michigan

10. NAME OF FATHER: — Benare

11. BIRTHPLACE OF FATHER (State or Country): Switzerland

12. MAIDEN NAME OF MOTHER: Not Known

13. BIRTHPLACE OF MOTHER (State or Country): Not Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Milton Barmore
(Address) St. Maries Idaho

15. Filed June 1 1921 — H E Hunt — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 1 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 25 1921 to June 1 1921 that I last saw h.. alive on June 1 1921 and that death occurred on the date stated above, at 9.30 A.M.

The CAUSE OF DEATH* was as follows:

Cellulitis of neck

(Duration) ..... Yrs. ..... mos. 7 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

6/1 1921 (Signed) D Cornwall M. D.

(Address) St Maries

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Woodlawn Cemetery — DATE OF BURIAL: 6/3 1921

20. UNDERTAKER: H E Hunt Co — ADDRESS: St. Maries

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34686
Registered No. 25

RECEIVED
JUL 13 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
Registration District No. 32
Primary Registration District No. 2049
County of Benewah
City of St Maries (Ward) St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John J Keenan

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: June (Month) 15 (Day) 1868 (Year)

7. AGE: 52 Yrs. 10 Mos. 6 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Woodsman
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Canada

10. NAME OF FATHER: Florence Keenan

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Bridget Campbell

13. BIRTHPLACE OF MOTHER (State or Country): Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Patrick W Keenan
(Address) Fernwood

15. Filed June 4 1921 H E Hunt Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 21 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....,
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at 12:30 P.M.
The CAUSE OF DEATH* was as follows:
Accidental drowning.

..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H Haleom Coroner M. D.
June 4 1921 (Address) St Maries Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Woodlawn — DATE OF BURIAL: 6-5-1921

20. UNDERTAKER: H E Hunt Co — ADDRESS: St Maries

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JUL 13 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 32

Primary Registration District No. 2049

File No. 34687

County of Benewah

City of St. Maries, St.)

Registered No. 27

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sam Callas (Saterios Kakakegelos)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH: May 26 1896 (Month) (Day) (Year)

7. AGE: 24 Yrs. 9 Mos. 11 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Greece

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country): Greece

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country): Greece

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Taken from Irish Papers
(Address)

15. Filed June 6 1921 H E Hunt Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 5 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 5 1921 to June 5 1921 that I last saw h.. alive on June 5 1921, and that death occurred on the date stated above, at 6:20 P M.

The CAUSE OF DEATH* was as follows:
Gunshot Wounds - right lung - liver - abdomen

(Duration) ..... Yrs. ..... mos. 14 hrs

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H E Hunt M. D.
6/6 1921 (Address) St Maries

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Woodlawn Cemetery — DATE OF BURIAL: June 8 1921

20. UNDERTAKER: H. E. Hunt Co — ADDRESS: St. Maries Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JUL 13 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Benewah — Registration District No. 32

City of St Maries — Primary Registration District No. 2049

(No. ..... St.)

File No. 34688

Registered No. 26

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jane White

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Single

6. DATE OF BIRTH: Dec. (Month) 25 (Day) 1920 (Year)

7. AGE: Yrs. 5 Mos. 12 ds. — IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: X
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Wash. B White

11. BIRTHPLACE OF FATHER (State or Country): Kentucky

12. MAIDEN NAME OF MOTHER: Ida B Ritter

13. BIRTHPLACE OF MOTHER (State or Country): Wis

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W B White
(Address) St Maries

15. Filed June 6 1921 — H E Hunt, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 6 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 15 1921 to June 6 1921, that I last saw her alive on June 5 1921, and that death occurred on the date stated above, at 9:20 A.M.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) — Yrs. mos. 12 ds.

Contributory (Secondary): Pertussis

(Duration) yrs. mos. 28 ds.

(Signed) C O'Call M. D.

June 6 1921 (Address) St Maries Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Woodlawn	6/7 1921

20. UNDERTAKER	ADDRESS
H E Hunt Co	St Maries

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JUL 10 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 92

Primary Registration District No. 2049

File No. 34689

Registered No. 27

County of Benewah

City of Little Plummer, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Robert Edward Schmidt

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Male	white	single (Write the word.)

6. DATE OF BIRTH: Mar (Month) 17 (Day) 1915 (Year)

7. AGE: 6 Yrs. 2 Mos. 25 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: X
(b) General nature of industry, business or establishment in which employed (or employer): X

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: William F. Schmidt

11. BIRTHPLACE OF FATHER (State or Country): Nebraska

12. MAIDEN NAME OF MOTHER: Ruth Gordon

13. BIRTHPLACE OF MOTHER (State or Country): North Dakota

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) F. G. Schmidt
(Address) Bonners Ferry Ida

15. Filed June 13 1921 D. E. Hunt Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 12 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 12 1921, to June 12 1921 that I last saw h. was alive on same 19..., and that death occurred on the date stated above, at 9 A M.

The CAUSE OF DEATH* was as follows:
Accidental drowning at mill pond at the Smith Bros Lbr. Co. Ranch

.....(Duration) .....Yrs.....mos.....ds.

Contributory (Secondary)

.....(Duration) .....yrs.....mos.....ds.

(Signed) H. L. Alcorn, Coroner
Benewah Co.,
June 12 1921 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Wordlaw	6-14 1921

20. UNDERTAKER	ADDRESS
Mitchell & Metzger	St Maries Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34690

Registered No. 29

RECEIVED
JUL 13 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 32

Primary Registration District No. 2049

County of Benewah

City of St Maries (No.) (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Leon Demers

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Male	White	Married (Write the word.)

6. DATE OF BIRTH: Aug. (Month) 14 (Day) 1851 (Year)

7. AGE: 69 Yrs. 8 Mos. 6 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Banker
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Canada

10. NAME OF FATHER: John B Demers

11. BIRTHPLACE OF FATHER (State or Country): Canada

12. MAIDEN NAME OF MOTHER: Edwie Gauthier

13. BIRTHPLACE OF MOTHER (State or Country): Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Leon Demers
(Address) St Maries

15. Filed June 21 1921 H Eckman Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 20 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1 1921, to June 20 1921, that I last saw ~~him~~ alive on June 20 1921, and that death occurred on the date stated above, at 8 P M.

The CAUSE OF DEATH* was as follows:

Nephritis and Arterio Sclerosis

(Duration) 2 Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Owen D Peet M. D.

June 22 1921 (Address) St Maries Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
St Maries Idaho	6/24 1921
20. UNDERTAKER	ADDRESS
H Eckman Co.	St Maries

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
JUL 13 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 32
Primary Registration District No. 2049

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34691
Registered No. 90

1. PLACE OF DEATH

County of Bennewah
City of St Maries (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William Shae

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH ..... (Month) ..... (Day) 1843 (Year)

7. AGE 78 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Ireland

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) D. C. Cranny
(Address) St Maries

15. Filed June 23 1921 T. E. Elliott Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 22 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 4 1921, to June 22 1921, that I last saw h. liv alive on June 22 1921, and that death occurred on the date stated above, at 8:20 P.M.

The CAUSE OF DEATH* was as follows:
Uremia - Chronic nephritis

(Duration) Yrs. 1 mos. 2 ds.
Contributory (Secondary) Fractured hip
(Duration) yrs. 1 mos. 18 ds.

(Signed) D. Townsend M. D.
6/22 1921 (Address) St. Maries

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Woodlawn	6-25-1921

20. UNDERTAKER	ADDRESS
T. E. Elliott	St Maries

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
JUL 10 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

34692

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 31

Primary Registration District No.

File No. 1

County of Benewah

City of Wemel (No. , St.)

Registered No. 46

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Anne Bennet

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F.	W.	Widowed

6. DATE OF BIRTH 1839
(Month) (Day) (Year)

7. AGE 82 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Indiana

10. NAME OF FATHER Not known

11. BIRTHPLACE OF FATHER (State or Country) " "

12. MAIDEN NAME OF MOTHER " "

13. BIRTHPLACE OF MOTHER (State or Country) " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Sister Mathias - Nurse

(Address) Wemel, Idaho

15.

Filed June 17 1921

Y. L. Bihan
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51083

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 16 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....

that I last saw h..... alive on ..... 19.....,

and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Dislocated hip — 52 years
sickness

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

19..... (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF ~~BURIAL OR~~ REMOVAL Worley

DATE OF BURIAL June 18 1921

20. UNDERTAKER

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JUL 10 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 31 — 3469

County of Benewah — Registration District No. ____

City of Dennet (St.) — File No. 1

Registered No. 40

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Catherine Welsh

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Widow

6. DATE OF BIRTH: Jan (Month) 20 (Day) 1830 (Year)

7. AGE: 91 Yrs. 4 Mos. 17 ds. — IF LESS than 1 day how many ____ hrs. or ____ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Canada

10. NAME OF FATHER: not known

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Tiber Mathias (Nurse)
(Address) Dennet, Idaho

15. Filed June 7 1921 — J. E. Bihan, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 6 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 28 1919, to June 6 1921, that I last saw her alive on June 6 1921, and that death occurred on the date stated above, at 9.30 A.M.
The CAUSE OF DEATH* was as follows:
Cancer of eye + old age

(Duration) 4 Yrs. ____ mos. ____ ds.

Contributory (Secondary)

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) ____ M. D.

19____ (Address) ____

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 4 yrs. 11 mos. ____ days. In the State ____ yrs. ____ mos. ____ days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Dennet Idaho — DATE OF BURIAL: June 7 1921

20. UNDERTAKER: J. Fahrni — ADDRESS: Dennet

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JUL 13 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

34694

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 121

Primary Registration District No. 2194

File No.

County of Bingham

City of Blackfoot (No. 1 Idaho Insane Asylum St.)

Registered No. 86

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charlotte Amelia Adams

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Female	Caucasian	Single (Write the word.)

6. DATE OF BIRTH

..... (Month) ..... (Day) 1885 (Year)

7. AGE

36 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Rigby, Idaho

10. NAME OF FATHER Daniel K. Adams

11. BIRTHPLACE OF FATHER (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (State or Country) Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) according to Ceylon Boring Martha E. Knight Bookkeeper

(Address) Blackfoot, Idaho

15. Filed June 21 1921 Mrs Hulda E. Pierce Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June (Month) 1 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar. 13 1919 to June 1 1921 that I last saw her alive on May 31 1921, and that death occurred on the date stated above, at 6:30 P.M.

The CAUSE OF DEATH* was as follows:

Status Epilepticus

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Richard G. Eaton M. D.

June 1 1921 (Address) Blackfoot, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 13 yrs. 7 mos. 22 days. In the State 36 yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? all her life

Former or usual residence Rigby, Idaho.

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Rigby Idaho	6/23 1921
20. UNDERTAKER E J Funk	ADDRESS Blackfoot Idaho

SUN-YORK CO., PRINTERS & BINDERS, BOISE 51088

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JUL 13 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 121

Primary Registration District No. 2194

File No. 34605

Registered No. 87

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Bingham

City of Blackfoot (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Carolina Free Haag

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: married (Write the word.)

6. DATE OF BIRTH: April (Month) 29 (Day) 1866 (Year)

7. AGE: 55 Yrs. 1 Mos. 7 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: housewife

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Switzerland

10. NAME OF FATHER: ~~Unknown~~ John Fowy Frei

11. BIRTHPLACE OF FATHER (State or Country): unknown Switzerland

12. MAIDEN NAME OF MOTHER: unknown Anna Engker

13. BIRTHPLACE OF MOTHER (State or Country): unknown Switzerland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Hospital Records

(Address) Blackfoot Idaho

15. Filed June 8 1921 Mrs. Hulda E. Gibson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 6th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from January 1907 to June 6th 1921, that I last saw her alive on June 5th 1921, and that death occurred on the date stated above, at 9 A. M.

The CAUSE OF DEATH* was as follows:

Sanitation from auto-infection

(Duration) Yrs. 2 mos. ds.

Contributory (Secondary) Chronic depressive mania (Duration) 15 yrs. mos. ds.

(Signed) E. W. Hoover M. D.

6-6 1921 (Address) Blackfoot

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 15 yrs. mos. days. In the State 20 yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence Paris Idaho

19. PLACE OF BURIAL OR REMOVAL: Payson Utah — DATE OF BURIAL: On arrival

20. UNDERTAKER: Ed L. Eggli — ADDRESS: Blackfoot

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
JUL 13 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
Registration District No. 121
Primary Registration District No. 2194
File No. 34696
Registered No. 88
County of Bingham
City of Blackfoot (If not in city give township) (Street and No. or location) East of Sugar Factory St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Antonia Varrelo Cabrera

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: Mexican
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married
6. DATE OF BIRTH. Don't Know (Month) (Day) 1 (Year)
7. AGE: 44 Yrs. ..... Mos. ..... ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Mexico
10. NAME OF FATHER: Urbano Varrelo
11. BIRTHPLACE OF FATHER (State or Country): Mexico
12. MAIDEN NAME OF MOTHER: Lorenza Melendez
13. BIRTHPLACE OF MOTHER (State or Country): Mexico
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Maximo Cabrera
(Address) Blackfoot Ida
15. Filed June 6 1921 Mrs Nalin E. Eaton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 6 (Day) 1921 (Year)
17. I HEREBY CERTIFY, That I attended deceased from May 1 1921, to June 6 1921, that I last saw her alive on June 5 1921, and that death occured on the date stated above, at 3 P.M.
The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis
(Duration) 7 Yrs. — mos. — ds.
Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) W. W. Beck M. D.
June 6 1921 (Address) Blackfoot, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Blackfoot Cem. DATE OF BURIAL: June 6 1921
20. UNDERTAKER: Maximo Cabrera ADDRESS: Blackfoot Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24654

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
JUL 15 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
Registration District No. 731
Primary Registration District No. 2154
File No. 34607
County of Bingham
City of Blackfoot (If not in incorporated limits, give township.) St.)
Registered No. 89
If death occurs away from usual residence, give facts called for under special information.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.
2. FULL NAME Esther Rudolph

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F.	W.	Married

6. DATE OF BIRTH: May 14 (Month) (Day) 1917 (Year)

7. AGE: 4 Yrs. Mos. 25 Ds. IF LESS than 1 day how many ____ hrs. or ____ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Jacob Rudolph

11. BIRTHPLACE OF FATHER (State or Country): Le Dark.

12. MAIDEN NAME OF MOTHER: Carrie Matthiesen

13. BIRTHPLACE OF MOTHER (State or Country): Russia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jacob Rudolph
(Address) Blackfoot Ida Route 1

15. Filed June 8 1921 Mrs Nellie E Petrie Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 7 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I ~~attended deceased from~~ Immediately
death 19____, to 19____
~~that I last saw h... alive on~~ 19____
and that death occurred on the date stated above, at ____ M.

The CAUSE OF DEATH* was as follows:
Drowned

(Duration) ____ Yrs. ____ mos. ____ ds.
Contributory (Secondary)
(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) Dr E. Petrie M. D.
June 8 1921 (Address) c/o Petrie Blackfoot Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Groveland Ida
DATE OF BURIAL: June 9 1921

20. UNDERTAKER: Jacob Rudolph
ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JUL 13 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 2174
File No. 34698
Registered No. 90

1. PLACE OF DEATH
County of Bingham
City of Blackfoot (If outside limits, give township.) Idaho Insane Asylum (St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ruby Bridges
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Female	White	Married (Write the word.)

6. DATE OF BIRTH
..... (Month) ..... (Day) 1 (Year)

7. AGE
31 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Inmate Idaho
(b) General nature of industry, business or establishment in which employed (or employer) Insane Asylum

9. BIRTHPLACE (State or Country) Kansas

10. NAME OF FATHER Don't Know,

11. BIRTHPLACE OF FATHER (State or Country) Don't know

12. MAIDEN NAME OF MOTHER Don't know

13. BIRTHPLACE OF MOTHER (State or Country) Don't know.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ed L Egli Coroner
(Address) Blackfoot Idaho

15. Filed June 9 1921 Mc Walter E. Watson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
June (Month) 7 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....
and that death occurred on the date stated above, at 8 A M.

The CAUSE OF DEATH* was as follows:
Poisoned from drinking denatured alcohol
Suicidal
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Ed L Egli Coroner M. D.
6/10 1921 (Address) Blackfoot Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. 2 mos. ..... days. In the State 2 yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence Caldwell Ida

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Denver Colo	On arrival 1921

20. UNDERTAKER	ADDRESS
Ed L Egli	Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JUL 19 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 127
Primary Registration District No. 2194
File No. 34699
Registered No. 75

1. PLACE OF DEATH

County of Bingham
City of Blackfoot (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Ellen Goodenough

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widow (Write the word.)

6. DATE OF BIRTH: Aug. (Month) 6 (Day) 1843 (Year)

7. AGE: 77 Yrs. 10 Mos. 12 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Samuel Bill

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Angeline Lackey

13. BIRTHPLACE OF MOTHER (State or Country): New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Samuel Goodenough
(Address) Blackfoot Idaho.

15. Filed June 20 1921 Mrs Nadine E. Robins
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 18 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 17 1921, to June 18 1921
that I last saw h.er alive on June 18 1921
and that death occurred on the date stated above, at 5:10 p.m.
The CAUSE OF DEATH* was as follows:
La Grippe followed with Bronchitis

(Duration) Yrs. 1 mos. 7 ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) J. O. Hamptin M. D.
6/20 1921 (Address) Blackfoot Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Ferguson Idaho | DATE OF BURIAL: 19

20. UNDERTAKER: E. J. Funk | ADDRESS: Blackfoot Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
JUL 13 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34700
Registered No. 74

1. PLACE OF DEATH
County of Bingham — Registration District No. 121
City of Firth — Primary Registration District No. 2194
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Virginia Maskin
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1 (Year)

7. AGE: 3 Yrs. — Mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Ernest L Maskin

11. BIRTHPLACE OF FATHER (State or Country): Virginia

12. MAIDEN NAME OF MOTHER: Gardner

13. BIRTHPLACE OF MOTHER (State or Country): ~~Kan~~ Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. J. Ramsey
(Address) Firth Idaho

15. Filed June 16 1921 Wm Hunter E Patrick
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 16 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 16 1921, to June 16 1921, that I last saw her alive on June 16 1921, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Pneumonia.

(Duration) ..... Yrs. ..... mos. 4 ds.

Contributory (Secondary) Whooping Cough.

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F. W. Mitchell M. D.

6/16 1921 (Address) Blackfoot, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: West Firth — DATE OF BURIAL: 6-16 1921

20. UNDERTAKER: E. O. Funk — ADDRESS: Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JUL 15 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34701
Registered No. 93

1. PLACE OF DEATH
County of Bingham Registration District No. 121
City of Pingree Primary Registration District No. 2194
(St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Donald Ray Fuqua

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH
May (Month) 31 (Day) 1921 (Year)

7. AGE
Yrs. Mos. 15 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Pingree Idaho

10. NAME OF FATHER C. Ray Fuqua

11. BIRTHPLACE OF FATHER (State or Country) Mass

12. MAIDEN NAME OF MOTHER Helen Vera Wright

13. BIRTHPLACE OF MOTHER (State or Country) Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. R. Fuqua
(Address) Pingree Idaho

15. Filed June 15 1921 Mrs Walter E. Nixon Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
June (Month) 14 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 2nd 1921, to June 14 1921, that I last saw him alive on June 13 1921, and that death occurred on the date stated above, at 8:10 P.M.
The CAUSE OF DEATH* was as follows:
Erysipelas
(Duration) Yrs. mos. 10 ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) J. O. Humphreys M. D.
6/15/1921 (Address) Blackfoot Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Riverside Cem Rockford Idaho — DATE OF BURIAL June 16 1921

20. UNDERTAKER C. R. Fuqua — ADDRESS Pingree Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34702

Registered No. 92

Registration District No. 2

Primary Registration District No. 2194

RECEIVED
JUL 13 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Bingham

City of Blackfoot (If outside limits, give township) State Hospital (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Margaret Dunn

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
female	white	married

6. DATE OF BIRTH

(Month) (Day) 1857 (Year)

7. AGE

64 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: house wife

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Arkansas

10. NAME OF FATHER unknown

11. BIRTHPLACE OF FATHER (State or Country) unknown

12. MAIDEN NAME OF MOTHER unknown

13. BIRTHPLACE OF MOTHER (State or Country) unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Hospital Records R P Eaton M D. Assistant physician

(Address) Blackfoot Idaho

15. Filed June 18 1921 W. O. Haven E. P. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June (Month) 13 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 22 1921, to June 13 1921, that I last saw her alive on June 13 1921, and that death occurred on the date stated above, at 8 A.M.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

(Duration) Sudden Yrs. mos. ds.

Contributory (Secondary) Previous stroke of apoplexy

(Duration) 1 yrs. 1 mos. ds.

(Signed) C A Hagen M. D.

6-13 1921 (Address) Blackfoot Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 0 yrs. 1 mos. 23 days. In the State 1 yrs. 7 mos. days

Where was disease contracted if not at place of death?

Former or usual residence Boise, Idaho

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Fairview Cemetery	6-18 1921

20. UNDERTAKER E J Peck ADDRESS Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
JUL 13 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 2194
File No. 34703
Registered No. 91

1. PLACE OF DEATH

County of Bingham
City of Blackfoot (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Bridget Sullivan

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	Caucasian	Single

6. DATE OF BIRTH ..... (Month) ..... (Day) 1875 (Year)

7. AGE 46 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Servant girl
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Ireland

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (State or Country) Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) according to Asylum Records Matthew E. High - Bookkeeper
(Address) Idaho Insane Asylum Blackfoot Idaho

15. Filed June 8 1921 Wm. Taliaferro Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 6 (Month) 8 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 12 1919, to June 8 1921, that I last saw h.er alive on June 8 1921, and that death occurred on the date stated above, at 12:12 P.M.

The CAUSE OF DEATH* was as follows:

Status Epilepticus

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Epilepsy

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Ed A. Hoppen M. D.

6-8 1921 (Address) Blackfoot Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 25 yrs. 6 mos. 9 days. In the State 30 yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? Don't know

Former or usual residence Payette, Idaho

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Asylum Cemetery	..... 19.....
20. UNDERTAKER Chas. J. Wright	ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JUL 13 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bingham Registration District No. 121

City of Shelley (No. ..... St.) Primary Registration District No. 2174

File No. 34715

Registered No. 97

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Joseph Josephson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Infant (Write the word.)

6. DATE OF BIRTH: June (Month) 25 (Day) 1921 (Year)

7. AGE: Prematute Yrs. ..... Mos. ..... ds. IF LESS than 1 day how many 2½ hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Shelley Ida.

10. NAME OF FATHER: Joseph Abraham Josephson

11. BIRTHPLACE OF FATHER (State or Country): Willard Utah

12. MAIDEN NAME OF MOTHER: Nella Jacobson

13. BIRTHPLACE OF MOTHER (State or Country): Shelley Ida.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) .....
(Address) .....

15. Filed June 25 1921 Mrs Nalen E. Patrick Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 25 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 25 1921, to June 25 1921 that I last saw h[illegible] alive on June 25 1921 and that death occurred on the date stated above, at 9.30 A. M.

The CAUSE OF DEATH* was as follows:
Prematute (6½ months)

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. P. Egbert M. D.

June 25 1921 (Address) Shelley Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL 19
20. UNDERTAKER	ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JUL 13 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH — Registration District No. 121
County of Bingham — Primary Registration District No. 2194
City of Blackfoot (No. State Hospital St.)
File No. 34706
Registered No. 98
If death occurs away from usual residence, give facts called for under special information.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME James B. Taylor

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH — (Month) — (Day) 1855 (Year)

7. AGE — 66 Yrs. — Mos. — ds. — IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Mechanic
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Pennsylvania

10. NAME OF FATHER unknown

11. BIRTHPLACE OF FATHER (State or Country) unknown

12. MAIDEN NAME OF MOTHER unknown

13. BIRTHPLACE OF MOTHER (State or Country) unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Hospital Records, Physician
(Address) Blackfoot, Idaho

15. Filed June 27 1921 — W. Nalen C. Latour, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH — June (Month) 27 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 22 1921, to June 27 1921, that I last saw him alive on June 26 1921, and that death occurred on the date stated above, at 12:15 M.
The CAUSE OF DEATH* was as follows:
Uremic coma
(Duration) Yrs. mos. 4 ds.
Contributory (Secondary) Chronic nephritis
(Duration) 3 yrs. mos. ds.
(Signed) C. N. Hoover M. D.
June 27 1921 (Address) Blackfoot Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients or Recent Residents.)
At place of death yrs. mos. 5 days. In the State ? yrs. mos. days
Where was disease contracted if not at place of death? —
Former or usual residence Boise, Idaho

19. PLACE OF BURIAL OR REMOVAL: Boise Idaho — DATE OF BURIAL 19

20. UNDERTAKER: E. J. Peck — ADDRESS Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

RECEIVED AUG 6 1921 BUREAU OF VITAL STATISTICS

34707

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 116
Primary Registration District No. 2195
(No. ..... St.)
File No. 4
Registered No. 57

1. PLACE OF DEATH.
County of Bingham
City of Springfield
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lorey Shelman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Dec (Month) 15 (Day) 1902 (Year)

7. AGE: 18 Yrs. 6 Mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kansas

10. NAME OF FATHER: Lysander Shelman

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Lillian May Field

13. BIRTHPLACE OF MOTHER (State or Country): Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) L. Shelman
(Address) Springfield Ida

15. Filed July 11 1921 M. C. McCutchen Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 10 (Day) 21 191 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Drowning
accidental
(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) M. C. McCutchen M. D.
19 21 (Address) Aberdeen Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Springfield Ida — DATE OF BURIAL: July 12 1921

20. UNDERTAKER: Friends — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

EVANS - TOOK CO., PTRS. & STNRS. 24853

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34708
Registered No. 77

RECEIVED
JUL 13 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Bingham
City of Blackfoot
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 121
Primary Registration District No. 1007
(Name) Blackfoot General Hospital

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lena Ellen Bradley

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: July 21 1900 (Month) (Day) (Year)

7. AGE: 15 Yrs. 11 Mos. 1 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Council Idaho

10. NAME OF FATHER: Edward Bradley

11. BIRTHPLACE OF FATHER (State or Country): Moroni Utah

12. MAIDEN NAME OF MOTHER: Maude Good

13. BIRTHPLACE OF MOTHER (State or Country): Iowa.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Edward Bradley
(Address) Backfoot Ida

15.
Filed Jan 29 1921 Mrs Mabel E. Petree
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 29 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 26 1921 to June 29 1921 that I last saw her alive on June 29 1921 and that death occurred on the date stated above, at 6:30 P.M.

The CAUSE OF DEATH* was as follows:
Shock following operation for purposes nature, self inflicted
(Duration) Yrs. ..... mos. 3 ds.
Contributory (Secondary) Hemorrhage
(Duration) ..... yrs. ..... mos. 3 ds.

(Signed) W. E. Petree M. D.
June 29 1921 (Address) Blackfoot Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)
At place of death ..... yrs. ..... mos. ..... days. In this State ..... yrs. ..... mos. 1 days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Moreland Cemetery — DATE OF BURIAL: July 1921

20. UNDERTAKER: Ed L. Egli — ADDRESS: Blackfoot

MARGIN RESERVED FOR BINDING — WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED JUL 13 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH.

34709

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 116

Primary Registration District No. 2195

File No. 4

Registered No. 58

County of Bingham

City of Sterling (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jean Westley

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Single

6. DATE OF BIRTH. June 15 1921
(Month) (Day) (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Clarence H Westley

11. BIRTHPLACE OF FATHER (State or Country) Nevada

12. MAIDEN NAME OF MOTHER Viola Mae Lewis

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C. H. Westley

(Address) Sterling Ida

15. Filed June 15 21 1921 McCumber Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 15 21 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 15 1921 to June 15 1921, that I last saw h[illegible] alive on June 15 1921, and that death occured on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows: Premature birth 7th month

Inanition

.....(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

.....(Duration ..... yrs. ..... mos. ..... ds.

(Signed) W. C. McCumber M. D.

June 15 1921 (Address) Aberdeen Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
U. S. Ft. Cemetery Aberdeen Ida	June 17 1921
20. UNDERTAKER Friends	ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED JUL 13 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH.

34710

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 4

Registered No. 57

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No. 116

County of Bingham

Primary Registration District No. 2155

City of Spring field (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Columbia Fields

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Nov (Month) – (Day) 1860 (Year)

7. AGE: 60 Yrs. 7 Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: House work

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: James F Fields

11. BIRTHPLACE OF FATHER (State or Country): Indiana

12. MAIDEN NAME OF MOTHER: Araminta Coleman

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J Larsen Fields

(Address) Wilcox Kansas

15. Filed June 10 21 M C Mackinnon Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 9 21
(Month) (Day) 191 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 1 1921, to June 9 1921, that I last saw h[illegible] alive on June 8 1921, and that death occured on the date stated above, at 1P M.

The CAUSE OF DEATH* was as follows:

Ends d-myocarditis (Chronic)

(Duration) 20 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) M. C. Mackinnon M. D.

June 10 1921 (Address) Aberdeen Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Wichita Kans. DATE OF BURIAL: May 191

20. UNDERTAKER: E T Park ADDRESS: Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 24653

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

34711

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bingham
City of Blackfoot
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 127
Primary Registration District No. 2774
(No. 9 Marth Shelling St.)

RECEIVED
AUG 19 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME Ezra H Simons

File No.
Registered No. 1161
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Nov (Month) 26 (Day) 1864 (Year)

7. AGE: 00 yrs. 6 mos. 8 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, professsion, or particular kind of work: Farmer Rancher
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Penn.

10. NAME OF FATHER: Levis Simons

11. BIRTHPLACE OF FATHER (State or Country): Penn

12. MAIDEN NAME OF MOTHER: Fisher

13. BIRTHPLACE OF MOTHER (State or Country): Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ezra H. Simons Wife
(Address) Blackfoot

15. Filed July 6 1921 Mrs Nellie E. Fisher Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 4 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 4 1921, to June 4 1921, that I last saw him alive on 191, and that death occurred on the date stated above, at 11:30 P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia -

Influenza - Bronchial trouble.

(Duration) yrs. mos. ds.

Contributory (Secondary) Hypostatic congestion of Lungs

(Duration) several yrs. mos. ds.

(Signed) C. W. Anderson M. D.

19 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was Disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Fem Cem Cemetery | DATE OF BURIAL: 191

20. UNDERTAKER: E J Finch | ADDRESS: Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3472
Registered No. 101

1. PLACE OF DEATH

County of Bingham — Registration District No. 91 [illegible]

City of Blackfoot (No. ... State Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

RECEIVED
AUG 10 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME Martha White

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: widowed (Write the word.)

6. DATE OF BIRTH: 8/49 (Month) (Day) (Year)

7. AGE: 72 Yrs. ... Mos. ... ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: housework
(b) General nature of industry, business or establishment in which employed (or employer): ...

9. BIRTHPLACE (State or Country): American

10. NAME OF FATHER: was certained

11. BIRTHPLACE OF FATHER (State or Country): was certained

12. MAIDEN NAME OF MOTHER: was certained

13. BIRTHPLACE OF MOTHER (State or Country): was certained

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Hospital Records
(Address) Dr. R. S. Eaton Blackfoot Idaho

15. Filed July 1st 1921 [illegible] Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July 7 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1 1921, to July 7 1921 that I last saw h[illegible] alive on July 7 1921 and that death occurred on the date stated above, at 4:20 P.M.

THE CAUSE OF DEATH* was as follows:
Exhaustion of acute mania

(Duration) Yrs. 1 mos. 21 ds.
Contributory (Secondary) diarrhoea
(Duration) ... yrs. ... mos. 21 ds.

(Signed) C. V. Towne M. D.
July 7 1921 (Address) Blackfoot, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. 1 mos. 7 days. In the State 8 yrs. ... mos. ... days
Where was disease contracted if not at place of death? ...
Former or usual residence Cambridge Idaho

19. PLACE OF BURIAL OR REMOVAL: Hospital Cemetery — DATE OF BURIAL: July 9 1921

20. UNDERTAKER: Robt King Supr — ADDRESS: Blackfoot Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3473
Registered No. 112

1. PLACE OF DEATH

County of Bingham
City of Blackfoot (If not in incorporated limits, give township.) St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 21
Primary Registration District No. 2114
RECEIVED AUG 1 1921 BUREAU OF VITAL STATISTICS

2. FULL NAME Carl J. Anthony

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Feb (Month) 13 (Day) 1920 (Year)

7. AGE: 1 Yrs. 5 Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Albert Anthony

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Esther Jensen

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Albert Anthony
(Address)

15. Filed Aug 13 1921 Mrs Hubert E. Fabre Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 8 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 1920 to July 8 1921
that I last saw him alive on July 8 1921
and that death occurred on the date stated above, at 8:30 P.M.
The CAUSE OF DEATH* was as follows:

Exitus Collitis

(Duration) Yrs. mos. ds.
Contributory (Secondary) Enteritis
(Duration) yrs. mos. ds.

(Signed) H. J. Simmons M. D.
7/9 1921 (Address) Blackfoot Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Fort Idaho | DATE OF BURIAL: July 12 1921

20. UNDERTAKER: Albert Anthony | ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 2194
File No. 34714
Registered No. 103

RECEIVED
AUG 10 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH.
County of Bingham
City of Blackfoot (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Susannah Claunch
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Wid
6. DATE OF BIRTH. June (Month) 10 (Day) 1842 (Year)
7. AGE ..... Yrs. ..... Mos. ..... ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....
9. BIRTHPLACE (State or Country) Idaho
10. NAME OF FATHER Lloyd Church
11. BIRTHPLACE OF FATHER (State or Country) Ky.
12. MAIDEN NAME OF MOTHER Nora Weston
13. BIRTHPLACE OF MOTHER (State or Country) Ky
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Lloyd Claunch
(Address) .....
15. Filed July 11 1921 Mrs Nadine E. Petree Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 10 (Day) 1921 (Year)
17. I HEREBY CERTIFY, That I attended deceased from July 10 1921 to July 10 1921, that I last saw her alive on July 10 1921, and that death occured on the date stated above, at 12 M.
The CAUSE OF DEATH* was as follows:
Mal Partus
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) J. W. Mitchell M. D.
19..... (Address) .....

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Aberdeen Idaho	7/11 1921
20. UNDERTAKER E. Funk	ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STNRS. 24658

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34715
Registered No. 104

1. PLACE OF DEATH
County of Bingham
City of Blackfoot
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 121
Primary Registration District No. 2114
No. Hospital St.)
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

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BUREAU OF VITAL STATISTICS

2. FULL NAME Theodor Jorgensen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Male	White	single (Write the word.)

6. DATE OF BIRTH
(Month) (Day) 1880 (Year)

7. AGE
41 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Unknown

10. NAME OF FATHER unknown

11. BIRTHPLACE OF FATHER (State or Country) unknown

12. MAIDEN NAME OF MOTHER unknown

13. BIRTHPLACE OF MOTHER (State or Country) unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Hosp. Record (Dr Eaton M.D.)
(Address) Blackfoot Idaho

15. Filed July 20 1921 Mrs Julia E. Peterson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
July (Month) 14 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 12 1921, to July 14 1921 that I last saw h[illegible] alive on July 14 1921, and that death occurred on the date stated above, at 7 P. M.
The CAUSE OF DEATH* was as follows:
Exhaustion from chronic dementia and gastritis
(Duration) Yrs. 2 mos. ds.
Contributory (Secondary) Dementia Praecox
(Duration) 20 yrs. mos. ds.
(Signed) C. A. Kaower M. D.
July 15 1921 (Address) Blackfoot Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. 13 mos. 2 days. In the State 20 yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence Pocatello Idaho

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Pocatello Ida	19

20. UNDERTAKER [illegible] ADDRESS Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
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FORM V. S. No. 5-25 M. 1-19.

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CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34717
Registered No. 206

1. PLACE OF DEATH
Registration District No. 121
Primary Registration District No. 2194
County of Bingham
City of Shelley (Ward) St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elmer Landon

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Apr. (Month) 27 (Day) 21 (Year)

7. AGE: Yrs. 2 Mos. 9 6 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Apprentice
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: David Landon

11. BIRTHPLACE OF FATHER (State or Country): Mich

12. MAIDEN NAME OF MOTHER: Elva Sibbett

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) David Landon
(Address) Shelley Idaho

15. Filed July 24 1921 W. Nolan E. Pitts
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 22 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 16 1921, to July 22 1921, that I last saw ~~him~~ alive on July 22 1921, and that death occurred on the date stated above, at 12 M.
The CAUSE OF DEATH* was as follows:

Malnutrition
(Duration) Yrs. mos. 6 ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) J. E. Roads M. D.
July 22 1921 (Address) Shelley Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Shelley Idaho
DATE OF BURIAL ..... 19.....

20. UNDERTAKER
ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34718

Registered No. 797

1. PLACE OF DEATH

County of Bingham

City of Blackfoot (If not in city or village give township) State Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 134

Primary Registration District No. 24

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BUREAU OF VITAL STATISTICS

2. Willie Baer

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
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PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: married (Write the word.)

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1893 (Year)

7. AGE: 28 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Russia

10. NAME OF FATHER: unknown

11. BIRTHPLACE OF FATHER (State or Country): Russia

12. MAIDEN NAME OF MOTHER: unknown

13. BIRTHPLACE OF MOTHER (State or Country): Russia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R. G. Eaton M. D. (Hospital Records)
(Address) Blackfoot Idaho

15. Filed July 30 1921 Mrs Nellie E. Tibbs
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 29 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 27 1921 to July 29 1921 that I last saw h[illegible] alive on July 29 1921 and that death occurred on the date stated above, at 1.30 P.M.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis

..... (Duration) ..... Yrs. 6 mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) R. V. Dorsey M. D.

July 3 1921. (Address) Blackfoot, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. 5 days. 25 In the State ? yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? ?
Former or usual residence Payette, Idaho

19. PLACE OF BURIAL OR REMOVAL: Asylum Cemetery
DATE OF BURIAL: July 30 1921

20. UNDERTAKER: Chas. J. Wright
ADDRESS: Blackfoot, Ida

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

Registration District No. 121

Registration District No. 9174

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34719

Registered No. 135

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AUG 10 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Bingham

City of Blackfoot (No. 1921 State Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Samuel David Fullmer

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	white	married

6. DATE OF BIRTH: Nov (Month) 4 (Day) 1856 (Year)

7. AGE: 65 Yrs. 8 Mos. 26 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: John S. Fullmer

11. BIRTHPLACE OF FATHER (State or Country): unknown

12. MAIDEN NAME OF MOTHER: Mary Ann Price

13. BIRTHPLACE OF MOTHER (State or Country): Tennessee

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Hospital Records R. G. Ears M.D.
(Address) Blackfoot Idaho

15. Filed July 30 1921 Mc Nakes E. Pike Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 29th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 18 1921, to July 29 1921 that I last saw him alive on July 29 1921 and that death occurred on the date stated above, at 7.45 P.M.

The CAUSE OF DEATH* was as follows:
Exhaustion following cerebral apoplexy

(Duration) Yrs. 1 mos. ds.
Contributory (Secondary) Cerebral Apoplexy
(Duration) 1 yrs. mos. ds.

(Signed) E. L. Eggen M. D.
7/30 1921 (Address) Blackfoot Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State 19 yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence Salem Idaho

19. PLACE OF BURIAL OR REMOVAL: Salem Ida. DATE OF BURIAL: July 31 1921

20. UNDERTAKER: Ed L. Eggen ADDRESS: Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

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Form V. S. No. 5 20M.1-16-12 RECEIVED JUL 21 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34720
Registered No. 15

1. PLACE OF DEATH. Registration District No. 57
County of Blaine Primary Registration District No. 2022
City of Bellevue (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William Bowden

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1 (Year)

7. AGE: 71 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Cumbrea. England

10. NAME OF FATHER: —

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Mrs. Maude E. Bowden
(Address): Bellevue Idaho

15. Filed July 10 1921 R. H. Wright Local Registrar

MEDICAL CERTIFICATE OF DEATH.

Dalton.

16. DATE OF DEATH: April (Month) 7 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 14 1921, to Apr 7 1921, that I last saw h in alive on Mar 4 1921 and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Heart disease

..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) None
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) R. H. Dalton M. D.
1921 (Address) Hailey Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Bellevue Ida. DATE OF BURIAL: April 8. 1921

20. UNDERTAKER: G. B. Harris ADDRESS: .....

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & SDRS. 19760

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34721
Registered No. 16

Registration District No. 57
Primary Registration District No. 2022

RECEIVED
JUL 21 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Blaine
City of Hailey (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Geo H. Turner.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widowed (Write the word.)

6. DATE OF BIRTH: April. 13. 1844 (Month) (Day) (Year)

7. AGE: 77 Yrs. 2 Mos. 16 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New York.

10. NAME OF FATHER: Mr Turner.

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) X Albert J Mockes
(Address) Hailey, Idaho.

15. Filed July 10 1921 Ruth H. Wright Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

Dutton.

16. DATE OF DEATH: April. 29. 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 29. 1921, to April 29 1921, that I last saw h.m alive on April 21 1921, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows: Cerebral Hemorrhage

(Duration) ..... Yrs. ..... mos. 1 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H H Dutton M. D.

19 ..... (Address) Hailey Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Hailey — DATE OF BURIAL: May 1st 19 21.

20. UNDERTAKER: J D Harris — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED JUL 21 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 57

Primary Registration District No. 2075

File No. 34722

Registered No. 17

County of Blaine

City of Carey (Ward, St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Baby Suffin.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. June (Month) 4 (Day) 1921 (Year)

7. AGE: ....Yrs....Mos. 2 ds.

IF LESS than 1 day how many ....hrs. or ....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer): ....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Stanley G Suffin

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Ruth McBride

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Stanley G Suffin

(Address) Carey Idaho.

15. Filed July 10 1921 R. H. Wright Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24858

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 6 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 4 1921, to June 6 1921, that I last saw him alive on June 6 1921, and that death occured on the date stated above, at 2:00 A. M.

The CAUSE OF DEATH* was as follows:

Premature birth

....(Duration) ....Yrs. ....mos. ....ds.

Contributory (Secondary) ....

....(Duration ....yrs. ....mos. ....ds.

(Signed) Houston C Snyder M. D.

19.... (Address) Carey Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death....yrs....mos....days. In the State....yrs....mos....days

Where was disease contracted if not at place of death?....

Former or usual residence ....

19. PLACE OF BURIAL OR REMOVAL: Carey, Ida — DATE OF BURIAL: 6-8 1921

20. UNDERTAKER: Fone. — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34723

Registered No. 18

1. PLACE OF DEATH.

County of Blaine — Registration District No. 57

City of Carey — Primary Registration District No. 2075

(If not in limits, give township) ..... St.)

If death occurs away from usual residence, give facts called for under special information.

BUREAU OF VITAL STATISTICS

2. FULL NAME Elizabeth Sampler

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	White	Widowed

6. DATE OF BIRTH.

Apr. (Month) 19 (Day) 1838 (Year)

7. AGE

83 Yrs. 1 Mos. 19 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Housewife

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Penn

10. NAME OF FATHER William Beaver

11. BIRTHPLACE OF FATHER (State or Country) Penn

12. MAIDEN NAME OF MOTHER Louzia George

13. BIRTHPLACE OF MOTHER (State or Country) Penn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) W H Sant

15. Filed July 10 1921 — R. H. Wright, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June (Month) 7 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 7 1921, to June 9 1921, that I last saw her alive on ..... 191..., and that death occured on the date stated above, at 12.01 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(Duration) ..... Yrs. ..... mos. 1 ds.

Contributory (Secondary) Senility

(Duration ..... yrs. 4 mos. ..... ds.

(Signed) Hamilton C. Snyder M. D.

19.... (Address) Carey

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL — Carey Idaho — DATE OF BURIAL June 8 1921

20. UNDERTAKER — R. D. Harris — ADDRESS Hailey

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 57

County of Blaine

Primary Registration District No. 2022

File No. 34724

City of Hailey (St.)

Registered No. 19

If death occurs away from usual residence, give facts called for under special information.

BUREAU OF VITAL STATISTICS

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Thos. Edwin Wilson.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widowed.

6. DATE OF BIRTH: June 18, 1873 (Month) (Day) (Year)

7. AGE: 48 Yrs. 11 Mos. 22 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Accountant.

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Oregon.

10. NAME OF FATHER: B. W. Wilson.

11. BIRTHPLACE OF FATHER (State or Country): Maine.

12. MAIDEN NAME OF MOTHER: P. A. Yantis.

13. BIRTHPLACE OF MOTHER (State or Country): Missouri.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) X B. W. Wilson

(Address) Corvallis Oregon

15. Filed July 10 1921 R. H. Wright Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June. 9. 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June, 3 1921, to June, 9 1921 that I last saw him alive on June, 9 1921 and that death occurred on the date stated above, at 6 P M.

The CAUSE OF DEATH* was as follows:

Spotted Fever (Tick)

(Duration) ..... Yrs. ..... mos. 6 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Robert H. Wright M. D.

6-10 1921 (Address) Hailey Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Corvallis Ore. — DATE OF BURIAL ..... 19.....

20. UNDERTAKER: R. D. Harris — ADDRESS: Hailey

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34725
Registered No. 20

1. PLACE OF DEATH

County of Blaine Registration District No. 57

City of Hailey (If outside limits of city or village, give township.) Primary Registration District No. 2022 St.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED JUL 21 1921 BUREAU OF VITAL STATISTICS

2. FULL NAME Jesse Ralph Nichols.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: married. (Write the word.)

6. DATE OF BIRTH: Oct. 31. (Month) (Day) 1889 (Year)

7. AGE: 31 Yrs. 7 Mos. 9 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer.

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Virginia

10. NAME OF FATHER: J. E. Nichols

11. BIRTHPLACE OF FATHER (State or Country): ✓

12. MAIDEN NAME OF MOTHER: ✓

13. BIRTHPLACE OF MOTHER (State or Country): ✓

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs J.R. Nichols

(Address) Obedian, Ida.

15. Filed July 10 1921 R.H. Wright Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June. 10 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May. 21 1921 to June. 10, 1921 that I last saw h. alive on June. 10, 1921 and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows: Spotted Fever (Tick)

(Duration) ..... Yrs. ..... mos. 20 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Robert H. Wright M. D.

6-11 1921 (Address) Hailey Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Virginia — DATE OF BURIAL ..... 19.....

20. UNDERTAKER: R. D. Harris — ADDRESS: Hailey

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19. RECEIVED JUL 26 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Boise Registration District No. 12
City of Centerville (No. ..... St.) Primary Registration District No. 12
File No. 3472
Registered No. 8

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ah Grin.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: colored.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH ..... (Month) ..... (Day) 1 (Year)

7. AGE 70 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: mining
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) China.

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) .....
(Address) .....

15. Filed ..... 19..... Geo E Robison Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH about July 10th. 19..... (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19....., to ..... 19.....,
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows: found dead

..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
..... 19..... (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Centerville. DATE OF BURIAL ..... 19.....

20. UNDERTAKER ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
JUL 26 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 12
Primary Registration District No. 12

File No. 34727
Registered No. 7.

1. PLACE OF DEATH

County of Boise
City of Placerville (St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Elviah Cruderman.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH: May (Month) 10. (Day) 1834 (Year)

7. AGE: 87 Yrs. 2 Mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: mining
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Norway.

10. NAME OF FATHER: Not known

11. BIRTHPLACE OF FATHER (State or Country): "

12. MAIDEN NAME OF MOTHER: "

13. BIRTHPLACE OF MOTHER (State or Country): "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Nels Rude.
(Address)

15. Filed July 22 1921 — Peter E Robsen, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 14 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....,
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
old age.

..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
..... 19..... (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Placerville — DATE OF BURIAL: July 15 1921

20. UNDERTAKER — ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19. JUL 26 1924

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 12

County of Boise

Primary Registration District No. 12

File No. 34728

City of Horse Shoe Bend (No. ..... St.)

Registered No. 6

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William Kanble.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widdower

6. DATE OF BIRTH: not known. (Month) (Day) 1 (Year)

7. AGE: 65 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: farming

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): South Dakota

10. NAME OF FATHER: "

11. BIRTHPLACE OF FATHER (State or Country): "

12. MAIDEN NAME OF MOTHER: "

13. BIRTHPLACE OF MOTHER (State or Country): "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15. Filed July 30 1924

Mrs. Edith Robson
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 61088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July 3d 1924 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....,
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Killed in Auto accident

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

..... 19..... (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Horse Shoe Bend — DATE OF BURIAL: July 5 1924

20. UNDERTAKER — ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

34729

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
AUG 5 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 85
Primary Registration District No. 2185
File No. 1
Registered No. 42

County of Bonner
City of Priest River (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lorraine Dunn

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: May 28 1916 (Month) (Day) (Year)

7. AGE: 5 Yrs. 1 Mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wash.

10. NAME OF FATHER: F.M.Dunn

11. BIRTHPLACE OF FATHER (State or Country): Ore.

12. MAIDEN NAME OF MOTHER: Ethel Allen

13. BIRTHPLACE OF MOTHER (State or Country): Wash.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Clark McWallace
(Address) Priest River Ida.

15. Filed August 1 1921 — Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 18 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 17 1921, to July 18 1921, that I last saw her alive on July 18 1921, and that death occurred on the date stated above, at 4.50 M.

The CAUSE OF DEATH* was as follows:

Extensive burns of body and limbs.

(Duration) ..... hrs. ..... mos. 1 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [signature] M. D.

July 19 21 (Address) Priest River

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Priest River, Ida. — DATE OF BURIAL: July 20 1921

20. UNDERTAKER: Wallace, Neighbor — ADDRESS: Priest River, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
AUG 18 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Bonner

City of Sandpoint (No. 416 Alder)

Registration District No. 78

Primary Registration District No. 2155

File No. 34730

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Fred Leusch

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Oct. (Month) 8 (Day) 1854 (Year)

7. AGE: 67 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Cigar Manufactor

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ind.

10. NAME OF FATHER: Ludwig Leusch

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Fredericka Leusch

13. BIRTHPLACE OF MOTHER (State or Country): Germany.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Fred Leusch

(Address) Sandpoint Ida.

15. Filed June 8 1921 Floyd Ellsworth Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 2 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1920 to May 31 1921 that I last saw him alive on May 25 1921, and that death occurred on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Cancer

(Duration) 2 Yrs. — mos. — ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) C. T. Anderson M. D.

6/ 1921 (Address) Sandpoint, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Sandpoint, Ida. DATE OF BURIAL: 6/3 1921

20. UNDERTAKER: B. N. Pugh ADDRESS: Sandpoint, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

RECEIVED AUG 18 1921 BUREAU OF VITAL STATISTICS

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34732
Registered No.

1. PLACE OF DEATH
County of Bonner
City of Kootenai
(No. ..... St.)
Registration District No. 78
Primary Registration District No. 21

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Don Keith Miller.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: July (Month) 12 (Day) 1911 (Year)

7. AGE: 10 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: School Boy
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: Don D Miller

11. BIRTHPLACE OF FATHER (State or Country): Michigan

12. MAIDEN NAME OF MOTHER: Amy Verbacke

13. BIRTHPLACE OF MOTHER (State or Country): Kans.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Don D Miller
(Address) Kootenai, Ida.

15. Filed June 8 1921 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 7 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 7 1921, to May 7 1921, that I last saw him alive on May 7 1921, and that death occurred on the date stated above, at 6 A M.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage, due to injury.

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) M. R. Valentine M. D.

5-10 1921 (Address) Sandpoint, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Sandpoint, Ida. DATE OF BURIAL: 5/9 1921

20. UNDERTAKER: B. N. Pugh, ADDRESS: Sandpoint, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 78
Primary Registration District No. 2155
File No. 34733
Registered No.

RECEIVED
AUG 18 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Bonner
City of Sandpoint
(No. City Hospital)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital or other institution or camp, give its NAME instead of street and number.

2. FULL NAME Elizabeth Anderson

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: single (Write the word.)

6. DATE OF BIRTH: April (Month) 11 (Day) 1893 (Year)

7. AGE: 28 Yrs. 1 Mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer): Home

9. BIRTHPLACE (State or Country): Mich

10. NAME OF FATHER: Ludwig Anderson

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Marie Apsahl

13. BIRTHPLACE OF MOTHER (State or Country): Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Anna L. Anderson
(Address) Spokane, Wash.

15. Filed June 8 1921 Floyd Clark Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 16 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb- 1917, to May-16 1921 that I last saw her alive on May-15- 1921, and that death occurred on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis

(Duration) 4 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Floyd Clark M. D.
19 ..... (Address) Sandpoint, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Sandpoint, Ida. DATE OF BURIAL: 5/18 1921

20. UNDERTAKER: B. H. Leigh ADDRESS: Sandpoint, Ida.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 78
Primary Registration District No. 2005
File No. 34734
Registered No.

RECEIVED
AUG 18 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Boise
City of Garden Valley
(No. ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charles Krause

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Unknown (Month) (Day) 1873 (Year)

7. AGE: 48 Yrs. ... Mos. ... ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: R.R. Conductor
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Texas

10. NAME OF FATHER: — Mark.

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: "

13. BIRTHPLACE OF MOTHER (State or Country): "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) James E. Krause
(Address) Spokane, Wash.

15. Filed June 8 1921 Hazel Ellis
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 5 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ... 19... to ... 19...
that I last saw h... alive on ... 19...
and that death occurred on the date stated above, at ... M.

The CAUSE OF DEATH* was as follows:
(a) Injs. R.R. accident at Bulger, Boise Co., Both arms severed, also body cut in two, Injs. died instantly
(Duration) 1 min. Yrs. ... Mos. ... ds.
Contributory (Secondary)
(Duration) ... yrs. ... mos. ... ds.

(Signed) W. M. Kemp M. D.
June 5, 1921 (Address) Hope, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Garden Valley
DATE OF BURIAL: June 9, 1921

20. UNDERTAKER: R. B. Finch
ADDRESS: Garden Valley, Ida.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34735

Registered No. .....

If death occurred in a hospital or institution or camp, give its NAME instead of street and number.

RECEIVED
AUG 18 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH.

County of Bannock

City of .....

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 78

Primary Registration District No. 215-5

(No. On Ranch Spirit Lake (St.)

2. FULL NAME Robert J. Anderson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Oct (Month) 12 (Day) 1864 ~~1827~~ (Year)

7. AGE: 56 Yrs. 7 Mos. 16 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION

(a) Trade, profession or particular kind of work... Laborer

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) California

10. NAME OF FATHER Thomas Anderson

11. BIRTHPLACE OF FATHER (State or Country) N. Y.

12. MAIDEN NAME OF MOTHER Rebecka Fuller

13. BIRTHPLACE OF MOTHER (State or Country) Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm A Anderson

(Address) Clay & Town Idaho

15.

Filed June 8 1921 Floyd E Clark Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May (Month) 28 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 30 1921, to May 28 1921, that I last saw h[illegible] alive on May 10 1921, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Causes

Affecting tongue and jaw.

(Duration) 1 Yrs. 0 mos. 0 ds.

Contributory (Secondary) Probably bad teeth -

(Duration Several yrs. — mos. — ds.

(Signed) Carl A Lamb M. D.

5-28 1921 (Address) Spirit Lake

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Spirit Lake Ida | DATE OF BURIAL: May 29 1921

20. UNDERTAKER: C. W. Glen | ADDRESS: Rathdrum Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 18
Primary Registration District No.
File No. 34736
Registered No.

RECEIVED
AUG 18 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Bonner
City of Sand Point (Limits) (Camp) No.
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME W. L. Ellis

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Widower

6. DATE OF BIRTH: Unknown (Month) (Day) (Year)

7. AGE: about 60 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Logger
(b) General nature of industry, business or establishment in which employed (or employer): Woods

9. BIRTHPLACE (State or Country): Unknown

10. NAME OF FATHER: "

11. BIRTHPLACE OF FATHER (State or Country): "

12. MAIDEN NAME OF MOTHER: "

13. BIRTHPLACE OF MOTHER (State or Country): "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. A. Fuqua
(Address) Sand Point, Ida.

15. Filed Aug 13 1921 Roy C. Clements Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 20 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from did not see him alive 19...
that I last saw h... alive on ...19...,
and that death occurred on the date stated above, at ...M.
The CAUSE OF DEATH* was as follows: Acute Indigestion

(Duration) ...Yrs. ...mos. ...ds.
Contributory (Secondary)
(Duration) ...yrs. ...mos. ...ds.

(Signed) W. M. Ruegg M. D.
June 6, 1921. (Address) Kopfer, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ...yrs. ...mos. ...days. In the State ...yrs. ...mos. ...days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Sand Point Ida. DATE OF BURIAL: July 12 1921.
20. UNDERTAKER: E. A. Fuqua ADDRESS: Sand Point, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 78
Primary Registration District No. 7152
(No.)
File No. 34737
Registered No.

RECEIVED
AUG 18 1921
BUREAU OF VITAL STATISTICS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH

County of Bonner

City or Town of Samuels, Ida.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Archie D. Hulsizer

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: October (Month) 9 (Day) 1897 (Year)

7. AGE: 23 Yrs. 9 Mos. 13 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Truck driver

(b) General nature of industry, business or establishment in which employed (or employer): Hauling gravel on highway

9. BIRTHPLACE (State or Country): Humboldt, Iowa

10. NAME OF FATHER: Amzy Hulsizer

11. BIRTHPLACE OF FATHER (State or Country): Humboldt, Iowa

12. MAIDEN NAME OF MOTHER: Ella Jonsone

13. BIRTHPLACE OF MOTHER (State or Country): Humboldt Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Roy Hulsizer

(Address) Scotia, Wash

15. Filed Aug 13 1921 [signature] Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 22 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....

that I last saw h... alive on ... and that death occurred on the date stated above, at 2:30 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

Contributory (Secondary) Bright's disease

(Duration) ... Yrs. ... mos. ... ds.

(Signed) W. M. Knapp M. D.

7-23 1921 (Address) Hope, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Newport, Wash. (Removal) | DATE OF BURIAL: 7-24 1921

20. UNDERTAKER: Otis M. Dale | ADDRESS: Sandpoint, Ida.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 78 RECEIVED AUG 18 1921 BUREAU OF VITAL STATISTICS
Primary Registration District No. 2 153
File No. 34738
(No. ..... St.) Registered No. .....

1. PLACE OF DEATH
County of Bonner
City of Bonners Ferry
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William V. Van Hordenberg.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: June (Month) 3 (Day) 1906 (Year)

7. AGE: 15 Yrs. 1 Mos. 19 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Central Point, Oregon

10. NAME OF FATHER: Peter V. VanHordenberg

11. BIRTHPLACE OF FATHER (State or Country): St. Louis, Mo.

12. MAIDEN NAME OF MOTHER: Kate Vaughan

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) .....
(Address) .....

15. Filed Aug 13 1921 [redacted] Local Reg.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 22 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 16 1921, to July 22 1921, that I last saw h.... alive on July 21 1921, and that death occurred on the date stated above, at 1:19 M.

The CAUSE OF DEATH* was as follows:
Acute Appendicitis

(Duration) ..... Yrs. ..... mos. 5 ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E. V. Hackamore M. D.
7-23 1921 (Address) Sandpoint.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Sandpoint Ida. DATE OF BURIAL: 7-24 1921

20. UNDERTAKER: Otis M. Dale ADDRESS: Sandpoint Ida.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 18
Primary Registration District No. 6
File No. 24739

RECEIVED
AUG 18 1921
BUREAU OF VITAL STATISTICS

Registered No.

1. PLACE OF DEATH

County of Boundary
City of Sand Point
(No. City Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Anna B. Jones

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Female	White	Married

6. DATE OF BIRTH Nov. (Month) 30 (Day) 1873 (Year)

7. AGE 47 Yrs. ... Mos. ... ds.

IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer): At Home

9. BIRTHPLACE (State or Country): Switzerland

10. NAME OF FATHER: Jacob Rytenbach

11. BIRTHPLACE OF FATHER (State or Country): Switzerland

12. MAIDEN NAME OF MOTHER: Anna Snider

13. BIRTHPLACE OF MOTHER (State or Country): Switzerland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Clifford Jones

(Address) Sand Point, Ida.

15. Filed Aug. 13 1921 Boyd C. Kendall Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 30 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 20 1921 to July 30 1921 that I last saw h.. alive on July 30 1921, and that death occurred on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Endocarditis

(Duration) 5 months ds.

Contributory (Secondary) ... (Duration) ... yrs. ... mos. ... ds.

(Signed) B. F. Angelmire M. D.

Aug. 1921 (Address) Sand Point, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Sand Point Ida.	Aug. 2, 1921.

20. UNDERTAKER	ADDRESS
E. M. Lough	Sand Point, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 78
Primary Registration District No. 24
File No. 34740
Registered No.

RECEIVED
AUG 18 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Bonner
City of Sand Point
(No. House, Hosp. Inst. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Isabel Sharai

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6. DATE OF BIRTH: June (Month) 8 (Day) 1919 (Year)

7. AGE: 2 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ida

10. NAME OF FATHER: Francis Sharai

11. BIRTHPLACE OF FATHER (State or Country): Mich

12. MAIDEN NAME OF MOTHER: Agnus Simmons

13. BIRTHPLACE OF MOTHER (State or Country): Minn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Francis Sharai
(Address) Hope, Ida.

15. Filed Aug 13 1921 Floyd G Wendle Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 10, (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 8 1921 to July 10 1921
that I last saw her alive on July 10 1921
and that death occurred on the date stated above, at 4 P.M.
The CAUSE OF DEATH* was as follows:
Accidental burning

(Duration) Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) Floyd G Wendle M. D.
July 1921 (Address) Sand Point, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Hope, Ida. DATE OF BURIAL: July 11, 1921
20. UNDERTAKER: B W Pugh ADDRESS: Sand Point, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 18
Primary Registration District No. 215
File No. 34741
Registered No.

RECEIVED AUG 18 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Bonner

City of Sandpoint Ida. (No.)

If death occurred away from usual residence, give facts called for under special information.

2. FULL NAME Philip Coulter

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH: Jan (Month) ..... 1 (Day) ..... (Year)

7. AGE: 86 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Unknown

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: "

13. BIRTHPLACE OF MOTHER (State or Country): "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15. Filed Aug 13 19 21 Floyd C. Neville Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 20 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1920 19..., to July 20 1921, that I last saw him alive on July 19 1921, and that death occurred on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Senility

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Arterio Sclerosis

..... (Duration) 1 yrs. ..... mos. ..... ds.

(Signed) Floyd C. Neville M. D.

July 21 1921 (Address) Sandpoint.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lakeview cemetery Sandpoint Ida

DATE OF BURIAL: July 22 1921

20. UNDERTAKER: Arbie M. Dale

ADDRESS: Sandpoint Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 78
Primary Registration District No. 2 9 5 1
File No. 34742

RECEIVED
AUG 18 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Bonner
City of Sand Point
(No. City Hospital) St. Registered No.
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Robert Frankowski

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: May 11 1854
(Month) (Day) (Year)

7. AGE: 67 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher
(b) General nature of industry, business or establishment in which employed (or employer): Retired

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: Jacke Frankowski

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Robt Frankowski
(Address) Hope, Ida.

15. Filed July 8 1921
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 20, 1921.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1921, to June - 20 1921
that I last saw h.... alive on June - 20 1921
and that death occurred on the date stated above, at 9 P. M.
The CAUSE OF DEATH* was as follows:

Lp Grippe

(Duration) Yrs. mos. 9 ds.
Contributory (Secondary) Chronic Endocarditis
(Duration) 7 yrs. mos. ds.

(Signed) Floyd E. Lucas M. D.
1921 (Address) Sand Point, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence Hope Idaho Rural

19. PLACE OF BURIAL OR REMOVAL: Sand Point, Ida
DATE OF BURIAL: June 22 1921

20. UNDERTAKER: [illegible]
ADDRESS: Sand Point, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 78
Primary Registration District No. 215-5
File No. 34744
Registered No.

1. PLACE OF DEATH
County of Bonneville
City of Idaho Falls
(No. 416 Cliff)
If death occurs away from usual residence, give facts called for under special information.

RECEIVED
AUG 18 1921
BUREAU OF VITAL STATISTICS

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME (Infant) Nelson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Never Married)
6. DATE OF BIRTH: May 25, 1921 (Month, Day, Year)
7. AGE: ..... Yrs. ..... Mos. 10 ds.
IF LESS than 1 day: how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....
9. BIRTHPLACE (State or Country): Ida
10. NAME OF FATHER: Frank Nelson
11. BIRTHPLACE OF FATHER (State or Country): Mo
12. MAIDEN NAME OF MOTHER: Edna Vique
13. BIRTHPLACE OF MOTHER (State or Country): Ks
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Frank Nelson
(Address) Idaho Falls, Ida.
15. Filed July 8 1921
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 5, 1921 (Month, Day, Year)
17. I HEREBY CERTIFY, That I attended deceased from May 25 1921 to June 5 1921, that I last saw h... alive on June 1 1921, and that death occurred on the date stated above, at 4:30 A.M.
The CAUSE OF DEATH* was as follows:
Premature birth.
Born at about six months.
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) See affidavit. Dept Law Enforcement.
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) C. J. Payne M. D.
7-1 1921 (Address) Idaho Falls, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Westmont, Ida. DATE OF BURIAL: June 5, 1921.
20. UNDERTAKER: ADDRESS:

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34745

Registration District No. 78
Primary Registration District No. 2457
(No. Glenns Ferry, Ida.)
Registered No.

RECEIVED
AUG 18 1921
BUREAU OF VITAL STATISTICS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH

County of Bonner

City of Sand Point

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Carl Erik Boberg

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH

Unknown (Month) (Day) 1862 (Year)

7. AGE

59 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Rancher

(b) General nature of industry, business or establishment in which employed (or employer) Active

9. BIRTHPLACE (State or Country) Sweden

10. NAME OF FATHER — Boberg

11. BIRTHPLACE OF FATHER (State or Country) Sweden

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (State or Country) "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Olie Ransom

(Address) Glenns Ferry, Ida.

15. Filed July 8 1921

Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June (Month) 13 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1918, to June 1921, that I last saw h. 1m alive on May 1921, and that death occurred on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:

Dilation of heart

(Duration) Yrs. mos. ds.

Contributory (Secondary) Exophthalmic Goiter

(Duration) 3 yrs. mos. ds.

(Signed) Fred E. Clements M.D.

1921 (Address) Sand Point, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Glengary, Ida. | DATE OF BURIAL June 15 1921

20. UNDERTAKER E. E. Keogh | ADDRESS Sand Point

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 79
Primary Registration District No. 215-5
File No. 34746
Registered No.

RECEIVED
AUG 18 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Bonner
City of Sand Point
(No. 1223 Pine)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Annie Bailey
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6. DATE OF BIRTH: Aug. (Month) 11 (Day) 1897 (Year)

7. AGE: 24 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer): At Home

9. BIRTHPLACE (State or Country): Mich.

10. NAME OF FATHER: Richard Chapman

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Ellen Gray

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Bailey
(Address) 1223 Pine St, Sand Point, Ida.

15. Filed July 8 1921 Roy E. Wardle Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 18 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 6 1921, to June 18 1921
that I last saw her alive on June 18 1921,
and that death occurred on the date stated above, at 5.10 P.M.

The CAUSE OF DEATH* was as follows:
Brights disease complicated with Pneumonia and possibly, some Tuberculus infection
about (Duration) 11/12 Yrs. mos. ds.
Contributory (Secondary) Following operation for appendicitas
(Duration) yrs. mos. ds.

(Signed) T. B Pell D. O., M. D.
June, 1921. (Address) Sand Point, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Cold Water, Mich. DATE OF BURIAL: June 25, 1921.
20. UNDERTAKER: J. K. Tough ADDRESS: Sand Point, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
JUL 22 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34647
Registered No. 49

1. PLACE OF DEATH
County of Bonneville
City of Idaho Falls (Ward) St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 73
Primary Registration District No. 21-0

2. FULL NAME Rosa Kilbourne

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: ? (Month) 1 (Day) (Year)

7. AGE: 24 Yrs. ? Mos. ? ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Sheep Herder
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Tenn.

10. NAME OF FATHER: J. D. Kilbourne

11. BIRTHPLACE OF FATHER (State or Country): Tenn

12. MAIDEN NAME OF MOTHER: ?

13. BIRTHPLACE OF MOTHER (State or Country): ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jas Laird
(Address) Idaho Falls

15. Filed 6/23 1921 [signature] Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 21 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 16 1921, to June 21 1921, that I last saw h-- alive on June 21 1921, and that death occurred on the date stated above, at 10 PM.

The CAUSE OF DEATH* was as follows:

Septicemia

(Duration) ..... Yrs. ..... mos. 10 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [signature] M. D.

6/21 1921 (Address) Idaho Falls, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Talbott, Tenn — DATE OF BURIAL: 6/24 1921

20. UNDERTAKER: C C Dunwoody — ADDRESS: Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED JUL 22 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 73

Primary Registration District No. 21 V-0

County of Bonneville

City of Idaho Falls (or Village, Township or Precinct) (St.)

File No. 34718

Registered No. 47

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Caroline Heinz

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: ? (Month) ? (Day) 1869 (Year)

7. AGE: 57 Yrs. ? Mos. ? ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: John Pepperley

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Christina Shultz

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C E Dunnavadey

(Address) Idaho Falls, Rexburg, Ida

15. Filed 6/21 1921 [illegible] Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 21 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 10 1921, to June 21 1921, that I last saw h.er alive on June 21 1921, and that death occurred on the date stated above, at 8:30 M.

The CAUSE OF DEATH* was as follows:

Obstruction of bowel following operation for perforating Ulcer of Duodenum

(Duration) Yrs. mos. 3 ds.

Contributory (Secondary) Chronic Duodenal Ulcer

(Duration) yrs. mos. ds.

(Signed) H R Hatch M. D.

June 21 1921 (Address) Idaho Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rexburg, Ida — DATE OF BURIAL: 6/23 1921

20. UNDERTAKER: C E Dunnavadey — ADDRESS: Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34779
Registered No. 47

RECEIVED
JUL 22 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Bonneville Registration District No. 73
City of Idaho Falls Primary Registration District No. 21N-0
(No. St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Baby O'Brien
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Infant

6. DATE OF BIRTH: May 17 (Month) (Day) 21 (Year)

7. AGE: 0 Yrs. 0 Mos. 0 ds.
IF LESS than 1 day how many 12 hrs. or ____ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho Falls

10. NAME OF FATHER: Fred O'Brien

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Lillian ?

13. BIRTHPLACE OF MOTHER (State or Country): Wis

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Mrs Fred O'Brien
(Address): Idaho Falls

15. Filed June 9 1921 C E Linnaman Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 13 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 12 1921 to May 13 1921, that I last saw him alive on May 13 1921, and that death occurred on the date stated above, at 3a M.
The CAUSE OF DEATH* was as follows:
Premature birth

(Duration) ____ Yrs. ____ mos. ____ ds.
Contributory (Secondary)
(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) Geo. A. Claycomb M. D.
5/13 1921 (Address) Idaho Falls, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Idaho Falls — DATE OF BURIAL: 5/13 1921

20. UNDERTAKER: C E Linnaman — ADDRESS: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY; PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

1 Copy

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JUL 22 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 73

County of Bonneville — Primary Registration District No. 21-0

City of Idaho Falls (St.)

File No. 34750

Registered No. 46

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Arthur E. Smith

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: April 10 1883 (Month) (Day) (Year)

7. AGE: 38 Yrs. 1 Mos. 24 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Transfer business
(b) General nature of industry, business or establishment in which employed (or employer): Driving truck

9. BIRTHPLACE (State or Country): Utah.

10. NAME OF FATHER: W. F. Smith

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Amelia Taunton

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. E. Dunwoody
(Address) Idaho Falls Ida.

15. Filed June 9 1921 — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 3 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....
and that death occurred on the date stated above, at 11 a M.
The CAUSE OF DEATH* was as follows:
"Unavoidable accident - Struck by train at crossing."

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. E. Dunwoody M. D.
6/4 1921 (Address) Idaho Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Idaho Falls Idaho. DATE OF BURIAL: 6/4 1921

20. UNDERTAKER: C. E. Dunwoody. ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 23

Primary Registration District No. 2170

File No. 3451

Registered No. 41

County of Bannock

City of Edahaven (If outside limits, give township.) St.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
JUL 22 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME Stephen Butler

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): M

6. DATE OF BIRTH: January 21 (Month) (Day) 1874 (Year)

7. AGE: 47 Yrs. 5 Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farming
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Alma Butler

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Lucy Butler

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Butler
(Address) City

15. Filed 6/9 1921 W Dunwoody Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aprox. 25 June (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Drowning - accidental
Fell in deep Cistern.

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C E Dunwoody Coroner M.D.
6/7 1921 (Address) Idaho Falls, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Idaho Falls — DATE OF BURIAL: 6/10 1921

20. UNDERTAKER: C E Dunwoody — ADDRESS: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34752
Registered No. 4

RECEIVED
JUL 22 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
Registration District No. 13
Primary Registration District No. 2150
County of Bonneville
City of Idaho Falls (If outside limits of city or village, give township) St. Lukes Hospital (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs. Agnes Lawlor

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Female	White	Married (Write the word.)

6. DATE OF BIRTH: Oct (Month) 17 (Day) 1873 (Year)

7. AGE: 48 Yrs. 7 Mos. 25 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Michigan

10. NAME OF FATHER John Sullivan

11. BIRTHPLACE OF FATHER (State or Country) Ireland

12. MAIDEN NAME OF MOTHER Mary O'Hara

13. BIRTHPLACE OF MOTHER (State or Country) Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. Joseph Reilly
(Address) Butte Mont.

15. Filed June 20 1921 W. [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 14 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 12 1921, to June 14 1921, that I last saw h[er] alive on June 14 1921, and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Cystitis
General Tuberculosis
(Duration) ..... Yrs. ..... mos. 3 ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.
6 1921 (Address) Lakeside Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Butte Mont. | DATE OF BURIAL: June 19 21

20. UNDERTAKER: Cliff Hare | ADDRESS: Idaho Falls Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 79.
Primary Registration District No. 2156.
File No. 34753
Registered No. .....

RECEIVED
AUG 13 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH.

County of Boundary
City of Bonners Ferry (If outside limits, give township) St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME James Anthony Hanrahan

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
male	white	married

6. DATE OF BIRTH. May (Month) 11 (Day) 1850 (Year)

7. AGE 71 Yrs. 1 Mos. 24 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Shoemaker
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Penn.

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (State or Country) Penn.

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (State or Country) Penn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs D. A Hanrahan
(Address) .....

15. Filed July 5th 1921. E E Fry Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 4 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 12 1921, to July 4 1921, that I last saw him alive on July 4th 1921, and that death occured on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(Duration) ..... Yrs. ..... mos. 15 ds.

Contributory (Secondary) Cystitis

(Duration ..... yrs. ..... mos. 7 ds.

(Signed) E E Fry M. D.

19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Bonners Ferry Ida	7/6 1921
20. UNDERTAKER O R Stookey	ADDRESS Bonners Ferry

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRNS - YORK CO., PTRS. & STNRS. 24652

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 79.

County of Boundary Primary Registration District No. 2156.

City of Bonners Ferry (No. ..... St.)

File No. 34756

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

RECEIVED
AUG 13, 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME Mrs. Blashfield

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
F	W	Married

6. DATE OF BIRTH April 10 1851
(Month) (Day) (Year)

7. AGE 70 yrs. 3 mos. 16 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work House Wife
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Germany

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (State or Country) Germany

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (State or Country) Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) M. O. Jordan
(Address) 1513 Front St Kaiser Mont

15.
Filed July 29th 1921 E E Fry
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH July 26 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1919, to July 26 1921, that I last saw h[illegible] alive on July 26 1921, and that death occurred on the date stated above, at 9A. M.

The CAUSE OF DEATH* was as follows:

Chronic interstitial Nephritis

(Duration) 2 yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E E Fry M. D.

7/27 1921 (Address) Bonners Ferry, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Kaiser Mont	..... 191...
20. UNDERTAKER	ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34757
Registered No.

Registration District No. 24
Primary Registration District No. 2156.

1. PLACE OF DEATH
County of Boundary
City of Bonners Ferry (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

AUG 30 1921
BUREAU OF VITAL STATISTICS

2. NAME Eliza Jane Fowler
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Apr (Month) 27 (Day) 1848 (Year)

7. AGE: 73 Yrs. 3 Mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ill.

10. NAME OF FATHER: John Hann

11. BIRTHPLACE OF FATHER (State or Country): Kentucky

12. MAIDEN NAME OF MOTHER: Margaret Stinson

13. BIRTHPLACE OF MOTHER (State or Country): Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) D. J. Fowler
(Address) Troy Mont.

15. Filed July 30th 21
E. E. Fry
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 29 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 1920, to July 29 1921, that I last saw h[illegible] alive on July 29 1921, and that death occurred on the date stated above, at 2 P. M.
The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage -

(Duration) ..... Yrs. 7 mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E. E. Fry M. D.
7/30 1921 (Address) Bonners Ferry, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: [illegible]
DATE OF BURIAL: July 31 1921

20. UNDERTAKER: [illegible] Stookey
ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34758
Registered No.

1. PLACE OF DEATH
County of Boundary
City of Bonners Ferry (If outside limits, give township.) St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 79.
Primary Registration District No. 215-6.

RECEIVED
AUG 13 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME John Henry Taylor
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widower (Write the word.)
6. DATE OF BIRTH: Oct. 13th. 1851 (Month) (Day) (Year)
7. AGE: 69 Yrs. 9 Mos. 17 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Painter
(b) General nature of industry, business or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): England.
10. NAME OF FATHER: Not known
11. BIRTHPLACE OF FATHER (State or Country): England
12. MAIDEN NAME OF MOTHER: Not known
13. BIRTHPLACE OF MOTHER (State or Country): England
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Burton Warner
(Address) Lenia, Idaho.
15. Filed July 31 1921 E E Fry, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July 30 1921 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from ..... 19..., to July 27 1921 that I last saw h.. alive on July 27 1921, and that death occurred on the date stated above, at 5 P. M.
The CAUSE OF DEATH* was as follows:
Cerebral Hemmorhage
(Duration) ..... Yrs. ..... mos. 5 ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) E E Fry M. D.
7/31 1921 (Address) Bonners Ferry, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Sylvan Rest - Lenia Ida — DATE OF BURIAL: July 31 1921
20. UNDERTAKER: E. J. Gunther — ADDRESS: Lenia Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED JUL 16 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34759

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Boundary

City of Bonners Ferry

Registration District No. 71.

Primary Registration District No. 715-6.

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Minerva Lovina Fry

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Jan (Month) 5 (Day) 1849 (Year)

7. AGE: 72 Yrs. 5 Mos. 3 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Ferris Brown Smith

11. BIRTHPLACE OF FATHER (State or Country): N. Y.

12. MAIDEN NAME OF MOTHER: Nancy Jane Gilland

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) A. G. Fry

(Address) Bonners Ferry Ida.

15. Filed June 9th 1921 E E Fry Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 8 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 5 1921, to June 8 1921, that I last saw h[illegible] alive on June 8 1921, and that death occured on the date stated above, at 11 A. M.

The CAUSE OF DEATH* was as follows:

Angina Pectoris.

(Duration) (2) Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) E E Fry M. D.

6/9/1921 (Address) Bonners Ferry, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Bonners Ferry Ida | DATE OF BURIAL: June 7 1921

20. UNDERTAKER: O R Stookey | ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BKBS. 24653

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED JUL 16 1931 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 79

Primary Registration District No. 715-6

File No. 34760

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Boundary

City of Bonners Ferry (No. (Bridge St. Sigmond) St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME F. H. Sigmond

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	W	Divorced

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE About 64 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Prospector

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) unknown

10. NAME OF FATHER unknown

11. BIRTHPLACE OF FATHER (State or Country) unknown

12. MAIDEN NAME OF MOTHER unknown

13. BIRTHPLACE OF MOTHER (State or Country) unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) O R Stookey

(Address) .....

15. Filed June 11 th 1931 E E Fry Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 9 (Day) 1931 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at 5 A M.

The CAUSE OF DEATH* was as follows:

Myocarditis (?)
(Instantaneous death)

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Sepsis (Ludwig's Angina)

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) E E Fry M. D.

6/11 1931 (Address) Bonners Ferry Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Bonners Ferry Ida — DATE OF BURIAL June 11 1931

20. UNDERTAKER O R Stookey — ADDRESS Bonners Ferry Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STNRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED JUL 16 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34761
Registered No. .....

1. PLACE OF DEATH

Registration District No. 79.
Primary Registration District No. 315-6.
County of Boundary
City of Bonners Ferry (If outside limits, give township) ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Sarah Catherine Roseburgh

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
F	W	Widowed

6. DATE OF BIRTH. Apr. (Month) 8 (Day) 1846 (Year)

7. AGE 75 Yrs. 2 Mos. 16 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Missouri

10. NAME OF FATHER Gillett

11. BIRTHPLACE OF FATHER (State or Country) Unknown

12. MAIDEN NAME OF MOTHER unknown

13. BIRTHPLACE OF MOTHER (State or Country) unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs S. Roseburgh
(Address) Bonners Ferry Ida

15. Filed June 25th 1921. [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 24th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 7th 1921, to June 24 1921, that I last saw h alive on June 24 1921, and that death occured on the date stated above, at 4 P. M.
The CAUSE OF DEATH* was as follows:
Cerebral Hemmorhage

(Duration) ..... Yrs. ..... mos. 14 ds.
Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) [signature] M. D.
6/25 1921. (Address) Bonners Ferry Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Bonners Ferry Ida	6/26 1921
20. UNDERTAKER	ADDRESS
[signature]	Bonners Ferry Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STNRS. 24658

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
AUG 10 1921
BUREAU OF VITAL STATISTICS

Registration District No. 5-9
Primary Registration District No.
File No. 34762
Registered No.

1. PLACE OF DEATH
County of Butte
City of Arco (No. St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Gustave Kunz Jr.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6. DATE OF BIRTH: Mar (Month) 21 (Day) 1916 (Year)

7. AGE: 5 Yrs. 4 Mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Rudolph M. Kunz

11. BIRTHPLACE OF FATHER (State or Country): Penn

12. MAIDEN NAME OF MOTHER: Anne Van Patton

13. BIRTHPLACE OF MOTHER (State or Country): Mich

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R M Kunz
(Address) arco Ida

15. Filed 8-9-1921 F.M. Cannon Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 25 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 22 1921, to July 25 1921, that I last saw him alive on July 25 1921, and that death occurred on the date stated above, at 2:0 P.M.

The CAUSE OF DEATH* was as follows:

Fractured Skull

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F.M. Cannon M. D.

..... 19..... (Address) arco, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: arco Ida — DATE OF BURIAL: 7-26-1921

20. UNDERTAKER: Powell — ADDRESS: arco Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34763

RECEIVED
AUG 10 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Butte
City of Moore (If outside limits of city or village, write the word "Out.")
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 59
Primary Registration District No. 2129
File No. 34763
Registered No.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Joseph L Jeppeson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single
6. DATE OF BIRTH: Jan 22 1886 (Month) (Day) (Year)
7. AGE: 35 Yrs. 6 Mos. 26 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Utah
10. NAME OF FATHER: N. J. Jeppeson
11. BIRTHPLACE OF FATHER (State or Country): Utah
12. MAIDEN NAME OF MOTHER: Marie ——
13. BIRTHPLACE OF MOTHER (State or Country): Utah
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C R Jeppeson
(Address) Moore
15. Filed 8/9 — 21 E M Cannon Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 17 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 16 1921, to July 16 1921, that I last saw him alive on July 16 1921, and that death occurred on the date stated above, at 1a. M.

The CAUSE OF DEATH* was as follows:

Cardiac Hypertrophy

(Duration) 4 Yrs. ..... mos. ..... ds.

Contributory (Secondary) Epilepsy

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E M Cannon M. D.

7/19 1921 (Address) Moore Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR ~~REMOVAL~~: Moore Ida — DATE OF BURIAL: July 19 1921

20. UNDERTAKER: C R Jeppeson — ADDRESS: Moore Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Camas

City of Hill City

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 58 d

Primary Registration District No. 2138

(No. ..... St.)

File No. 34764

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ira Edgar Stokes

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): single

6. DATE OF BIRTH: July (Month) 10th (Day) 1921 (Year)

7. AGE: ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many 6 hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Camas Co. Idaho

10. NAME OF FATHER: James Britt Stokes

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Maud Laughlin

13. BIRTHPLACE OF MOTHER (State or Country): Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Miss Stokes (per LW)

(Address) Hill City, Idaho

15. Filed Aug. 7th 1921 L Wilencheck Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 10th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 10th 1921, to July 10th 1921, that I last saw him alive on July 10th 1921, and that death occurred on the date stated above, at 10:30 A.M.

The CAUSE OF DEATH* was as follows:

Congenital Debility

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) L Wilencheck M. D.

Aug 7th 1921 (Address) Fairfield, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL ..... 19.....

20. UNDERTAKER | ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34767

Registered No.

Registration District No.

Primary Registration District No.

(No. 409 5th Ave S.)

RECEIVED
AUG 10 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Canyon

City of Nampa

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME F. A. Weidner

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: April (Month) 27 (Day) 1912 (Year)

7. AGE: 9 Yrs. 3 Mos. 8 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mo.

10. NAME OF FATHER: F. A. Weidner

11. BIRTHPLACE OF FATHER (State or Country): Mo

12. MAIDEN NAME OF MOTHER: Mina Steinman

13. BIRTHPLACE OF MOTHER (State or Country): Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs F A Weidner

(Address) Nampa Ida.

15. Filed Aug 10 1921 Pearl Grabb Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH. Aug (Month) 5 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 30m, 8/5 1912, to 5 Am 8/5 1921 that I last saw h.. alive on 19.., and that death occurred on the date stated above, at 5 0 M.

The CAUSE OF DEATH* was as follows:

Drowning

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Chilton & Belknap M. D.

8/10 1921 (Address) For Nampa Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Kohlelawn Cem — DATE OF BURIAL: 8/10 1921

20. UNDERTAKER: Fred K Robinson — ADDRESS: Nampa Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

EVANS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
AUG 10 1921
BUREAU OF VITAL STATISTICS

Registration District No. 7
Primary Registration District No. 2056
File No. 34769
Registered No.

1. PLACE OF DEATH
County of Canyon
City of
(No. St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William Francis Bowers
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: July (Month) 19 (Day) 1916 (Year)

7. AGE: 5 Yrs. 3 Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: V
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: P. D. Bowers

11. BIRTHPLACE OF FATHER (State or Country): Nebraska

12. MAIDEN NAME OF MOTHER: Mary E Parker

13. BIRTHPLACE OF MOTHER (State or Country): Alabama

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): P D Bowers
(Address): Nampa Ida

15. Filed July 26 1921 Pearle Dudley Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 21 (Day) 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 20 1921 to July 21 1921 that I last saw him alive on July 21 1921 and that death occurred on the date stated above, at 1:30 A.M.

The CAUSE OF DEATH* was as follows:

Meningitis

(Duration) Yrs. 1 mos. 7 ds.

Contributory (Secondary) Acute Infectious Jaundice

(Duration) yrs. mos. 14 ds.

(Signed) Leo N. Chilton M. D.

1921 (Address) Nampa, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Kohlerlawn Cem. DATE OF BURIAL: 7/23 1921

20. UNDERTAKER: F K Robinson ADDRESS: Nampa

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 2006
File No. 34770
Registered No.

RECEIVED
AUG 10 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Canyon
City of Nampa
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Herbert Fiedler

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Jan (Month) 12 (Day) 1850 (Year)

7. AGE: 71 Yrs. 6 Mos. 25 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: Fritz Fiedler

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Marie Marquard

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Catharine Fiedler
(Address) Nampa Ida

15. Filed July 26 1921 Pearle Dodd
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 14 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 9 1921 to July 14 1921
that I last saw him alive on July 14 1921
and that death occurred on the date stated above, at 9.30 P. M.
The CAUSE OF DEATH* was as follows:

Carcinoma of Ascending Colon & Stomach

(Duration) Yrs. 7 mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Leo W. Chilton M. D.
7/14/1921 (Address) Nampa Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: American Falls — DATE OF BURIAL: ..... 19.....

20. UNDERTAKER: F K Robinson — ADDRESS: Nampa

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

C 13

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 2006
File No. 34771
Registered No.

1. PLACE OF DEATH
County of Canyon
City of Melba
(No. St.)
If death occurs away from usual residence, give facts called for under special information.

RECEIVED
AUG 10 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME Baby Simpson.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Single

6. DATE OF BIRTH: July (Month) 21 (Day) 1921 (Year)

7. AGE: 0 Yrs. 0 Mos. 0 ds.
IF LESS than 1 day how many 4 hrs. or 45 min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Melba, Canyon Co., Ida.

10. NAME OF FATHER: Charles E. Simpson

11. BIRTHPLACE OF FATHER (State or Country): Tenn.

12. MAIDEN NAME OF MOTHER: Evora McPhail

13. BIRTHPLACE OF MOTHER (State or Country): Tenn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Charles E. Simpson
(Address) Melba Idaho

15. Filed Aug 8 1921 Pearle Dodds Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 21 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 21, 1921, to July 21, 1921, that I last saw her alive on July 21, 1921, and that death occurred on the date stated above, at 9 P. M.
The CAUSE OF DEATH* was as follows:
Prematurity.
(Duration) Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) Samuel H. Swayne M. D.
19 (Address) Melba, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Melba, Idaho	July 22 1921
20. UNDERTAKER: none	ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34772

Registered No.

1. PLACE OF DEATH

County of Canyon

City of Nampa

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 7

Primary Registration District No. 2006

(No. 6 St. - Nampa)

RECEIVED
AUG 10 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME Robert Bryant

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH: July (Month) 18 (Day) 1921 (Year)

7. AGE: — Yrs. — Mos. 20 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: V

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: R. B. Bryant

11. BIRTHPLACE OF FATHER (State or Country): Mo.

12. MAIDEN NAME OF MOTHER: Nita Hilton

13. BIRTHPLACE OF MOTHER (State or Country): Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) R. B. Bryant

(Address) R 7 Box 44

15. Filed, August 8 1921 Pearle Dodds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 7 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....

that I last saw h..... alive on ..... 19.....

and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Strangled to death

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

19..... (Address) Pearle Dodds

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Kohlerlawn — DATE OF BURIAL: 8-8 1921

20. UNDERTAKER: None — ADDRESS

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Mongum

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34773
Registered No.

1. PLACE OF DEATH

County of Canyon
City of Nampa
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 7
Primary Registration District No. 1006
(No. Kurts Add. St.)

RECEIVED
AUG 10 1921
BUREAU OF VITAL STATISTICS

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Amanda C. Hoffstetter

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Fem	White	Married

6. DATE OF BIRTH: July 17, 1852
(Month) (Day) (Year)

7. AGE: 69 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mo.

10. NAME OF FATHER: Daniel Link

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Nancy Thompson

13. BIRTHPLACE OF MOTHER (State or Country): Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Tom Baker
(Address) Nampa Idaho.

15.
Filed August 10 1921 Pearle Dodds
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July 20, 1921.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 15 1920 to July 20 1921
that I last saw her alive on July 20 1921
and that death occurred on the date stated above, at 6:30 P.M.
The CAUSE OF DEATH* was as follows:
Endocardement + failure of heart
(Duration) 2 Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) J. P. Murray M. D.
7/21/21 (Address) Nampa, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Kohlerlawn Cemetery	7/22 1921
20. UNDERTAKER	ADDRESS
Fred K Robinson	Nampa Ida

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34774

Registered No.

Registration District No. 7

Primary Registration District No. 204

(No. 224 [illegible] St.)

RECEIVED
AUG 10 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Canyon

City of Nampa

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Avrian J. Loveland

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Feb (Month) 11 (Day) 1902 (Year)

7. AGE: 19 Yrs. ... Mos. ... ds.

IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer) ...

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Frank Martin

11. BIRTHPLACE OF FATHER (State or Country): Nebraska

12. MAIDEN NAME OF MOTHER: Lily Glidden

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Margaret Martin

(Address) Nampa Ida

15. Filed August 10 1921 Pearle Dodds Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 9 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 4 1921, to Aug 9 1921 that I last saw h.Er alive on Aug 9 1921 and that death occurred on the date stated above, at 4.50 A.M.

The CAUSE OF DEATH* was as follows:

Dyspraemia

(Duration) ... Yrs. ... mos. 21 ds.

Contributory (Secondary) Mrs Cassidy born unknown Carcinoma (Duration) ... yrs. ... mos. 2 ds.

(Signed) J H Murray M. D.

8/9/1921 (Address) Nampa Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death? ...

Former or usual residence ...

19. PLACE OF BURIAL OR REMOVAL: Rohrlaun — DATE OF BURIAL: 8-11 1921

20. UNDERTAKER: Grant Robinson — ADDRESS: Nampa Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34775
Registered No.

Registration District No.
Primary Registration District No. 5 Ada

1. PLACE OF DEATH
County of Canyon
City of Nampa
(No. St.)
If death occurs away from usual residence, give facts called for under special information.

RECEIVED AUG 6 1921 VITAL STATISTICS

2. FULL NAME Mary Ellen Ward

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Feb 22 1 (Month) (Day) (Year)

7. AGE: 57 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: L. F. Maple

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Hannah Elma

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) X Wm George Ward
(Address) East Palestine Ohio

15. Filed Aug 10 1921 Pearle Dodds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug - 1 - 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 15th 1921, to Aug - 1 - 1921 that I last saw her alive on Aug - 1 - 1921 and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Dyspnoea Tetany
Following removal of cancerous breast
(Duration) Yrs. 1 mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) Thos E. Mangum M. D.
Aug 2 1921 (Address) Nampa Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

PLACE OF BURIAL OR REMOVAL: East Palestine Ohio
DATE OF BURIAL: 19

20. UNDERTAKER: Fred K. Robinson
ADDRESS: Nampa Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

BYNS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34776

Registered No.

RECEIVED
AUG 10 1921
BUREAU OF VITAL STATISTICS

Registration District No. 7

Primary Registration District No. 1006

1. PLACE OF DEATH

County of Canyon

City of Nampa

(No. 1304 2nd Ave St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elsie Morrison

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Aug (Month) (Day) 1896 (Year)

7. AGE: 24 Yrs. 10 Mos. — ds.

IF LESS than 1 day how many.....hrs. or.....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Seth Morrison

11. BIRTHPLACE OF FATHER (State or Country): Nevada

12. MAIDEN NAME OF MOTHER: Katie Lamb

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Seth Morrison

(Address) Nampa Ida

15. Filed July 26 1921 Pearle Dodds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 11 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 1921, to July 13 1921, that I last saw her alive on July 11 1921, and that death occurred on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) Yrs 5 mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Geo. R. Proctor M. D.

7/25/1921 (Address) Nampa, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Fairview Cem — DATE OF BURIAL: 7-13 1921

20. UNDERTAKER: L K Robinson — ADDRESS: Nampa Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

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FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 1086
File No. 24778
Registered No.

RECEIVED
AUG 10 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Canyon
City of Nampa
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Loyd McLaughlin

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1 (Year)

7. AGE: 3 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: ——
(b) General nature of industry, business or establishment in which employed (or employer): ——

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: J. L. McLaughlin

11. BIRTHPLACE OF FATHER (State or Country): Ida Falls

12. MAIDEN NAME OF MOTHER: Sorenson

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. L. McLaughlin
(Address) Nampa Idaho

15. Filed July 26 1921 Pearle Dodds Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 23 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Drowned in Phillis ditch

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) I Pearle Dodds ~~M. D.~~

19..... (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Kohlerlawn Cem — DATE OF BURIAL: 7-26 19 21

20. UNDERTAKER: Fred K Robinson — ADDRESS: Nampa Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 1006
File No. 34779
Registered No.

1. PLACE OF DEATH
County of Canyon
City of Nampa
(No. 1012 [illegible] St.)
If death occurs away from usual residence, give facts called for under special information.

RECEIVED
AUG 10 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME Alvin Myrtle Deck
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Sep. (Month) 20 (Day) 1871 (Year)

7. AGE: 49 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mo.

10. NAME OF FATHER: H. B. Powers

11. BIRTHPLACE OF FATHER (State or Country): Ill.

12. MAIDEN NAME OF MOTHER: Maria Pettit

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Geo. R. Deck
(Address) Nampa Ida

15. Filed July 26 1921 Pearle Dodds Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 23 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from about July 1, 1921, to July 23, 1921, that I last saw h[illegible] alive on July 23, 1921, and that death occurred on the date stated above, at 11:30 A.M.

The CAUSE OF DEATH* was as follows:
Carcinoma of liver and spleen. (Cont[illegible] days)

(Duration) ? Yrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) Geo. R. Rorton M. D.
July 24, 1921 (Address) Nampa, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Meridian Cem — DATE OF BURIAL: 7-24-19 21

20. UNDERTAKER: Fred K Robinson — ADDRESS: Nampa Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

S - P

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34780
Registered No.

1. PLACE OF DEATH
County of Canyon
City of Nampa
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 7
Primary Registration District No. 1006
(No. ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Peter Adams

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: ~~Married~~ (or Widowed) Widowed

6. DATE OF BIRTH: Feb (Month) 24 (Day) 1837 (Year)

7. AGE: 84 Yrs. 4 Mos. 16 ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry, business or establishment in which employed (or employer): (Retired)

9. BIRTHPLACE (State or Country): N.Y.

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): "

12. MAIDEN NAME OF MOTHER: "

13. BIRTHPLACE OF MOTHER (State or Country): "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. E. Allen
(Address) Nampa Ida.

15. Filed July 26 1921 Pearle Dodds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 10 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1 1920 to July 10 1921 that I last saw h... in alive on July 9 1921 and that death occurred on the date stated above, at 6.30 P.M.

The CAUSE OF DEATH* was as follows:

Senility

(Duration) 84 Yrs. 4 mos. 16 ds.

Contributory (Secondary) ... (Duration) ... yrs. ... mos. ... ds.

(Signed) E. L. McLellan M. D.

7/11 1921 (Address) NAMPA, IDAHO.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Nampa Ida. DATE OF BURIAL: 7-11 1921

20. UNDERTAKER: Fred K. Robinson ADDRESS: Nampa Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY; PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34782

Registered No. 78

RECEIVED
AUG 13 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Canyon

City of Caldwell

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 3

Primary Registration District No. 5

(No. .... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary C. Myers.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1858 (Year)

7. AGE: 63 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: Shaffer

11. BIRTHPLACE OF FATHER (State or Country): Don't Know.

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) T. A. Cox

(Address) Caldwell Ida

15. Filed Aug. 8 1921 — Jos. L. Meyer. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 7 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 5 1921, to Aug 7 1921 that I last saw h.er alive on Aug 7 1921, and that death occurred on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

..... (Duration) ..... Yrs. ..... mos. 4 ds.

Contributory (Secondary) Cardio-renal disease

..... (Duration) 6 yrs. ..... mos. ..... ds.

(Signed) G D Montgomery M. D.

Aug 8 1921 (Address) Caldwell, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill — DATE OF BURIAL: 8-8 1921

20. UNDERTAKER: C. A. Peckham — ADDRESS: Caldwell, Ida

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3

Primary Registration District No. 2005

File No. 34783

Registered No. 77

RECEIVED
AUG 13 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Canyon

City of Caldwell

If death occurs away from usual residence, give facts called for under special information.

(No. ..... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Joseph McIntyre

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widowed

6. DATE OF BIRTH: Oct (Month) 23 (Day) 1857 (Year)

7. AGE: 63 Yrs. 9 Mos. 8 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife.
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Texas.

10. NAME OF FATHER: Joseph McIntyre

11. BIRTHPLACE OF FATHER (State or Country): Don't know

12. MAIDEN NAME OF MOTHER: Martha Gilbert

13. BIRTHPLACE OF MOTHER (State or Country): Don't know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Mayson Holden
(Address) Caldwell Idaho.

15.
Filed Aug. 4 1921 John V. Meyer.
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 1 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 15 1921, to Aug 1st 1921, that I last saw h.er alive on July 31 1921, and that death occurred on the date stated above, at 7-30 P.M.

The CAUSE OF DEATH* was as follows:
Acute inflammatory rheumatism

(Duration) ..... Yrs. ..... mos. 10 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) M. H. Talliman M. D.

9/4 1921 (Address) Boise.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Jordan Valley. DATE OF BURIAL: Aug 4 1921

20. UNDERTAKER: V. Peckham ADDRESS: Caldwell

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34784
Registered No. 76

RECEIVED
AUG 13 1921
BUREAU OF VITAL STATISTICS

Registration District No. 3
Primary Registration District No. 2005
(No. ..... , ... St.)

1. **PLACE OF DEATH**

County of Canyon
City of Caldwell
If death occurs away from usual residence, give facts called for under special information.

2. **FULL NAME** Chas Edward Howard

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	white	Married

6. **DATE OF BIRTH** Nov. (Month) 18 (Day) 1841 (Year)

7. **AGE** 79 Yrs. 8 Mos. 13 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. **OCCUPATION**
(a) Trade, profession or particular kind of work: Rancher
(b) General nature of industry, business or establishment in which employed (or employer):

9. **BIRTHPLACE** (State or Country) Michigan

10. **NAME OF FATHER** Orrin F Howard

11. **BIRTHPLACE OF FATHER** (State or Country) Connecticut

12. **MAIDEN NAME OF MOTHER** Cornelia Peck

13. **BIRTHPLACE OF MOTHER** (State or Country) New York

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**
(Informant) Mrs. J. E. Hummel
(Address) Caldwell Ida

15. Filed Aug 3 1921 John L. Meyers
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH** Aug (Month) 1 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1917, to Aug 1 1917
that I last saw living alive on July 25 1921,
and that death occurred on the date stated above, at 6 P.M.
The CAUSE OF DEATH* was as follows:
Tuberculosis of Lungs

..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory
(Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Dr. Dora G. Weymouth M.D.
Aug 3 1921 (Address) Caldwell C. Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Canyon Hill	8—3 1921
20. UNDERTAKER	**ADDRESS**
C. P. Pedersen	Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34785
Registered No. 75

RECEIVED
AUG 13 1921
BUREAU OF VITAL STATISTICS

1. **PLACE OF DEATH**

County of Canyon

City of Caldwell.

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 3

Primary Registration District No. 2005

(No. ..... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. **FULL NAME** Lucinda Huffman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	white	married

6. **DATE OF BIRTH** Dec (Month) 28 (Day) 1849 (Year)

7. **AGE** 71 Yrs. 7 Mos. 3 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. **OCCUPATION**
(a) Trade, profession or particular kind of work: Housewife.
(b) General nature of industry, business or establishment in which employed (or employer):

9. **BIRTHPLACE** (State or Country) Kentucky

10. **NAME OF FATHER** Allen Huffman

11. **BIRTHPLACE OF FATHER** (State or Country) Kentucky

12. **MAIDEN NAME OF MOTHER** Clarinda Hoffman

13. **BIRTHPLACE OF MOTHER** (State or Country) Kentucky

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**
(Informant) W. F. Peters
(Address) Homedale Idaho

15. Filed Aug 2 1921 John V. Meyers. Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH** July (Month) 31 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 27 1921, to July 30 1921, that I last saw h.er alive on July 30 1921, and that death occurred on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... Yrs. ..... mos. 7 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. W. Byrd M. D.

Aug 1921 (Address) Wilder Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Canyon Hill	8-2 1921
20. UNDERTAKER	**ADDRESS**
J. W. Peckham	Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34786
Registered No. 74

1. PLACE OF DEATH

County of Canyon
City of Caldwell
(No. ..... St.)

Registration District No. .....
Primary Registration District No. 7905

RECEIVED
AUG 13 1921
BUREAU OF VITAL STATISTICS

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Rachel [illegible] St. Clair

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F.	W.	Single

6. DATE OF BIRTH: Oct (Month) 7 (Day) 1919 (Year)

7. AGE: 1 Yrs. 1 Mos. 17 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Mo.

10. NAME OF FATHER Loyd M. St. Clair

11. BIRTHPLACE OF FATHER (State or Country) Mo-

12. MAIDEN NAME OF MOTHER Ruth J. Barber

13. BIRTHPLACE OF MOTHER (State or Country) Mo-

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Loyd M. St Clair
(Address) Wyaconda mo.

15. Filed Aug. 2- 1921 John H. Meyer
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 26 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Typhoid fever

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. H. Clark M. D.
8/2 1921 (Address) Caldwell Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Wyaconda mo
DATE OF BURIAL ..... 19.....

20. UNDERTAKER: CASE FURNITURE CO.
ADDRESS: Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

RECEIVED
AUG 13 1921
BUREAU OF VITAL STATISTICS

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 24787

Registered No. 73

1. **PLACE OF DEATH**

County of Canyon

City of Caldwell

Registration District No.

Primary Registration District No.

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. **FULL NAME** Mrs Bessie Margaret Claybaugh

PERSONAL AND STATISTICAL PARTICULARS

3. **SEX** female

4. **COLOR OR RACE** white

5. **SINGLE, MARRIED, WIDOWED OR DIVORCED** (Write the word.) married

6. **DATE OF BIRTH** Sept 6 1887
(Month) (Day) (Year)

7. **AGE** 33 Yrs. 10 Mos. 20 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. **OCCUPATION**
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry, business or establishment in which employed (or employer):

9. **BIRTHPLACE** (State or Country) Illinois

10. **NAME OF FATHER** John S. Johnston

11. **BIRTHPLACE OF FATHER** (State or Country) Ireland

12. **MAIDEN NAME OF MOTHER** Margaret Hodges

13. **BIRTHPLACE OF MOTHER** (State or Country) Kansas

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**
(Informant) C J Claybaugh
(Address) Caldwell Idaho

15. Filed July 29 1921 John B. Meyer. Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH** July 26 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 6 1921 to July 26 1921 that I last saw h.er alive on July 26, 1921 and that death occurred on the date stated above, at 3.4 M.

The CAUSE OF DEATH* was as follows:

Chronic valvular heart disease. (Mitral Stenosis)

(Duration) Date Yrs. from Childhood mos. ds.

Contributory (Secondary) Angina pectoris.

(Duration) Some duration yrs. mos. ds.

(Signed) Carl Warner M.D.

July 27 1921 (Address) Caldwell, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. **PLACE OF BURIAL OR REMOVAL** Pleasant Ridge — **DATE OF BURIAL** 7-29 1921

20. **UNDERTAKER** C. W. Peckham — **ADDRESS** Caldwell Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED JUL 14 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 2005
File No. 34788
Registered No. 71

1. PLACE OF DEATH

County of Canyon
City of Middleton (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Anna Virginia Moberly

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married

6. DATE OF BIRTH: June (Month) 30 (Day) 1854 (Year)

7. AGE: 67 Yrs. — Mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Home wife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Virginia

10. NAME OF FATHER: Michael Fiserton

11. BIRTHPLACE OF FATHER (State or Country): Don't know

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. H. Moberly
(Address) Middleton, Ida.

15. Filed July 10 — 1921 John L. Meyer
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 8 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 1 1920, to July 8th 1921
that I last saw h.er alive on July 8th 1921,
and that death occurred on the date stated above, at 3. P. M.
The CAUSE OF DEATH* was as follows:
Complications of Liver Troubles

(Duration) 1 Yrs. 4 mos. 7 ds.

Contributory (Secondary)
(Duration) — yrs. — mos. — ds.

(Signed) J. W. Farmer M. D.
7-10 1921 (Address) Middleton

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Middleton Cemetery — DATE OF BURIAL: 7-10 1921

20. UNDERTAKER: E. V. Beckham — ADDRESS: Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
PRESSURE REQUIRED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED JUL 14 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Canyon — Registration District No. 3

City of Nampa — Primary Registration District No. 2005

(No. ..... St.)

File No. 3489

Registered No. 70

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Bertha I. Diehl

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (or widowed)

6. DATE OF BIRTH: July (Month) 30 (Day) 1860 (Year)

7. AGE: 60 Yrs. 11 Mos. 6 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife.

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Canada

10. NAME OF FATHER: A. T. Lewis

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Emily Sawyer

13. BIRTHPLACE OF MOTHER (State or Country): New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jake D. Wilson

(Address) Nampa Ida.

15. Filed July 8 — 1921 — John L. Meyers, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 6 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 5 1921, to July 5 1921 that I last saw her alive on July 5 1921 and that death occurred on the date stated above, at 12:45 P.M.

The CAUSE OF DEATH* was as follows:

Cancer of Uterus

(Duration) 4 Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. N. Mitchell M. D.

7-8 1921 (Address) Parma Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill — DATE OF BURIAL: 7-8 1921

20. UNDERTAKER: E. V. Pickham — ADDRESS: Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34790

Registered No. 69

RECEIVED
JUL 14 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Canyon — Registration District No. 3

City of Caldwell — Primary Registration District No. 2005

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Truman Winston Harmon

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M.	W.	Single

6. DATE OF BIRTH: May (Month) 16 (Day) 1919 (Year)

7. AGE: 2 Yrs. 1 Mos. 20 ds. — IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Child at St. Lukes
(b) General nature of industry, business or establishment in which employed (or employer): Boise Idaho

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: John Harmon

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Inez L. Hallford

13. BIRTHPLACE OF MOTHER (State or Country): Wells

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Harmon
(Address) R.1. Caldwell Ida

15. Filed July 8 1921 — John L. Meyer — Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 6 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 4 1921, to July 6 1921
that I last saw h... alive on July 6 1921
and that death occurred on the date stated above, at 5-6 M.
The CAUSE OF DEATH* was as follows:
Shock from injuries received from being hit by a street car.

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J S Springer M. D.
7-8 1921 (Address) Boise Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill — DATE OF BURIAL: 7-8 1921

20. UNDERTAKER: CASE FURNITURE CO. CALDWELL, IDAHO — ADDRESS: Caldwell

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED
JUL 14 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 1005
File No. 34791
Registered No. 68

1. PLACE OF DEATH
County of Canyon
City of Caldwell (St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Baby Dryden
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.):

6. DATE OF BIRTH: July (Month) 2 (Day) 1921 (Year)

7. AGE: ....Yrs....Mos....ds.
IF LESS than 1 day how many 9 hrs. or ....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho. Caldwell

10. NAME OF FATHER: Thos. N. Dryden

11. BIRTHPLACE OF FATHER (State or Country): Idaho.

12. MAIDEN NAME OF MOTHER: Maude Williams

13. BIRTHPLACE OF MOTHER (State or Country): Illinois.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Thos. N. Dryden
(Address): Caldwell Idaho

15. Filed July 3 1921 John K. Meyer, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 3 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1 1921, to July 3 1921, that I last saw h. alive on July 3 1921, and that death occurred on the date stated above, at H. A. M.

The CAUSE OF DEATH* was as follows:
Atelec-tasis

.....(Duration) ....Yrs....mos....ds.
Contributory (Secondary)
.....(Duration) ....yrs....mos....ds.

(Signed) C. L. Stone M. D.
7/3 1921 (Address) Caldwell Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill. DATE OF BURIAL: 7—3 1921

20. UNDERTAKER: E. V. Peckham ADDRESS: Caldwell

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
JUL 14 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 3

Primary Registration District No. 2005

County of Canyon

City of Caldwell (If outside limits, give township.) St.)

File No. 34792

Registered No. 67

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Lundholm

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	W—	Single

6. DATE OF BIRTH 1852
(Month) (Day) (Year)

7. AGE 69 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Worked in mine
(b) General nature of industry, business or establishment in which employed (or employer): also sheep herder

9. BIRTHPLACE (State or Country) Sweden

10. NAME OF FATHER — Lundholm

11. BIRTHPLACE OF FATHER (State or Country) Sweden

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER (State or Country) Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs T. G. Pierson
(Address) Caldwell Ida

15. Filed July 3 - 1921 John L. Meyer
Local Registrar

EVANS-PRAIR CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
July (Month) 2 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 26 1921 to July 2 1921
that I last saw him alive on July 1 1921
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows: Carcinoma (Gastric)

(Duration) 1 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) C. McKaley M. D.

July 8 1921 (Address) Caldwell Ida

*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill — DATE OF BURIAL: 7-3 1921

20. UNDERTAKER: CASE FURNITURE CO. — ADDRESS: Caldwell

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY; PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED
JUL 14 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 3

Primary Registration District No. 2005

File No. 34794

County of Canyon

City of Caldwell (No. ..... St.)

Registered No. 65

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Bert Smart

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6. DATE OF BIRTH: Nov. (Month) 22 (Day) 18 (Year)

7. AGE: 50 Yrs. 7 Mos. 1 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Rancher

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: Frank M. Smart

11. BIRTHPLACE OF FATHER (State or Country): Dark Grave

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Bert Smart

(Address) Notus, Ida

15. Filed June 25 1921 John L. Meyer — Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 23 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 22 1921, to June 23 1921

that I last saw h[illegible] alive on June 23 1921

and that death occurred on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Acute dilatation of Stomach

(Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary) Duodenal ulcer ? cancer

Stenosis (Duration) Not known yrs. ..... mos. ..... ds.

(Signed) J. R. Coen M. D.

6/24 1921 (Address) Caldwell

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill — DATE OF BURIAL: 6-26 1921

20. UNDERTAKER: C. V. Peckham — ADDRESS: Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED
JUL 14 1921
BUREAU OF VITAL STATISTICS
STATE OF IDAHO

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34795
Registered No. 64

1. PLACE OF DEATH

Registration District No. 9
Primary Registration District No. 2005

County of Canyon
City of ~~Nampa~~ Caldwell (or) .....St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Hazel Virginia Gallimore

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Dec. (Month) 9 (Day) 1912 (Year)

7. AGE: 8 Yrs. 6 Mos. 10 ds.
IF LESS than 1 day how many.....hrs. or.....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: S. D. Gallimore

11. BIRTHPLACE OF FATHER (State or Country): Virginia

12. MAIDEN NAME OF MOTHER: Novella Bell Murphy

13. BIRTHPLACE OF MOTHER (State or Country): North Carolina

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) S. D. Gallimore
(Address) Nampa Idaho.

15. Filed June 20 1921 John C. Meyers Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 19 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 19 1921 to June 19 1921 that I last saw h.. alive on June 19, and that death occurred on the date stated above, at 8 P M.

The CAUSE OF DEATH* was as follows:
Fracture base of skull, from automobile accident

(Duration) Yrs. mos. about 1 hour ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) C. M. Kelley M. D.
6-20-1921 (Address) Caldwell Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Kohler Lawn, Nampa — DATE OF BURIAL: 6-20-1921

20. UNDERTAKER: C. W. Peckham — ADDRESS: Caldwell Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

Gomery

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED
JUL 14 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 3

Primary Registration District No. 1005

File No. 34796

Registered No. 63

County of Canyon

City of Caldwell (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lloid George Stevens

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
male	white	single

6. DATE OF BIRTH: Oct (Month) 28 (Day) 1918 (Year)

7. AGE: 2 Yrs. 7 Mos. 20 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Nebraska

10. NAME OF FATHER: J. C. Stevens,

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Blanch Gifford

13. BIRTHPLACE OF MOTHER (State or Country): Nebraska

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. C. Stevens
(Address) Caldwell Ida

15. Filed June 20 - 1921 John L. Meyers. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 18 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 17 1921, to June 18 1921, that I last saw h[illegible] alive on June 18 1921, and that death occurred on the date stated above, at 8½ A.M.

The CAUSE OF DEATH* was as follows:

Uremic poisoning

(Duration) ..... Yrs. ..... mos. 10 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G. D. Montgomery M. D.

19..... (Address) Caldwell, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Canyon Hill	6-20-1921
20. UNDERTAKER	**ADDRESS**
C. V. Peckham	Caldwell Ida

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51067

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED
JUL 14 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 3
Primary Registration District No. 1005
File No. 34797
Registered No. 62

County of Canyon
City of Caldwell (Name) St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs. Susan Lebree Hawkins

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): widow

6. DATE OF BIRTH: July (Month) 20 (Day) 1835 (Year)

7. AGE: 85 Yrs. 10 Mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kentucky

10. NAME OF FATHER: Wm. Whitley

11. BIRTHPLACE OF FATHER (State or Country): Kentucky

12. MAIDEN NAME OF MOTHER: Dorit Adams

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs E B Smith
(Address) Caldwell Idaho

15. Filed June 17 1921 John S. Meyers Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 16 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 3 1921, to June 16 1921 that I last saw her alive on June 3 1921 and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Chr. Nephritis
Myocarditis

(Duration) 1 Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) M Kaley M. D.
6-16 1921 (Address) Caldwell Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill — DATE OF BURIAL: 6-17 1921

20. UNDERTAKER: D. V. Feltham — ADDRESS: Caldwell

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
JUL 14 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 3
Primary Registration District No. 1005
File No. 34798
Registered No. 61

County of Canyon
City of Caldwell (No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Donna Aletha Blayney

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Nov. 25 1904 (Month) (Day) (Year)

7. AGE: 14 Yrs. 6 Mos. 19 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Oregon

10. NAME OF FATHER: J. V. Blayney.

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Nora A. Neer.

13. BIRTHPLACE OF MOTHER (State or Country): Illinois.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): J. V. Blayney
(Address): Caldwell Idaho

15. Filed June 15 1921 John V. Mayes
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 14 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 13 1921, to June 14 1921, that I last saw h.r. alive on June 14 1921, and that death occurred on the date stated above, at 12.45 P.M.

The CAUSE OF DEATH* was as follows:

Ac. Uraemia -

(Duration) Yrs. mos. 1 ds.

Contributory (Secondary): Nephritis

(Duration) yrs. 6+ mos. ds.

(Signed) Geo Dudley M. D.

19..... (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Canyon Hill	6-16 1921
20. UNDERTAKER	ADDRESS
C. A. Beckham	Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-16-13

REGISTERED
AUG 2 192
BUREAU OF STATISTICS

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 82

County of Lemhi

Primary Registration District No. 2159

File No. 34799

City of Sula Springs, Idl (No. ..... St.)

Registered No. 4

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Geo Van

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, ~~MARRIED, WIDOWED OR DIVORCED~~. (Write the word.)

6. DATE OF BIRTH. Not Known (Month) 1 (Day) (Year)

7. AGE: Acct 48 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Sheep-herder

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Not Known

10. NAME OF FATHER Not Known

11. BIRTHPLACE OF FATHER (State or Country) Not Known

12. MAIDEN NAME OF MOTHER Not Known

13. BIRTHPLACE OF MOTHER (State or Country) Not Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ellis Kaerly

(Address) Sula Springs Idho

15.

Filed July 16 1921 Ellis Kaerly Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 16 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1 1921, to June 16 1921, that I last saw h[illegible] alive on June 16 1921, and that death occured on the date stated above, at 1P M.

The CAUSE OF DEATH* was as follows:

Infection of Left Leg due to wound

(Duration) ..... Yrs. ..... mos. 20 ds.

Contributory (Secondary) None

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Ellis Kaerly M. D.

Jul 16 1921 (Address) Sula Springs Idah

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Sula Springs Idah — DATE OF BURIAL: July 17 1921

20. UNDERTAKER: E D Whitmer — ADDRESS: Sula Springs

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24858

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34800
Registered No.

Registration District No. 82
Primary Registration District No. 2159

1. PLACE OF DEATH
County of Caribou
City of Soda Springs Idaho
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charles E. Rudd
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: June (Month) 27 (Day) 1860 (Year)

7. AGE: 60 Yrs. 11 Mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER: Charles Rudd

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Gustava Anderson

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A. A. Rudd
(Address) Sidney Nebr.

15. Filed June 11 1921 ..... Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 11 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 4 1921, to June 11 1921, that I last saw h[illegible] alive on June 10 1921, and that death occurred on the date stated above, at 7 P M.

The CAUSE OF DEATH* was as follows:
Diabetes Mellitus

(Duration) 10 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.
19 ..... (Address) Soda Springs Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Aug Nebraska — DATE OF BURIAL: June 15 1921

20. UNDERTAKER: Schumacher Bros — ADDRESS: Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF [redacted]

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. [illegible]
Primary Registration District No. 2176
File No. 34801
Registered No. 324

1. PLACE OF DEATH

County of Cassia
City of Burley
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Swan Johnson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH: July (Month) 24 (Day) 1872 (Year)

7. AGE: 48 Yrs. 10 Mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Sweeden

10. NAME OF FATHER: Ake Johnson

11. BIRTHPLACE OF FATHER (State or Country): Sweeden

12. MAIDEN NAME OF MOTHER: Magdalena

13. BIRTHPLACE OF MOTHER (State or Country): Sweeden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Jos. Nelson
(Address) R.F.D. 4 Burley Ida.

15. Filed June 7 1921 Dr. J.C. Patterson Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 4 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1 1921, to June 4 1921, that I last saw h[illegible] alive on June 3 1921, and that death occurred on the date stated above, at 5 [illegible] A.M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... Yrs. ..... mos. 5 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. C. Patterson M. D.

6-5-21 (Address) Burley, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Burley Ida. DATE OF BURIAL: June 6 1921.

20. UNDERTAKER: L.B. Gallogly ADDRESS: Burley Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 117
Primary Registration District No. 216
File No. 34802
Registered No. 523

1. **PLACE OF DEATH**

County of Cassia
City of Burley
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. **FULL NAME** Mary Isebel Platte.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F.	W.	Married

6. **DATE OF BIRTH** Feb. 7 (Month) (Day) 1892 (Year)
~~April~~ ~~9~~ 1892

7. **AGE** 29 Yrs. 4 Mos. 7 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. **OCCUPATION**
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business or establishment in which employed (or employer)

9. **BIRTHPLACE** (State or Country) Georgetown Ida.

10. **NAME OF FATHER** John L. Barnes.

11. **BIRTHPLACE OF FATHER** (State or Country) Salt Lake City Utah.

12. **MAIDEN NAME OF MOTHER** Isebel Smith.

13. **BIRTHPLACE OF MOTHER** (State or Country) Georgetown Ida.

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**
(Informant) Lyle Platte
(Address) Burley Ida.

15. Filed January 2 19 23 Pro J. C. Patterson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH** June 15 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 10th 1921, to June 15 1921, that I last saw h.... alive on June 15 1921, and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:
Uremia, following Gestation
for Nephritis

(Duration) ..... Yrs. ..... mos. 4 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. C. Patterson M. D.
6-16 1921 (Address) Burley, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. **PLACE OF BURIAL OR REMOVAL** Burley Ida. **DATE OF BURIAL** June 16 1921

20. **UNDERTAKER** L. B. Talleyy. **ADDRESS** Burley Ida.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Patterson

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 11

Primary Registration District No. 2196

File No. 3480

Registered No. 226

1. PLACE OF DEATH.

County of Cassia

City of Burley

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Elizabeth Jane Stewart

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Nov (Month) 17 (Day) 1862 (Year)

7. AGE: 58 Yrs. 6 Mos. 20 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: — Day

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Don't Know

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Hugh Price
(Address) Burley Ida

15. Filed June 15 1921 W. J. C. Patterson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 6 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 13 1921, to June 6 1921, that I last saw h[illegible] alive on June 6 1921 and that death occured on the date stated above, at 10A M.

The CAUSE OF DEATH* was as follows:
Diabetes Mellitus

(Duration) ..... Yrs. [illegible] mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. C. Patterson M. D.

6-7 1921 (Address) Burley, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Pleasant View Cemetery — DATE OF BURIAL: June 9 1921

20. UNDERTAKER: R. W. Watt — ADDRESS: Burley, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRON C. YORK CO., PTRS. & BDRS. 24658

Paterson, Dennis Chi

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 117
Primary Registration District No. 2196
File No. 34804
Registered No. 227

1. PLACE OF DEATH
County of Cassia
City of Burley
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mahomet Kail

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH: April (Month) 5 (Day) 1855 (Year)

7. AGE: 66 Yrs. 3 Mos. ## ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Carpenter
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: William Kail

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Wright

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A. P. Kail
(Address) Twin Falls Ida. R D 1.

15. Filed July 5 1921 Dr. J. C. Patterson Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 5 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 2 1921, to July 5 1921, that I last saw he alive on July 4 1921, and that death occurred on the date stated above, at 1230 P. M.

The CAUSE OF DEATH* was as follows:

Dropsy

(Duration) ..... Yrs. ..... mos. 3 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. C. Patterson M. D.

7-5 1921 (Address) Burley, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Filmore Ohio. DATE OF BURIAL: July 11 1921.

20. UNDERTAKER: L. B. Talleyg ADDRESS: Burley Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

FORM V. S. No. 5-A—25 M. 1-19.

Cutler.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 11
Primary Registration District No. 2191
File No. 34805
Registered No. 257

1. PLACE OF DEATH
County of Cassia
City of Burley
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Matilda Williams
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: April (Month) 4 (Day) 1872 (Year)

7. AGE: 49 Yrs. 2 Mos. 25 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Clifton Idaho.

10. NAME OF FATHER: Leverett VanLuvern

11. BIRTHPLACE OF FATHER (State or Country): Illinois

12. MAIDEN NAME OF MOTHER: Jennett Wilson

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John E. Williams
(Address) Burley Ida.

15. Filed July 2 1921 Dr. J. C. Patterson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 18-th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 7 1921, to June 18" 1921, that I last saw h.. alive on June 10" 1921, and that death occurred on the date stated above, at 4 P. M.
The CAUSE OF DEATH* was as follows:

Acute dilatation of Heart

(Duration) ..... Yrs. ..... mos. 1 ds.
Contributory (Secondary) Emphysema

(Duration) ..... yrs. ..... mos. 7 ds.

(Signed) F. H. Cutler M. D.
19..... (Address) Burley Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Elba Ida. DATE OF BURIAL: June 13 1921.

20. UNDERTAKER: L. B. Haggly ADDRESS: Burley Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34806
Registered No. 326

Registration District No. 11 7
Primary Registration District No. 2196
(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Cassia
City of Burley
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME No name

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. June 19 1921
(Month) (Day) (Year)

7. AGE: 4 hours
.....Yrs. .....Mos. .....ds.
IF LESS than 1 day how many .... hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE: Idaho
(State or Country)

10. NAME OF FATHER: E. M. Anderson

11. BIRTHPLACE OF FATHER: Utah
(State or Country)

12. MAIDEN NAME OF MOTHER: Laura Thornton

13. BIRTHPLACE OF MOTHER: Utah
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R. L. Storey
(Address) Burley Idaho

15.
Filed July 2, 1921 [illegible] C. Patterson
By Deputy Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 19 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 19 1921 at 3.30 pm to 7:30 P m to June 19 1921
that I last saw her alive on June 19 1921
and that death occurred on the date stated above, at 7:30 P.M.

The CAUSE OF DEATH* was as follows:
Premature birth

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) R. L. Storey M. D.
19.... (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: View Cassia Idaho ~~Ida~~ Ida — DATE OF BURIAL: June 20 1921

20. UNDERTAKER: Jos Hemglund — ADDRESS: Burley Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 117
Primary Registration District No. 2196
File No. 34808
Registered No. 24

1. PLACE OF DEATH

County of Cassia

City of Burley

(No. 1004, N. Oakley Ave. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Grace Free

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: ~~January~~ May. 7. 1921.
(Month) (Day) (Year)

7. AGE: Yrs. 1 Mos. 15 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Burley Ida.

10. NAME OF FATHER: Samuel K. Free.

11. BIRTHPLACE OF FATHER (State or Country): Kimberton Penn.

12. MAIDEN NAME OF MOTHER: Alice E. Thompson

13. BIRTHPLACE OF MOTHER (State or Country): Rockland Ida.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): S. K. Free.
(Address): N. Oakley Ave. Burley Ida.

15.
Filed June 22, 1921 Dr. J. C. Patterson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 22, 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 7 1921 to June 22 1921 that I last saw her alive on June 22 1921, and that death occurred on the date stated above, at 3:10 P.M.

The CAUSE OF DEATH* was as follows:

Meningocele

(Duration) Yrs. mos. 45 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. C. Patterson M. D.

6-23 1924 (Address) Burley, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rockland Idaho — DATE OF BURIAL: June 23 1921.

20. UNDERTAKER: L. B. Talcott — ADDRESS: Burley Ida.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 24869
Registered No. 225

1. PLACE OF DEATH
County of Cassia
City of Burley
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 11
Primary Registration District No. 21
(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME no name

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
m	white	Single

6. DATE OF BIRTH. June (Month) 19 (Day) 1921 (Year)

7. AGE 2 hours ..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many .... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Burley Idaho

10. NAME OF FATHER E. M. Anderson

11. BIRTHPLACE OF FATHER (State or Country) Pleasant Grove Utah

12. MAIDEN NAME OF MOTHER Laura Thornton

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Dr. R. J. Storey M. D.
(Address) Burley, Idaho.

15. Filed July 2, 1921 Dr. J. C. Patterson Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 19 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 19 1921 at 3 p.m. to 5 p.m. June 19 1921
that I last saw him alive on June 19 1921
and that death occurred on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:
Premature birth

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) R. J. Storey M. D.
..... 19.... (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days, In the State....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL View Cassia Co. Idaho — DATE OF BURIAL June 20 1921

20. UNDERTAKER Joe Hoagland acted as undertaker — ADDRESS Burley Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

RECEIVED JUL 23, 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34810
Registered No.

1. PLACE OF DEATH.
Registration District No.
County of Clearwater
State Registration District No.
City of Elk River (No. , St.)
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Helen Salberg

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: February (Month) 17 (Day) 1908 (Year)

7. AGE: 13 yrs. 4 mos. 2 ds.
IF LESS than 1 day how many .....hrs. or .....mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: School girl
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wisconsin

10. NAME OF FATHER: Louis Salberg

11. BIRTHPLACE OF FATHER (State or Country): Norway

12. MAIDEN NAME OF MOTHER: Hannah Voest

13. BIRTHPLACE OF MOTHER (State or Country): Wisconsin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Louis Salberg
(Address): Elk River Idaho

15.
Filed June 21 1921 Mrs F.P. McCormick Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June (Month) 19 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....191..., to ....191...,
that I last saw h....alive on ....191...,
and that death occurred on the date stated above, at ....M.
The CAUSE OF DEATH* was as follows:
accidental: Riding push car on heavy grade lost control thrown off Killed instantly
(Duration) ....yrs. ....mos. ....ds.
Contributory (Secondary)
(Duration) ....yrs. ....mos. ....ds.
(Signed) F.P. McCormick M. D.
19.... (Address) Elk River

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death....yrs....mos....days. In the State....yrs....mos....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Elk River Idaho
DATE OF BURIAL: June 21 1921
20. UNDERTAKER: W. E. Morris & Co
ADDRESS: Elk River Ida.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34811
Registered No. .....

RECEIVED
JUL 23 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH.
County of Clear water Registration District No. .....
City of Elk River Primary Registration District No. .....
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs Olga Danielson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married
6. DATE OF BIRTH: Nov. (Month) 22 (Day) 1871 (Year)
7. AGE: 49 Yrs. 7 Mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry, business, or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): Norway
10. NAME OF FATHER: Mat. Olson
11. BIRTHPLACE OF FATHER (State or Country): Norway
12. MAIDEN NAME OF MOTHER: Mary Peterson
13. BIRTHPLACE OF MOTHER (State or Country): Norway
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Geo. Danielson
(Address) Elk River
15. Filed July 7 1921 Wm F P McConnell Local Registrar

SVMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 7 (Day) 1921 (Year)
17. I HEREBY CERTIFY, That I attended deceased from March 1921, to June 15 1921, that I last saw her alive on June 15 1921, and that death occured on the date stated above, at 2 P. M.
The CAUSE OF DEATH* was as follows:
Pernicious Anaemia
(Duration) 49 Yrs. 7 mos. 15 ds.
Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) F P McConnell M. D.
July 7 1921 (Address) Elk River Idaho

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Sand Point Idaho — DATE OF BURIAL: July 9 1921
20. UNDERTAKER: W. S. Morris & Son — ADDRESS: Elk River Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

RECEIVED
AUG 10 1921
BUREAU OF VITAL STATISTICS

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34812
Registered No. 29

1. PLACE OF DEATH.
County of Clearwater,
City of Orofino, Idaho, (No. ....., ... St.)

Registration District No. .....
Primary Registration District No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME WILLIAM MC KINLEY.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married.

6. DATE OF BIRTH
January (Month) ..... (Day) 1844 (Year)

7. AGE
77 yrs. 6 mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... Farmer,
(b) General nature of industry business or establishment in which employed (or employer) ..... Stock raising, Fruit growing, grain growing, etc.,

9. BIRTHPLACE (State or Country)
Iowa,

10. NAME OF FATHER
?

11. BIRTHPLACE OF FATHER (State or Country)
?

12. MAIDEN NAME OF MOTHER
?

13. BIRTHPLACE OF MOTHER (State or Country)
?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) ..... W. H. Gilbertson
(Address) Orofino Idaho

15. Filed July 3 1921 ..... Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
July second, 1921.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 18 1920 to July 2 1921, that I last saw h alive on July 2 1921 and that death occurred on the date stated above, at 9 A. M.

The CAUSE OF DEATH* was as follows:
Arteriosclerosis

? ? ?
(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) Insanity,
(Duration) Unknown yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
July 21 1921 (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. 7 mos. 14 ds.
In the State about 4 yrs. 7 mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence Clagstone, Idaho,

19. PLACE OF BURIAL OR REMOVAL Sunnyview cemetery
DATE OF BURIAL July 4 1921

20. UNDERTAKER Gilbertson
ADDRESS Orofino

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

RECEIVED
AUG 16 1921
BUREAU OF VITAL STATISTICS

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34813
Registered No. 30

1. PLACE OF DEATH
County of Clearwater
City of Orofino
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No.
(No. ..... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Julia E Bradish

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: married (Write the word.)

6. DATE OF BIRTH: Sept (Month) 23 (Day) 1850 (Year)

7. AGE: 70 Yrs. 9 Mos. 12 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House Wife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Illinois Davis

10. NAME OF FATHER: —

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C E Bradish
(Address) Orofino Idaho

15. Filed July 5 1921 J M Tinsley Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 5 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 14 1921, to July 5 1921, that I last saw h[er] alive on July 5 1921, and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Cancer of Liver
(Duration) 8 mos. Yrs. mos. ds.
Contributory (Secondary) Chronic Gastritis
(Duration) 3 yrs. mos. ds.

(Signed) J M Tinsley M. D.
July 5 1921 (Address) Orofino Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Orofino Idaho — DATE OF BURIAL: July 7 1921
20. UNDERTAKER: Bobb and Son — ADDRESS: Orofino

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 90 RECEIVED AUG 10 1921 File No. 34814
Primary Registration District No. 2768 Registered No. 31

1. PLACE OF DEATH
County of Shoshone
City of Cronin (No. ..... St.) INSTITUTIONAL
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs E J Watson
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Feb (Month) 23 (Day) 1859 (Year)

7. AGE: 62 Yrs. 5 Mos. 17 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Ben Jackson

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Elyhut Freeman

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R J Wilkinson
(Address) Cronin Idaho

15. Filed July 10 1921 F M Towle Local Registrar

SYMS-YORK CO. PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 18 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1920 to July 18 1921
that I last saw h.. alive on July 9 1921
and that death occurred on the date stated above, at 7 A.M.
The CAUSE OF DEATH* was as follows: Chronic Myocarditis
(Duration) 20 Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Earle M Mansell M. D.
July 18 1921 (Address) Cronin Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Gilbert Idaho — DATE OF BURIAL: July 12 1921

20. UNDERTAKER: R J Wilkinson — ADDRESS: Cronin

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

RECEIVED
AUG 10 1921
BUREAU OF VITAL STATISTICS

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 24815
Registered No. 22

1. PLACE OF DEATH
County of Clearwater
City of Orofino
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 9
Primary Registration District No. 17

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lewis A Davis

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
male	white	Single

6. DATE OF BIRTH
..... (Month) ..... (Day) ..... 1 (Year)

7. AGE
about 28 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Minister
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE
(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER
(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Edward Bob
(Address) Orofino

15. Filed July 12 1921 ..... Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 11 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Accidental Drowning

..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Bailey M. D.
July 11 1921 (Address) Orofino Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Wallula Wash	July 17 1921
20. UNDERTAKER	ADDRESS
Orofino Bob and Son	Orofino

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34816
Registered No. 33

RECEIVED
AUG 10 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH.
County of Clearwater
City of Orofino
Registration District No. 6
Primary Registration District
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Joseph T. Arnold

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1847 (Year)

7. AGE: 74 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business or establishment in which employed (or employer): Farming

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown,

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. W. Arnold
(Address) Orofino Idaho

15. Filed July 14, 1921 J. M. Faig Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: July (Month) Thirteenth (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 15, 1921, to July 13 1921, that I last saw h[im] alive on July 13 1921 and that death occurred on the date stated above, at 8:35 P.M.

The CAUSE OF DEATH* was as follows:
Arteriosclerosis

..... (Duration) Unknown yrs. ..... mos. ..... ds.
Contributory (Secondary) Insanity
..... (Duration) Unknown yrs. ..... mos. ..... ds.
(Signed) Catherine Lennen M. D.
7/14 1921 (Address) Orofino Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. 29 ds. In the State 14 yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence: Near Palouse, Wn. in Idaho

19. PLACE OF BURIAL OR REMOVAL: Palouse Wn. DATE OF BURIAL: July 15 1921

20. UNDERTAKER: E. E. Forbes ADDRESS: Orofino Idaho

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 20
Primary Registration District No. 278
(No. ..... St.)

RECEIVED
AUG 10 1921
BUREAU OF VITAL STATISTICS

File No. 34817
Registered No. 34

1. PLACE OF DEATH
County of Clearwater
City of Orofino
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Martha Corcoleus

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: Red
5. ~~SINGLE, MARRIED~~, WIDOWED ~~OR DIVORCED~~ (Write the word.)

6. DATE OF BIRTH ..... (Month) ..... (Day) 1 (Year)

7. AGE: about 66 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: Edward Davis

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: ——

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) .....
(Address) .....

15. Filed July 17 1921 — J. M. Tandy, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 17 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 15 1921, to July 17 1921, that I last saw her alive on July 16 1921, and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:
General prostration from Pneumonia
(Duration) ..... Yrs. 2 mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Earle Morsell M. D.
July 7 1921 (Address) Orofino Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Oakdale Idaho	July 19 1921
20. UNDERTAKER	ADDRESS
Bohrer & Son	Orofino Ida

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 9 — RECEIVED — File No. 34818
Primary Registration District No. 3668 — AUG 10 1921 — Registered No. 35
(No. .....) — BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Kootenai
City of Cutpure
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Bertha Wapshilli

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: Red
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.):

6. DATE OF BIRTH: Oct 4 (Month) (Day) 1919 (Year)

7. AGE: 1 Yrs. 9 Mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work:
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Willie Wapshilli

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Nany Hoyt

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Willie Wapshilli
(Address) Cutdeson Idaho

15. Filed July 18 1921 — J. M. Faine — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 7/17/21 (Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from about June 1921 to July 1921
that I last saw h[illegible] alive on about July 1921
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Pulmonary tuberculosis

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Earle W Hosmer M. D.
7/17 1921 (Address) Cutdeson Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Ashlka Idaho — DATE OF BURIAL: July 1921

20. UNDERTAKER: [illegible] and Son — ADDRESS: Undertaker

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO. PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

RECEIVED
AUG 10 1921
BUREAU OF VITAL STATISTICS

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. ____
Primary Registration District No. ____
File No. 34819
Registered No. 32

1. PLACE OF DEATH
County of Clearwater
City of Orofino
(No. ____, ____ St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Baby Bonner
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX
4. COLOR OR RACE
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH ____ (Month) ____ (Day) 1 (Year)

7. AGE ____ Yrs. ____ Mos. ____ ds.
IF LESS than 1 day how many ____ hrs. or ____ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ____
(b) General nature of industry, business or establishment in which employed (or employer) ____

9. BIRTHPLACE (State or Country) Orofino Idaho

10. NAME OF FATHER Ruben Bonner

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Horsmill
(Address) Orofino Idaho

15. Filed July 20 1921 J M Faulk Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 19 (Day) 21 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ____ 19____, to ____ 19____ that I last saw h____ alive on ____ 19____, and that death occurred on the date stated above, at ____ M.

The CAUSE OF DEATH* was as follows:
Premature — 6 mo

(Duration) ____ Yrs. ____ mos. ____ ds.

Contributory (Secondary) ____
(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) Earle W Horsmill M. D.
19____ (Address) Orofino Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days
Where was disease contracted if not at place of death? ____
Former or usual residence ____

19. PLACE OF BURIAL OR REMOVAL Weippe Idaho | DATE OF BURIAL July 1921

20. UNDERTAKER E L Bell | ADDRESS Orofino

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO. PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 9 RECEIVED
Primary Registration District No. AUG 18 1921
BUREAU OF VITAL STATISTICS

File No. 34820
Registered No. 37

1. PLACE OF DEATH
County of Clearwater
City of Orofino
(No. .....)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary L Eby

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Wid

6. DATE OF BIRTH: May (Month) 1 (Day) 1850 (Year)

7. AGE: 71 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House Wife
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ind.

10. NAME OF FATHER: Shreve

11. BIRTHPLACE OF FATHER (State or Country): .....

12. MAIDEN NAME OF MOTHER: .....

13. BIRTHPLACE OF MOTHER (State or Country): .....

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ray Eby
(Address) Orofino Idaho

15. Filed July 20 1921 J M Vandy Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 20 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19 —,
and that death occurred on the date stated above, at 1 1/2 A.M.
The CAUSE OF DEATH* was as follows:
Cancer Peritonaeum
.....
.....
(Duration) 3 Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Eric N Hoseveld M. D.
July 20 1921 (Address) Orofino Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Frazer — DATE OF BURIAL: July 22 1921

20. UNDERTAKER: Ray Eby — ADDRESS: Orofino

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34821
Registered No. 38

1. PLACE OF DEATH.
County of Clearwater
City of Orofino
If death occurs away from usual residence, give facts called for under special information.

Registration District No. [illegible]
Primary Registration District No. 2468
(No. ..... , ...)

RECEIVED
AUG 15 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME Charles T. Haggerty

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: March (Month) 12 (Day) 1877 (Year)

7. AGE: 44 yrs. 4 mos. 16 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry business or establishment in which employed (or employer): Mining

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. U. Atteberry
(Address) Orofino, Idaho.

15. Filed July 28 1921 J. M. Tandy, Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: July (Month) 27th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 9th 1921, to July 27th 1921
that I last saw him alive on July 27th 1921
and that death occurred on the date stated above, at 4:45 P.M.

The CAUSE OF DEATH* was as follows:
Cerebral Hemmorrhage,

(Duration) ..... yrs. ..... mos. 3 ds.
Contributory (Secondary) Insanity
(Duration) Unknown yrs. ..... mos. ..... ds.

(Signed) John Stevens M. D.
July 27 1921 (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ✓ yrs. 3 mos. 19 ds. In the State about 4 yrs. 4 mos. ✓ ds.
Where was disease contracted, if not at place of death? Unknown,
Former or usual residence Burke, Idaho.

19. PLACE OF BURIAL OR REMOVAL: Sunnyside Cemetery — DATE OF BURIAL: Aug 1 1921

20. UNDERTAKER: J W Atteberry — ADDRESS: Orofino

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34822
Registered No. 12

RECEIVED
AUG 6 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Elmore
City of Mtn Home (If outside limits, give township.) St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 34
Primary Registration District No. 2022

2. FULL NAME Infant Son Garner
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH
7 (Month) 7 (Day) 1921 (Year)

7. AGE
..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many 2 hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE
(State or Country)

10. NAME OF FATHER Walter V Garner

11. BIRTHPLACE OF FATHER
(State or Country) Ida

12. MAIDEN NAME OF MOTHER Minnie Maudlin

13. BIRTHPLACE OF MOTHER
(State or Country) Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Minnie Garner
(Address) Mtn Home Ida

15.
Filed 8-1-1921 F E Evans
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
7 (Month) – 7 (Day) – 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 7-7-1921, to 7-7-1921 that I last saw h— alive on 7-7-1921, and that death occurred on the date stated above, at 6 A.M.

The CAUSE OF DEATH* was as follows:

Premature Birth
Seven Months

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory .....
(Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F E Evans M. D.
8-1-1921 (Address) Mtn Home Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Mtn Home Ida	7-7-1921

20. UNDERTAKER	ADDRESS
W Conover	Mtn Home

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 34
Primary Registration District No. 2020
File No. 34823
Registered No. 14

RECEIVED
AUG 6 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Elmore
City of Mtn Home (If outside limits of city or village, write the name of township.) St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary Lowry

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Widowed

6. DATE OF BIRTH ..... (Month) ..... (Day) 1847 (Year)

7. AGE 74 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country) Ontario

10. NAME OF FATHER John Moran

11. BIRTHPLACE OF FATHER (State or Country) Ireland

12. MAIDEN NAME OF MOTHER Mary Tierney

13. BIRTHPLACE OF MOTHER (State or Country) Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John R Lowry

(Address) Mtn Home Ida

15. Filed 7-25-1921 J E Evans Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 7 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 6 1921, to July 7 1921, that I last saw h.er alive on July 6 1921, and that death occurred on the date stated above, at 2:30 A M.

The CAUSE OF DEATH* was as follows: Chronic Interstitial Nephritis

..... (Duration) 1 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J E Evans M. D.

7-25 1921 (Address) Mtn Home Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Mtn Home Ida	7-8-1921
20. UNDERTAKER	**ADDRESS**
A W Conover	Mtn Home Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 34

Primary Registration District No. 2025

File No. 34825

County of Elmore

City of Mtn Home Ada (No. ..... St.)

Registered No. 9

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James F. Carns

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

RECEIVED
JUL 15 1921
BUREAU OF VITAL STATISTICS

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: single (Write the word.)

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1853 (Year)

7. AGE: 68 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Miner

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Plattville. Wis.

10. NAME OF FATHER: Abe Carns

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Ann Armstrong

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Cathryn A Stevens

(Address) Mt Home Ida

15.

Filed 7-1-1921

J E Stevens
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 8th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....

that I last saw h..... alive on ..... 19.....

and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Heart failure - acute dilation

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) sudden death

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. F. Eaton, Coroner M. D.

6/10 1921 (Address) Mtn Home, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL/OR REMOVAL: Mountain Home Ida

DATE OF BURIAL: 6-10 1921

20. UNDERTAKER: A. W. Conover

ADDRESS: Mtn Home

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED JUL 15 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Elmore — Registration District No. 34
City of Mtn Home — Primary Registration District No. 2020 — St.)
File No. 34826
Registered No. 10

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jessie M. Campbell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widower

6. DATE OF BIRTH: Oct. (Month) (Day) 1864 (Year)

7. AGE: 57 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ogden Utah

10. NAME OF FATHER: Joseph Campbell

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER: Clarissy

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. Robinson
(Address) Mtn Home Ida

15. Filed 7-1-1921 — J. E. Eaton Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 16 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....
and that death occurred on the date stated above, at 9:00 A.M.
The CAUSE OF DEATH* was as follows:
Heart failure — acute dilatation

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. E. Eaton Coroner
5/18 1921 (Address) Mtn Home Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mtn Home Cem — DATE OF BURIAL: May 18 1921

20. UNDERTAKER: Elk Conover — ADDRESS: Mtn Home

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34827
Registered No. 11

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH

Registration District No. 14

Primary Registration District No. 2020

County of Elmore

City of Mtn Home (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED JUL 15 1921 BUREAU OF VITAL STATISTICS

2. FULL NAME Margaret A. Jackson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F	White	Widow

6. DATE OF BIRTH: Dec (Month) 23 (Day) 1848 (Year)

7. AGE: 72 Yrs. 6 Mos. ..... ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): South Carolina

10. NAME OF FATHER: Mr. Halbert

11. BIRTHPLACE OF FATHER (State or Country): Don't Know

12. MAIDEN NAME OF MOTHER: Sicily Halbert

13. BIRTHPLACE OF MOTHER (State or Country): Lawrence Co. Alabama

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Frank Lee Jackson
(Address) Mountain Home, Ida

15.
Filed 7-1-1921
J. E. Conover
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 23 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 14 1921, to June 23 1921, that I last saw her alive on June 23 1921, and that death occurred on the date stated above, at 2-15 P. M.

The CAUSE OF DEATH* was as follows:
Myocarditis.

(Duration) 8 Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Dr. O. C. Hamilton M. D.

6-25-1921 (Address) Mt. Home Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Mtn Home	6-25-1921

20. UNDERTAKER	ADDRESS
A. W. Conover	Mtn Home

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
JUL 15 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 34

Primary Registration District No. 2020

File No. 34828

Registered No. 13

County of Elmore

City of Mtn Home (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Daphne Irene Bach

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Oct (Month) 24 (Day) 1905 (Year)

7. AGE: 15 Yrs. 8 Mos. 0 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Minn.

10. NAME OF FATHER: Chas. A Bach

11. BIRTHPLACE OF FATHER (State or Country): Minn

12. MAIDEN NAME OF MOTHER: Cora E Cranston

13. BIRTHPLACE OF MOTHER (State or Country): Wis

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) F M Bach

(Address) Mtn Home

15. Filed 6-24-1921

J E Evans
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 24 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 6-1-1921, to 6-24-1921, that I last saw her alive on 6-24-1921, and that death occurred on the date stated above, at 2:10 P M.

The CAUSE OF DEATH* was as follows:

Acute Articular Rheumatism
with Mitral Regurgitation

(Duration) 3 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J E Evans M. D.

6-24-1921 (Address) Mtn Home Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mtn Home Ida — DATE OF BURIAL: 6- -1921

20. UNDERTAKER: A V Conover — ADDRESS: Mtn Home

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 24829

Registered No.

Registration District No.

Primary Registration District No.

(No. ..... St.)

RECEIVED
AUG 10 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Franklin

City of Franklin

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Unnamed Shipley

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: July (Month) 11 (Day) 1921 (Year)

7. AGE: 0 Yrs. 0 Mos. 0 ds.

IF LESS than 1 day how many 0 hrs. or 15 min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: William Cecil Shipley

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Ellen Toms

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. C. Shipley

(Address) Franklin, Idaho

15.

Filed ..... 19.....

D. C. Rulon
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 11 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 11 1921, to July 11 1921, that I last saw h.m. alive on July 11 1921, and that death occurred on the date stated above, at 6:45 A.M.

The CAUSE OF DEATH* was as follows:

Apnea
5½ month Gestation —
result of premature partial separation of placenta (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Curtis Blank M. D.

7/11 1921 (Address) Preston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Franklin

DATE OF BURIAL: July 12 1921

20. UNDERTAKER

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34830
Registered No.

RECEIVED
AUG 10 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Franklin

City of Preston 5th Ward

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No. , St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Cyril B. Lund

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M.	W.	

6. DATE OF BIRTH: July (Month) 12 (Day) 1921 (Year)

7. AGE: Yrs. Mos. 6 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business or establishment in which employed (or employer) —

9. BIRTHPLACE (State or Country) Preston 5th Ward

10. NAME OF FATHER Charles Lund

11. BIRTHPLACE OF FATHER (State or Country) Richmond Ut.

12. MAIDEN NAME OF MOTHER Margaret Baker

13. BIRTHPLACE OF MOTHER (State or Country) Franklin Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Charles Lund
(Address) Preston

15. Filed 19 Dr A R Cullen Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 12 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 12 1921, to July 15 1921, that I last saw him alive on July 15 1921, and that death occurred on the date stated above, at 6 A. M.

The CAUSE OF DEATH* was as follows:

Not Known.
Was not right at birth. Simple Congenital Hydrocephalus. Possible Cerebral Hemorrhage

(Duration) Yrs. mos. 5 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Allen R Cullen M. D.

July 13 1921 (Address) Preston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Preston	July 18 1921
20. UNDERTAKER	ADDRESS
W. A. Skidmore	Preston Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34831
Registered No. 48

1. PLACE OF DEATH
County of Franklin
City of Preston
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

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BUREAU OF VITAL STATISTICS

Registration District No. 2119
Primary Registration District No. 37

2. FULL NAME James Herbert Barnes
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: August (Month) 16 (Day) 1884 (Year)

7. AGE: 36 Yrs. 11 Mos. 6 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business or establishment in which employed (or employer): Cement worker

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: Joseph Barnes

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Rebecca Ainscoughs

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Jas. H. Barnes
(Address) Preston Idaho

15. Filed Aug 6 1921
Dr A R Curtis
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 22 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 15 1920, to July 22 1921
that I last saw h.i.(?) alive on July 22 1921
and that death occurred on the date stated above, at 12:02 A.M.
The CAUSE OF DEATH* was as follows:
Aortic and Mitral Insufficiency
..... (Duration) ..... Yrs. 1 mos. ..... ds.
Contributory (Secondary) Rheumatism
..... (Duration) ..... yrs. 2 mos. ..... ds.
(Signed) Curtis Bland M. D.
July 23 1921 (Address) Preston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. 1 days. In the State 11 yrs. ..... mos. ..... days
Died at Mrs. Smiths Hospital
Where was disease contracted if not at place of death? In Army
Former or usual residence England

19. PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL
Preston Ida July 24 1921

20. UNDERTAKER: L. L. Lundquist ADDRESS: Logan, Utah

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Franklin

City of Fairview

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2119

Primary Registration District No. 27

(No. ..... , ... St.)

RECEIVED
AUG 10 1921
BUREAU OF VITAL STATISTICS

File No. 34822

Registered No. 44

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Thad Elbert Rawlins

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: July (Month) 5 (Day) 1921 (Year)

7. AGE: 0 Yrs. 0 Mos. 3 ds.

IF LESS than 1 day how many ..... hrs. or ✓ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Merlin Rawlins

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Emma Gilbert

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Merlin Rawlins

(Address) Preston, Idaho

15. Filed Aug 6 1921

Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 8 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 5 1921, to July 8 1921, that I last saw h.im alive on July 8 1921, and that death occurred on the date stated above, at 7 x o P.M.

The CAUSE OF DEATH* was as follows:

Unknown - began to have spells of turning blue - a few min. Convulsions - temp. (maximum) 107 -

(Duration) 0 Yrs. 0 mos. 18 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Louis Blanchard M. D.

July 9 1921 (Address) Preston, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Fairview

DATE OF BURIAL: July 10 1921

20. UNDERTAKER: None

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2119
Primary Registration District No. 27
File No. 24823
Registered No. 47

RECEIVED
AUG 10 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Franklin
City of Clifton
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Bernice Marler

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Apr. (Month) 14 (Day) 1920 (Year)

7. AGE: 1 Yrs. 3 Mos. 17 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: ✓
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Clifton Idaho

10. NAME OF FATHER: Franklin Marler.

11. BIRTHPLACE OF FATHER (State or Country): Clifton Idaho

12. MAIDEN NAME OF MOTHER: Janie N. Taylor

13. BIRTHPLACE OF MOTHER (State or Country): Clifton Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Verna Taylor.
(Address) Clifton Idaho

15. Filed Aug 6 1921.
Local Registrar

SYMS-YORK CO. PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 20 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Birth 19..., to July 20 1921, that I last saw her alive on July 10 1921, and that death occurred on the date stated above, at 7-20 P.M.
The CAUSE OF DEATH* was as follows:
Broncho Pneumonia

(Duration) ..... Yrs. ..... mos. 15 ds.
Contributory (Secondary) Congenital Chondrodystrophia
(Duration) 1 yrs. 3 mos. 17 ds.

(Signed) A. P. Cutler M. D.
7-31 1921 (Address) Preston Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Clifton Ida
DATE OF BURIAL: July 31 1921.
20. UNDERTAKER: C
ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 21824

Registered No. 345

RECEIVED
AUG 10 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Franklin

City of Oxford

(No. ..... St.)

Registration District No. 2119

Primary Registration District No. 27

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Clarissa Fleming

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: widow (Write the word.)

6. DATE OF BIRTH: July (Month) 31 (Day) 1843 (Year)

7. AGE: 77 Yrs. 11 Mos. 16 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer): Germany

9. BIRTHPLACE (State or Country)

10. NAME OF FATHER: Longhurst

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: unknown

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Thos Fleming

(Address) St. Paul, Minn.

15. Filed Aug 6 1921

Dr A R Curtis
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 16 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 8 1921, to July 16 1921, that I last saw h[illegible] alive on July 8 1921, and that death occurred on the date stated above, at 7:20 P.M.

The CAUSE OF DEATH* was as follows:

Senility — Arterio-sclerosis

(Duration) For Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Curtis Bland M. D.

7/16/1921 (Address) Preston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Oxford Idaho — DATE OF BURIAL: July 18 1921

20. UNDERTAKER: [illegible] Shumore — ADDRESS: Preston Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO. PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED AUG 3 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH: Registration District No. 102

County of Fremont Registration District No. 6

File No. 34835

City of Ashton (No. ..... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Catherine Butler

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Widowed

6. DATE OF BIRTH: Nov. (Month) 8 (Day) 1833 (Year)

7. AGE: 87 Yrs. 8 Mos. 13 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work — — — —

(b) General nature of industry, business or establishment in which employed (or employer) — — —

9. BIRTHPLACE (State or Country) Dee

10. NAME OF FATHER John Miller

11. BIRTHPLACE OF FATHER (State or Country) Kentucky

12. MAIDEN NAME OF MOTHER Elizabeth Anderson

13. BIRTHPLACE OF MOTHER (State or Country) Dee

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) Drummond Idaho

15. Filed 7-14- 1921 .....
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 7- (Month) 13 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 7-9 1921, to — — 19—, that I last saw h.. alive on 7-9- 1921, and that death occurred on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:

Mitral insufficiency

— (Duration) — Yrs. — mos. — ds.

Contributory (Secondary) LPK

— (Duration) — yrs. — mos. — ds.

(Signed) C. M. Madsen M. D.

7-14 1921 (Address) Ashton, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Marysville Idaho	7-15 1921

20. UNDERTAKER	ADDRESS
Lewis Risen	Ashton Idaho

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 24837

Registered No.

RECEIVED
AUG 3 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 102

Primary Registration District No. 6

County of Fremont

City of Ashton (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Harold Clifton Bratt

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Aug (Month) 4 (Day) 1903 (Year)

7. AGE: 17 Yrs. 11 Mos. 12 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farm Laborer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: Henry A Bratt

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Jane Posey

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Henry A Bratt

(Address) Ashton Idaho

15. Filed 7-17-1921 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 16 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from [illegible] 19..., to [illegible] 19..., that I last saw h..... alive on ..... 19..., and that death occurred on the date stated above, at [illegible] M.

The CAUSE OF DEATH* was as follows:

Accident

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E. S. Hazard M. D.

July 18 1921 (Address) Ashton Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Dixie View Cemetery

DATE OF BURIAL: 7-18-1921

20. UNDERTAKER: Lewis Reed

ADDRESS: Ashton Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED AUG 3 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

34838

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. [illegible]

Registered No.

1. PLACE OF DEATH

County of Fremont Registration District No. 102

City of ~~Out~~ Marysville (No. St.) Registration District No. 6

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Harriet Ann Swainston

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Widowed

6. DATE OF BIRTH: Sept (Month) 1 (Day) 1863 (Year)

7. AGE: 58 Yrs. 10 Mos. 10 ds.

IF LESS than 1 day how many..... hrs. or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: William Hughes

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Mary Garlick

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Hyrick

(Address) Marysville

15. Filed 7-11 1921 C. A. Meacham Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 7 (Month) 10 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Did not see to Because 19..., that I last saw him alive on Time of Death 19..., and that death occurred on the date stated above, at ...M.

The CAUSE OF DEATH* was as follows:

Heart Trouble

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary) Heart Trouble

(Duration) ... yrs. ... mos. ... ds.

(Signed) C. A. Meacham M. D.

7-11 1921 (Address) Ashton, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Marysville — DATE OF BURIAL: 7-11 1921

20. UNDERTAKER: Lewis Rieser — ADDRESS: Ashton Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED AUG 3 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34826

Registered No.

1. PLACE OF DEATH

County of Fremont — Registration District No. 112

City of Marysville — Primary Registration District No. 1

(No. ..... , ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Bessie Jane Wetherbee

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	

6. DATE OF BIRTH: June (Month) 22 (Day) 1920 (Year)

7. AGE: 1 Yrs. — Mos. 16 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work — —

(b) General nature of industry, business or establishment in which employed (or employer) — —

9. BIRTHPLACE (State or Country) Marysville Idaho

10. NAME OF FATHER Lester Wetherbee

11. BIRTHPLACE OF FATHER (State or Country) Parker Idaho

12. MAIDEN NAME OF MOTHER Fern Simons

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Lester Wetherbee

(Address) Linton Idaho

15.

Filed ..... 19 .....

Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 8 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 4 1921 to July 8 1921

that I last saw her alive on July 8 1921

and that death occurred on the date stated above, at 1:10 M.

The CAUSE OF DEATH* was as follows:

Internal injuries due to automobile accident

(Duration) 4 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) E. V. Sargent M. D.

7/8 1921 (Address) Ashton Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Marysville Idaho — DATE OF BURIAL: 7-9 1921

20. UNDERTAKER: Lewis Kiser — ADDRESS: Ashton Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

RECEIVED AUG 3 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

34840

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 102
Primary Registration District No. 6
File No. 2
Registered No.

1. PLACE OF DEATH
County of Fremont
City of Drummond (No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Zella Ann Stanger
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Dec. 4 1883 (Month) (Day) (Year)

7. AGE: 38 Yrs. 7 Mos. 21 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: J. E. Keeler

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Sarah A. Thorick

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. J. F. Hathaway
(Address) Victoria Idaho

15. Filed 7-27 1921 A. M. Mackay Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 7- 25- 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 7-25- 1921, to 7-26- 1921, that I last saw h— alive on 7-26- 1921, and that death occurred on the date stated above, at 6 P. M.
The CAUSE OF DEATH* was as follows:
Cor. Pulmonale Hemorrhage.
(Duration) — Yrs. — mos. — ds.
Contributory (Secondary) Chronic Hypertrophic Pulmonary Tb.
(Duration) — yrs. 6 mos. — ds.
(Signed) A. M. Mackay M. D.
7/26 1921 (Address) Ashton, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Richard Idaho — DATE OF BURIAL: 7-28-1921
20. UNDERTAKER: Lewis Kiser — ADDRESS: Ashton Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

RECEIVED AUG 3 1927 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

34842

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Fremont — Registration District No. 102 — File No. 2

City of Ashton — Primary Registration District No. 6 — Registered No.

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Alexander Owens

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.)
Male	White	Widowed

6. DATE OF BIRTH: August 18 (Month) (Day) 1845 (Year)

7. AGE: 75 Yrs. 11 Mos. 9 ds. — IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Indiana

10. NAME OF FATHER: Ashley Owens

11. BIRTHPLACE OF FATHER (State or Country): Don't Know

12. MAIDEN NAME OF MOTHER: Martha Andrews

13. BIRTHPLACE OF MOTHER (State or Country): Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Fred L. Owens
(Address) Ashton Idaho

15. Filed 7-29 1927 — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 27 (Day) 1927 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to July 27 1927, that I last saw h. alive on July 27 1927, and that death occurred on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Paralysis

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E. L. Sharp M. D.

July 29 1927 (Address) Ashton Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Fremont County — DATE OF BURIAL: 7-29 1927

20. UNDERTAKER: Lewis River — ADDRESS: Ashton, Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34844

Registered No.

1. PLACE OF DEATH
County of Fremont
City of St. Anthony, Ida. (or St.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
AUG 5 1921
BUREAU OF VITAL STATISTICS

Registration District No. 99
Primary Registration District No. 2177

2. FULL NAME Cilphia C. Hill

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

Female | 4. COLOR OR RACE: White | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Nov. 24th- 1896 (Month) (Day) (Year)

7. AGE: 24 Yrs. 5 Mos. 29 ds. (23)
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ida.

10. NAME OF FATHER: Fred Murri

11. BIRTHPLACE OF FATHER (State or Country): Switzerland

12. MAIDEN NAME OF MOTHER: Christina Miller

13. BIRTHPLACE OF MOTHER (State or Country): Switzerland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Charles F. Hill
(Address) St. Anthony Ida

15. Filed June 10 1921 W. Bewick Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 22-2I (Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from MayI5th-2I. 19 to My 22 19, that I last saw her alive on May 2 2 19, and that death occurred on the date stated above, at 3P.M.
The CAUSE OF DEATH* was as follows:

Septicemia.

(Duration) One Week Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. Frank Watkins M. D.
May 22-21. 19 (Address) St Anthony I da.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Milford Cemetery | DATE OF BURIAL: May 25 1921

20. UNDERTAKER: W M Hansen | ADDRESS: St. Anthony Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34845
Registered No.

1. PLACE OF DEATH

County of Gem — Registration District No. 6

City of Grosse — (No. ... St.) — Registration District No. Gross

If death occurs away from usual residence, give facts called for under special information.

RECEIVED AUG 15 1921 BUREAU OF VITAL STATISTICS

2. FULL NAME James Satterwhite

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: ... (Month) ... (Day) 1 (Year)

7. AGE: 46 Yrs. ... Mos. ... ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Agricultural
(b) General nature of industry, business or establishment in which employed (or employer): Stockraising

9. BIRTHPLACE (State or Country): X

10. NAME OF FATHER: X

11. BIRTHPLACE OF FATHER (State or Country): X

12. MAIDEN NAME OF MOTHER: X

13. BIRTHPLACE OF MOTHER (State or Country): X

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Elmer H. Nesbit
(Address) Gross, Ida

15.
Filed July 20 1921 — J. L. Taylor — Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 25 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ... 19..., to ... 19..., that I last saw h... alive on ... 19..., and that death occurred on the date stated above, at ... M.
The CAUSE OF DEATH* was as follows:

a Drowning

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary) ...

(Duration) ... yrs. ... mos. ... ds.

(Signed) W M Brown - Coroner M. D.

19... (Address) Emmett Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death? ...
Former or usual residence ...

19. PLACE OF BURIAL OR REMOVAL: Ola, Ida — DATE OF BURIAL: July 1921

20. UNDERTAKER: Mr. Buchnam — ADDRESS: Emmett

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34846
Registered No.

Registration District No.
Primary Registration District No.

AUG 25 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Gem
City of Ola
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lodisa Elyza Granger Ola Ida

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: X Dec (Month) 6 (Day) 1 (Year)

7. AGE: 68 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE
X (State or Country) Pennsylvania

10. NAME OF FATHER
X J C Terry

11. BIRTHPLACE OF FATHER
X (State or Country) Penna

12. MAIDEN NAME OF MOTHER
X Sarah Bishop

13. BIRTHPLACE OF MOTHER
X (State or Country) Penna

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
X (Informant) J W Granger
(Address)

15. Filed 7/29/ 19 21 J L Reynolds Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 9th (Day) 19 21 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1 19 21, to July 9th 19 21, that I last saw h er alive on June 20th 19 21, and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Diabetic Coma

(Duration) Yrs. mos. ds.

Contributory (Secondary) Diabetes Mellitus

(Duration) years yrs. mos. ds.

(Signed) Lou Bacon M. D.

July 11 19 21 (Address) Boise Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Ola — DATE OF BURIAL: 7/12 19 21

20. UNDERTAKER: Family — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34847
Registered No.

RECEIVED
AUG 15 1921
BUREAU OF VITAL STATISTICS

Registration District No.
Primary Registration District No. 6

1. PLACE OF DEATH

County of Gem
City of Emmett
(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Anne Larson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Married

6. DATE OF BIRTH Dec 15 1864
(Month) (Day) (Year)

7. AGE 56 Yrs. 6 Mos. 24 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Denmark

10. NAME OF FATHER O. Olsen

11. BIRTHPLACE OF FATHER (State or Country) Denmark.

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (State or Country) "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Louis Larson
(Address) Emmett Idaho

15.
Filed 7/14 1921
J. H. Reynolds
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 9 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 9 1921, to July 7 1921
that I last saw her alive on July 7 1921,
and that death occurred on the date stated above, at M.
The CAUSE OF DEATH* was as follows:
Carcinoma extranal genitals

(Duration) 1 yr Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) R. N. Cummings M. D.
7/10 1921 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Emmett Idaho
DATE OF BURIAL 7/11 1921

20. UNDERTAKER O. Bucknum
ADDRESS Emmett Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED AUG 15 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 24848

Registered No.

1. PLACE OF DEATH

Registration District No.

Primary Registration District No. 6

County of Gem

City of Emmett (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Roy Campbell Keithly

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	married

6. DATE OF BIRTH: Aug (Month) 26 (Day) 1888 (Year)

7. AGE: 32 Yrs. 10 Mos. 5 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Grocery Clerk

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): South Dakota

10. NAME OF FATHER: Willoughby Keithley

11. BIRTHPLACE OF FATHER (State or Country): unknown

12. MAIDEN NAME OF MOTHER: Kitty Giel

13. BIRTHPLACE OF MOTHER (State or Country): unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Carol Faye Keithly

(Address)

15. Filed 7/7/21 19.....

J. L. Reynolds
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 1 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 27 1921, to July 1 1921, that I last saw h... alive on July 1 1921, and that death occurred on the date stated above, at 9 P.M.

The CAUSE OF DEATH* was as follows:

Sarcoma involving Stomach Liver and Bowels

(Duration) about Yrs. 8 mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. L. Reynolds M. D.

7/7 1921 (Address) Emmett Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Emmett Idaho

DATE OF BURIAL: ..... 19.....

20. UNDERTAKER: C. D. Buckner

ADDRESS: Emmett Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

V

CERTIFICATE OF DEATH

Registration District No. 24 RECEIVED AUG 10 1921 BUREAU OF VITAL STATISTICS

Primary Registration District No.

(No. .....)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34849

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Gooding

City of Gooding

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Benjamin Hearp

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single (write the word.)

6. DATE OF BIRTH ..... (Month) ..... (Day) 1863 (Year)

7. AGE 58 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Farmer.

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) England.

10. NAME OF FATHER Not Known.

11. BIRTHPLACE OF FATHER (State or Country) England.

12. MAIDEN NAME OF MOTHER Not Known.

13. BIRTHPLACE OF MOTHER (State or Country) England.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jerry Church

(Address) .....

15. Filed July 15 1921 F. E. Campbell Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 14 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 23 1921, to July 14 1921, that I last saw him alive on July 13 1921, and that death occurred on the date stated above, at 5 A.M.

The CAUSE OF DEATH* was as follows: Lobar pneumonia, Bronchitis

about (Duration) One Yrs. ..... mos. ..... ds.

Contributory (Secondary) Paralysis

(Duration) ..... yrs. 3 mos. ..... ds.

(Signed) T. G. Johnson M.D.

7-14 1921 (Address) Gooding Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL North Dak **DATE OF BURIAL** 7/19 1921

20. UNDERTAKER A. W. Morgan **ADDRESS** Gooding Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED
AUG 10 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34850

Registered No. .....

Registration District No. 2224 ~~102~~

Primary Registration District No. .....

(No. ..... STATE ..... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Goodwin

City of Goodwin

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Loyd Donald Perry

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. Jan (Month) 28 (Day) 1920 (Year)

7. AGE: ....Yrs. 17 Mos. ....ds.

IF LESS than 1 day how many ....hrs. or ....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work....

(b) General nature of industry, business, or establishment in which employed (or employer)....

9. BIRTHPLACE (State or Country): Shoshone, Ida

10. NAME OF FATHER: John Perry

11. BIRTHPLACE OF FATHER (State or Country): Braga, Portugal

12. MAIDEN NAME OF MOTHER: Cordia Regan

13. BIRTHPLACE OF MOTHER (State or Country): Tennessee

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John A. Perry

(Address) Gooding Idaho

15. Filed 7-18 1921

H Keary M.D. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 16 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 11 1921, to July 16 1921, that I last saw him alive on July 16 1921, and that death occured on the date stated above, at 3. P. M.

The CAUSE OF DEATH* was as follows:

Cerebro-spinal meningitis

(Duration) ....Yrs. ....mos. 24 hrs.

Contributory (Secondary) Acute Gastro enteritis

(Duration ....yrs. ....mos. 10 ds.

(Signed) H E Pounds M. D.

July 1921 (Address) Gooding, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death....yrs....mos....days. In the State....yrs....mos....days

Where was disease contracted if not at place of death?....

Former or usual residence ....

19. PLACE OF BURIAL OR REMOVAL: Gooding Idaho — DATE OF BURIAL: 7-7 1921

20. UNDERTAKER: A E Thompson — ADDRESS: Gooding Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

EVANS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

RECEIVED AUG 10 1921 BUREAU OF VITAL STATISTICS

Registration District No. 24

Primary Registration District No. .....

(No. ..... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 24851

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Gooding

City of Gooding

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Harry M. Fike

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. Oct (Month) 24 (Day) 1880 (Year)

7. AGE: 40 Yrs. 8 Mos. 13 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Grain Dealer —

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Nebr —

10. NAME OF FATHER: James M. Fike

11. BIRTHPLACE OF FATHER (State or Country): Illinois

12. MAIDEN NAME OF MOTHER: Jennie Mull

13. BIRTHPLACE OF MOTHER (State or Country): Penn —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. H M Fike

(Address) Gooding, Idaho —

15. Filed July 7 1921 — F. F. Caymond, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 7 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 6 1921, to July 7 1921, that I last saw him alive on July 6 1921, and that death occured on the date stated above, at a..... M. Between midnight & 5 AM

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Acute Alcoholism —

..... (Duration ..... yrs. ..... mos. 4 ds.

(Signed) L W Cary ——— M. D.

7/7 1921 (Address) Gooding, Idaho —

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL ~~OR REMOVAL~~: Gooding, Idaho —

DATE OF BURIAL: 7/9/1921

20. UNDERTAKER: A. E. Thompson —

ADDRESS: Gooding, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24858

FORM V. S. No. 5-25 M. 1-16-18

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34852

Registered No. .....

Registration District No. .....

Primary Registration District No. .....

(No. ..... St.)

RECEIVED
AUG 10 1921
BUREAU OF VITAL STATISTICS

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Gooding

City of Gooding

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs. Jane Dooley

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. December (Month) 7 (Day) 1899 (Year)

7. AGE: 21 Yrs. 6 Mos. 11 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Sherman, Kansas

10. NAME OF FATHER: W. E. Spangler

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Nellie Bacus

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W. E. Spangler

(Address) Gooding, Idaho

15. Filed 6-25 1921

F. S. Camp M.D.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 18 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from [redacted] 29 1921, to June 18 1921, that I last saw h[redacted]e alive on June 18 1921, and that death occured on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

General peritonitis

(Duration) ..... Yrs. ..... mos. 10 ds.

Contributory (Secondary) Chronic salpingitis

(Duration 5 yrs. ..... mos. ..... ds.

(Signed) Dr. W. E. Lamb for W. Dooley M. D.

June 1921 (Address) Gooding Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Gooding — DATE OF BURIAL 6/20 1921

20. UNDERTAKER: A. R. Thompson — ADDRESS: Gooding - Ida.

SYMS - YORK CO., PTRS. & BDRS. 24858

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

RECEIVED AUG 10 1921 BUREAU OF VITAL STATISTICS

Registration District No. 24

Primary Registration District No.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 3485

Registered No.

1. PLACE OF DEATH

County of Gooding

City of Gooding

(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Morrell Davis Powell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	White	Married

6. DATE OF BIRTH: Oct (Month) 4 (Day) 1868 (Year)

7. AGE: 53 Yrs. 7 Mos. 16 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Dentist
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Indiana

10. NAME OF FATHER: Davis Powell

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Davis

13. BIRTHPLACE OF MOTHER (State or Country): Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Marie Powell
(Address) Gooding Ida

15. Filed 6-24 1921 F. L. Cranmer
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 20 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 10 1921, to May 20 1921, that I last saw h~~im~~ alive on May 20 1921, and that death occurred on the date stated above, at 8 A. M.

The CAUSE OF DEATH* was as follows:

Pneumonia (Lobar)

(Duration) ..... Yrs. ..... mos. 10 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. H. Cranmer M. D.

6/24 1921 (Address) Gooding Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Gooding Ida — DATE OF BURIAL: 6/23 1921

20. UNDERTAKER: A. E. Thompson — ADDRESS: Gooding

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

RECEIVED
AUG 10 1921
BUREAU OF VITAL STATISTICS

Registration District No. 1 2 5 4

Primary Registration District No.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 24854

Registered No.

1. PLACE OF DEATH

County of Gooding

City of Gooding

(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lot Huntington Hancock

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Male	White	Married

6. DATE OF BIRTH: Aug. (Month) 18 (Day) 1875 (Year)

7. AGE: 45 Yrs. 9 Mos. 25 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farming
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Salt Lake, Utah

10. NAME OF FATHER: John Hancock

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Julia Mellow

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Susie Hancock
(Address) Gooding Ida

15. Filed 6-16-1921

F. J. Campbell M.D.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 13 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1, 1921, to June 13 1921 that I last saw h alive on June 10 1921 and that death occurred on the date stated above, at 3 A. M.

The CAUSE OF DEATH* was as follows:

Mitral insufficiency

(Duration) Yrs. 18 mos. ds.

Contributory (Secondary) Anasarca

(Duration) yrs. 1 mos. ds.

(Signed) J. H. Cromwell M. D.

6/13 1921 (Address) Gooding Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Magna Utah — DATE OF BURIAL: 6/16 1921

20. UNDERTAKER: A E Thompson — ADDRESS: Gooding

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 24

Primary Registration District No.

(No. ... St.)

RECEIVED AUG 10 1921 BUREAU OF VITAL STATISTICS

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34855

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Gooding

City of Gooding

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary A. Lytle

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	white	married

6. DATE OF BIRTH. August (Month) 24 (Day) 1868 (Year)

7. AGE 52 Yrs. 9 Mos. 15 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work housewife
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Towanda, Penn.

10. NAME OF FATHER Theodore Neigh.

11. BIRTHPLACE OF FATHER (State or Country) Penn.

12. MAIDEN NAME OF MOTHER Stevenson

13. BIRTHPLACE OF MOTHER (State or Country) Penn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) O. B. Lytle
(Address) Hagerman, Ida.

15. Filed 6-10-1921 F. J. Camp M.D. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 9 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 7 1921, to June 9 1921, that I last saw her alive on June 9 1921, and that death occured on the date stated above, at 10 A. M.

The CAUSE OF DEATH* was as follows:
Acute dilitation of the heart due to fatty degeneration

(Duration) ... Yrs. ... mos. 10 minutes

Contributory (Secondary) Hemorrage from fibroid uterine

(Duration) 4 yrs. ... mos. ... ds.

(Signed) H. C. Camp M. D.

6/10 1921 (Address) Gooding Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs ... mos ... days. In the State ... yrs ... mos ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Hagerman, Ida. — DATE OF BURIAL 6/10 1921

20. UNDERTAKER A E Thompson — ADDRESS Gooding, Ida

SYMS - YORK CO., PTRS. & BOBS. 24653

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

RECEIVED
AUG 10 1921
BUREAU OF VITAL STATISTICS

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34856
Registered No.

1. PLACE OF DEATH
County of Gooding
City of Gooding
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District (or Town)
(No. , St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME. Hugh Vernon Woody

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	White	Single

6. DATE OF BIRTH: April (Month) 18 (Day) 1921 (Year)

7. AGE: Yrs. Mos. 27 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Gooding Co, Ida.

10. NAME OF FATHER: Chas A Woody

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Blanche F Gilmore

13. BIRTHPLACE OF MOTHER (State or Country): Nebraska

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Chas A Woody
(Address): Gooding Ida

15. Filed 6-17-1921 F. J. Caynor Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 15 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from October 10 1921 to May 15 1921
that I last saw him alive on October 14 1921,
and that death occurred on the date stated above, at 6 A.M.
The CAUSE OF DEATH* was as follows:

Whooping cough

(Duration) Yrs. mos. 7 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) J H Cromwell M. D.
5/15 1921 (Address) Gooding Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death? At home in Gooding
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Gooding — DATE OF BURIAL: 5/16 1921

20. UNDERTAKER: A E Thompson — ADDRESS: Gooding

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED JUL 14 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH. Registration District No. 106
County of Idaho Primary Registration District No. 2184
City of Stites (No. ..... St.)
File No. 34857
Registered No. 111
If death occurs away from usual residence, give facts called for under special information.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.
2. FULL NAME Jesse E Auslin

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH. Aug (Month) 2nd (Day) 1903 (Year)
7. AGE: 18 Yrs. 11 Mos. 11 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: General mrk
(b) General nature of industry, business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Idaho
10. NAME OF FATHER: Christoph Columbus Auslin
11. BIRTHPLACE OF FATHER (State or Country): Illinois
12. MAIDEN NAME OF MOTHER: Medora E Auslin
13. BIRTHPLACE OF MOTHER (State or Country): Missouri
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) C C Auslin
(Address) Stites -
15. Filed June 3 1921 J M Herbert Kuns Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 22nd (Day) 1921 (Year)
17. I HEREBY CERTIFY, That I attended deceased from May 28 1921, to June 22 1921, that I last saw h. him alive on June 22 1921, and that death occured on the date stated above, at 1 P M.
The CAUSE OF DEATH* was as follows: Acute fever due to acidosis

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) H W Wentworth M. D.
June 23 1921 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Stites — DATE OF BURIAL: June 24 1921
20. UNDERTAKER — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24658

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 103
Primary Registration District No. 1001
File No. 3485
Registered No. 28

RECEIVED
AUG 6 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Idaho
City of Grangeville (If outside limits of city or village, write Yes or No.) St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Leo Kabat

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: ~~Single~~ (Write the word.)

6. DATE OF BIRTH: June (Month) 24 (Day) 1899 (Year)

7. AGE: 22 Yrs. 5 Mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Painter
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wisconsin

10. NAME OF FATHER: John Kabat

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Louise Rupp

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Kabat
(Address) Grangeville

15. Filed Aug 1 1921 H S Stockton Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 20 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw ~~him~~ alive on ..... 19.....
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Accidental Drowning

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A J. Maugg Coroner M. D.
7/21 1921 (Address) Grangeville Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Prairie View — DATE OF BURIAL: July 23 1921

20. UNDERTAKER: A J. Maugg — ADDRESS: City

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
AUG 6 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 103
Registration District No. 2181
File No. 3485.9
Registered No. 21

1. PLACE OF DEATH
County of Idaho
City of Grangeville
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Peter Riebold

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widowed

6. DATE OF BIRTH: July (Month) 25 (Day) 1833 (Year)

7. AGE: 87 Yrs. 11 Mos. 28 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Germany.

10. NAME OF FATHER: ? Riebold

11. BIRTHPLACE OF FATHER (State or Country): Germany.

12. MAIDEN NAME OF MOTHER: ?

13. BIRTHPLACE OF MOTHER (State or Country): Germany.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) S. Riebold
(Address) Grangeville Idaho

15. Filed Aug 1 1921 G S Stockton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 22 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1 1921, to July 22 1921, that I last saw h.im alive on July 1 1921, and that death occurred on the date stated above, at 6.9 M.
The CAUSE OF DEATH* was as follows:
Senility
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Arteriosclerosis
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) G S Stockton M. D.
7/23 1921 (Address) Grangeville

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Fairview. DATE OF BURIAL: July 23 1921

20. UNDERTAKER: A J Maupy ADDRESS: Grangeville

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34860
Registered No. 19

1. PLACE OF DEATH.
County of Idaho
City of Grangeville (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

RECEIVED
AUG 6 1921
BUREAU OF VITAL STATISTICS

Registration District No. 103
Primary Registration District No. 2181

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Not named

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. July (Month) 13 (Day) 1921 (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many 3 hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho Co. Grangeville

10. NAME OF FATHER Samuel Andrews

11. BIRTHPLACE OF FATHER (State or Country) Soblet Idaho

12. MAIDEN NAME OF MOTHER Ruby Prest

13. BIRTHPLACE OF MOTHER (State or Country) Dalon Washington

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. E. L. Pratt
(Address) Grangeville

15.
Filed Aug 1 1921
G. L. Stockton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 13 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw her alive on ..... 191...,
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Stillborn

.....(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
.....(Duration ..... mos. ..... ds.
(Signed) G. B. Chipman M. D.
7/14 1921 (Address) Grangeville Ida.

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Prairie View — DATE OF BURIAL: July 14 1921

20. UNDERTAKER: E. L. Hancock — ADDRESS: Grangeville

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.

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SYMS - YORK CO., PTRS. & SORS. 24658

Form V. S. No. 5 20M.1-16-12

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AUG 6 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 103
Primary Registration District No. 2181
File No. 34861
Registered No. 18

1. PLACE OF DEATH.
County of Idaho
City of Cottonwood (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Henry Bramby Blake

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): married

6. DATE OF BIRTH: March (Month) 13 (Day) 1848 (Year)

7. AGE: 73 yrs. 3 mos. 19 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Doctor
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: Henry Bramby Blake

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Mary Biscoll Burke

13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Harry Blake
(Address) Star Rt. Lewiston

15.
Filed Aug 1 1921 G S Stockton Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: July (Month) 2 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Death, Sudden 191, to — 191, that I last saw him alive on July 1 1921, and that death occurred on the date stated above, at 8:10 P.M.,

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy.

Death was almost instantaneous.

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) Disseminated Sclerosis

(Duration) 10 yrs. ..... mos. ..... ds.

(Signed) Wesley F. Orr M. D.

7/2 1921 (Address) Cottonwood Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Moscow Idaho | DATE OF BURIAL: ..... 191...

20. UNDERTAKER: A J Mauge | ADDRESS: Genesee

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 30
Primary Registration District No. 1051
File No. 34863
Registered No. 951

RECEIVED
AUG 8 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene
(No. ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Rudolph Miller

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Widower

6. DATE OF BIRTH
June (Month) 27 (Day) 1843 (Year)

7. AGE
78 Yrs. 0 Mos. 25 ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business or establishment in which employed (or employer): Civil Service

9. BIRTHPLACE (State or Country) Maine

10. NAME OF FATHER [illegible]

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs John Zeiman
(Address) Spokane Wn

15.
Filed Aug 4 1921 D. H. Breman Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
July (Month) 22 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 2, 1921, to July 22 1921, that I last saw him alive on July 21 1921, and that death occurred on the date stated above, at 12:15 AM.

The CAUSE OF DEATH* was as follows:

Chronic Myocardial Degeneration

(Duration) Not known Yrs. ... mos. ... ds.

Contributory (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) J. C. Days M. D.
July 23 21 (Address) Coeur d Alene Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State 19 yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetery — DATE OF BURIAL: July 24 1921

20. UNDERTAKER: R B Mooney — ADDRESS: Coeur d'Alene

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34864
Registered No. 950

Registration District No. 30
Primary Registration District No. 1051

1. PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene (No. 841 Aug 6 1921 2nd St.)
If death occurs away from usual residence, give facts called for under special information.

RECEIVED
AUG 6 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME Ole Nelsen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M.	W.	Married

6. DATE OF BIRTH ..... (Month) ..... (Day) ..... 1 (Year)

7. AGE 63 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Norway

10. NAME OF FATHER —

11. BIRTHPLACE OF FATHER (State or Country) Norway

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER (State or Country) Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H N Meyers
(Address) 841 2d St

15. Filed Aug 4 1921 D D Drenna Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 17 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 9, 1921, to July 17 1921 that I last saw him alive on July 17 1921 and that death occurred on the date stated above, at 8 P.M.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus.

(Duration) Not known Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D D Drenna M. D.
July 6 1921 (Address) Coeur d Alene Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Forest-Cem. C'Dalene	7-18 1921

20. UNDERTAKER C Casseday — ADDRESS C'Dalene 209-2nd St

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34865
Registered No. 949

Registration District No. 30
Primary Registration District No. 1057

1. PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene
(No. Reed Apartments St.)
If death occurs away from usual residence, give facts called for under special information.

RECEIVED
AUG 6 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME Willard Chamberlain

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write word): Single

6. DATE OF BIRTH: July (Month) 25 (Day) 1903 (Year)

7. AGE: 17 Yrs. 11 Mos. 18 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: A V Chamberlain

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Daisy H Moller

13. BIRTHPLACE OF MOTHER (State or Country): Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A V Chamberlain
(Address) Coeur d'Alene Ida

15. Filed Aug 4 1921 D D Dreman Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 16 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 16, 1921 to July 16 1921
that I last saw him alive on July 16 1921,
and that death occurred on the date stated above, at 9 P.M.
The CAUSE OF DEATH* was as follows:

Internal injuries, automobile wreck.

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J D Wagner M. D.
July 4 1921 (Address) Coeur d'Alene Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State 17 yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence Coeur d'Alene Ida

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetery — DATE OF BURIAL: July 19 1921

20. UNDERTAKER: P B Mooney — ADDRESS: Coeur d'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 30
Primary Registration District No. 1031
File No. 34866
Registered No. 948

1. PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene. (No. ... St.)
If death occurs away from usual residence, give facts called for under special information.

RECEIVED AUG 6 19 21 BUREAU OF VITAL STATISTICS

2. FULL NAME Samuel McDougall

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: April 13 1906 (Month) (Day) (Year)

7. AGE: 24 Yrs. 2 Mos. 18 ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Truck driver
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Canada

10. NAME OF FATHER: Thos. McDougall

11. BIRTHPLACE OF FATHER (State or Country): Canada

12. MAIDEN NAME OF MOTHER: Morgarie Gelkei

13. BIRTHPLACE OF MOTHER (State or Country): Canada.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ernest McDougall
(Address) Meadow Creek Ida

15. Filed Aug 7 1921 S. D. Duncan Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July 11 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 4 1921, to ... 19..., that I last saw h... alive on July 11 1921, and that death occurred on the date stated above, at 9 P M.

The CAUSE OF DEATH* was as follows:
Legs Jolt in Chimney Breaking
Weak

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary)
(Duration) ... yrs. ... mos. ... ds.

(Signed) S. D. Duncan M. D.
7/13 1921 (Address) Coeur d'Alene

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetery | DATE OF BURIAL: 7/14 1921

20. UNDERTAKER: C Cassedy | ADDRESS: Coeur d'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 30
Primary Registration District No. 1051
File No. 3486?
Registered No. 947

1. PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene, (No. 906 Montana St.)
If death occurs away from usual residence, give facts called for under special information.

RECEIVED AUG 6 BUREAU

2. FULL NAME Chas. Herman Frans

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Dec. (Month) 29 (Day) 1861 (Year)

7. AGE: 59 Yrs. 6 Mos. 30 ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Lumber worker
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Finland

10. NAME OF FATHER: — — —

11. BIRTHPLACE OF FATHER (State or Country): Finland

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): Finland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Lydia Salmi
(Address) 1425 6th

15. Filed Aug 4 1921 D D Drena Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 9 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 5 1921 to July 9 1921
that I last saw h... alive on July 9 1921,
and that death occurred on the date stated above, at 5-9 A. M.
The CAUSE OF DEATH* was as follows:
Broncho-pneumonia.
(Influenza)?
(Duration) ... Yrs. ... mos. 9 ds.
Contributory (Secondary)
(Duration) ... yrs. ... mos. ... ds.
(Signed) John Elwood M. D.
July 9 1921. (Address) Coeur d'Alene Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Forest-Lem. I. O. O. F. | DATE OF BURIAL: 7-11 1921

20. UNDERTAKER: C. Casseday | ADDRESS: C'D'Alene

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

Duplicate

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 30
Primary Registration District No. 1031
File No. 24868
Registered No. 944

RECEIVED
AUG 6 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene (No. 9 4th St. Sherman St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John O'Brien
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH: June (Month) 23 (Day) 1836 (Year)

7. AGE: 85 Yrs. 0 Mos. 12 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Major in Army
(b) General nature of industry, business or establishment in which employed (or employer): Retired

9. BIRTHPLACE (State or Country): Ireland

10. NAME OF FATHER: John O'Brien

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Agnes Fearon
(Address) Coeur d'Alene Ida

15. Filed Aug 7 1921 D D Drenna Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 5 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 23 1921 to July 5 1921, that I last saw h... m... alive on July 4 1921, and that death occurred on the date stated above, at 1:50 A.M.

The CAUSE OF DEATH* was as follows:

Senility

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J H Wyatt M. D.
July 5 1921 (Address) Coeur d'Alene Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State 35 yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: St Thomas Cemetery | DATE OF BURIAL: July 7 1921

20. UNDERTAKER: C B Mooney | ADDRESS: Coeur d'Alene Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

RECEIVED
AUG 6 1921
BUREAU OF VITAL STATISTICS

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 30
Primary Registration District No. 1051
File No. 24869
Registered No. 948

1. PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene (No. 1118 Coeur d'Alene Ave. (St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary Bauer

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widow

6. DATE OF BIRTH: Dec (Month) 29 (Day) 1871 (Year)

7. AGE: 50 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): France

10. NAME OF FATHER: Frank Meyer

11. BIRTHPLACE OF FATHER (State or Country): France

12. MAIDEN NAME OF MOTHER: Mary Uhl.

13. BIRTHPLACE OF MOTHER (State or Country): France

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Frank Meyer
(Address) Coeur d'Alene Ida

15. Filed Aug 4 1921 D.D.Drenna Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 4 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 4 1921, to July 4 1921, that I last saw her alive on July 4 1921, and that death occurred on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:
Apoplexy

(Duration) Yrs. mos. ds.
Contributory (Secondary): Paralysis
(Duration) yrs. mos. ds.

(Signed) D.D.Drennan M. D.
7/5 1921 (Address) Coeur d'Alene Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. 5 mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Chicago Ill — DATE OF BURIAL: Aug 6 1921

20. UNDERTAKER: J B Mooney — ADDRESS: Coeur d'Alene

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34870
Registered No. 946

1. PLACE OF DEATH
County of Kootenai
City of Coeur d Alene
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 30
Primary Registration District No. 1051
(No. Near Coeur d Alene St.)

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AUG 6 1921
BUREAU OF VITAL STATISTICS

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William J Jandell

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word.)
Male	White	Single

6. DATE OF BIRTH
May (Month) (Day) 1864 (Year)

7. AGE
50 Yrs. 2 Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Swamper
(b) General nature of industry, business or establishment in which employed (or employer) Knows Logging Camp

9. BIRTHPLACE
(State or Country) Mo.

10. NAME OF FATHER
James J Jandell

11. BIRTHPLACE OF FATHER
(State or Country) Unknown

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J H Kirk
(Address) Spokane, Wn.

15.
Filed Aug 4 1921 D D Brennan Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
July (Month) 26 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..., to ..... 19...,
that I last saw h..... alive on ..... 19...,
and that death occurred on the date stated above, at 12:30 P M.
The CAUSE OF DEATH* was as follows: A Bull Crushed by falling Tree (accidental)

(Duration) ... Yrs. ... mos. ... ds.
Contributory (Secondary)
(Duration) ... yrs. ... mos. ... ds.

(Signed) P. B. Mooney Coroner M. D.
19... (Address) Coeur d'alene Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. 7 days
Where was disease contracted if not at place of death?
Former or usual residence Spokane Wn.

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Spokane Wn	Aug 27 1921

20. UNDERTAKER	ADDRESS
P B Mooney	Coeur d'alene Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

34871

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 5

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Latah

City of Bovill

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 66

Primary Registration District No. 2146

(No. ..... Bovill Hospital St.)

RECEIVED
AUG 6 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME Oscar Johnson

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Do not know (Month) (Day) 1 (Year)

7. AGE: 41 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Logger

(b) General nature of industry, business, or establishment in which employed (or employer): Winston Rosenberry Co

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER: Do not know

11. BIRTHPLACE OF FATHER (State or Country): Do not know

12. MAIDEN NAME OF MOTHER: Do not know

13. BIRTHPLACE OF MOTHER (State or Country): Do not know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) .....

15.

Filed July 5th 1921

Wm P. Gibson
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 5 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 4 1912, to July 5 1921, that I last saw him alive on July 3 1921, and that death occured on the date stated above, at 10 P M.

The CAUSE OF DEATH* was as follows:

Traumatic Rupture of Small bowel + Shock Following Operation for relief of Colic

(Duration) ..... Yrs. ..... mos. 1 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. Gibson M. D.

7/5 1921 (Address) Bovill

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Bovill

DATE OF BURIAL: 7/5 1921

20. UNDERTAKER: Glen Grice

ADDRESS: Moscow Ida

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34873
Registered No. ____
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH. Registration District No. 64
County of Latah Primary Registration District No. 2144
City of Troy (No. ____, ____ St.)
If death occurs away from usual residence, give facts called for under special information.

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AUG 5 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME Mary Jane Hays

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH: June (Month) 1 (Day) 1851 (Year)

7. AGE: 70 yrs. 1 mos. 24 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Monroe Co. Iowa

10. NAME OF FATHER: Jacob Cox

11. BIRTHPLACE OF FATHER (State or Country): Kentucky

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Henry E Hays
(Address): Troy Ida

15.
Filed July 27 1921 Lucy M Pickard Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: July (Month) 24 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 15 1921, to July 24 1921, that I last saw h/w alive on July 22 1921, and that death occurred on the date stated above, at 6 P M.

The CAUSE OF DEATH* was as follows:
Carcinoma of Uterus

(Duration) 2 yrs. ____ mos. ____ ds.

Contributory (Secondary)
(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) P B Hodgeden M. D.
7th 1921 (Address) Troy Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Moscow Idaho
DATE OF BURIAL: July 28 1921

20. UNDERTAKER: John J Pickard
ADDRESS: Troy Idaho

SYMS - YORK CO., PTRS. & BDRS. 9760

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 61
Primary Registration District No. 1011
File No. 34874
Registered No. 46

RECEIVED
AUG 6 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Latah
City of Moscow (If outside limits of city or village, write RURAL and give name of township.) St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Anna Dale Reed.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Jan (Month) 19 (Day) 1884 (Year)

7. AGE: 37 Yrs. 6 Mos. 6 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Indiana

10. NAME OF FATHER: Will D. Dale

11. BIRTHPLACE OF FATHER (State or Country): Indiana

12. MAIDEN NAME OF MOTHER: Mary E. Lee

13. BIRTHPLACE OF MOTHER (State or Country): Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A. B. Reed
(Address) Moscow

15. Filed July 26 1921 W. H. Matthews Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 25 (Day) 19 21 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 22nd 1921, to July 25th 1921, that I last saw her alive on July 25th 1921, and that death occurred on the date stated above, at 12 10 P.M.

The CAUSE OF DEATH* was as follows:
Acute general peritonitis

(Duration) ..... Yrs. ..... mos. 4 ds.
Contributory (Secondary) Duodenal ulcer
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. W. Stevenson M.D.
7/26 1921 (Address) Moscow

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Moscow Cem. DATE OF BURIAL: 7/29 1921

20. UNDERTAKER: Chapman & Price ADDRESS: Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 61
Primary Registration District No. 1011
File No. 34875
Registered No. 39

RECEIVED AUG 6 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Latah
City of Moscow
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lucile Fay Hodges

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.):

6. DATE OF BIRTH: Sept 27 1920 (Month) (Day) (Year)

7. AGE: Yrs. 0 Mos. 24 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Washington

10. NAME OF FATHER: Glynn L Hodges

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Lelia Haynes

13. BIRTHPLACE OF MOTHER (State or Country): Wash

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) G. L. Hodges
(Address) Pullman Wash

15. Filed July 23 1921 M H Carithers Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July 23 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 9. 1921 to July 23 1921 that I last saw h.r alive on July 23 1921 and that death occurred on the date stated above, at 3 35 P.M.

The CAUSE OF DEATH* was as follows:

Intussusception

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) R. L. Hitchman M. D.

7/23 1921 (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Pleasant View — DATE OF BURIAL: 7/25 1921

20. UNDERTAKER: Pleasant View — ADDRESS: Pullman

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 61
Primary Registration District No. 1011
File No. 34877
Registered No. 37

RECEIVED
AUG 6 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Latah
City of Moscow (If outside limits, give township.) St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lucy Emmaline Thompson
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Nov. (Month) 27 (Day) 1842 (Year)

7. AGE: 78 Yrs. 7 Mos. 16 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: John Crowe

11. BIRTHPLACE OF FATHER (State or Country): not known

12. MAIDEN NAME OF MOTHER: Mary Kent

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs A. F. Chase
(Address) Moscow Idaho

15. Filed 7/14 1921 M Hawthorne Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 13 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 5th 1920, to July 13 1921, that I last saw her alive on May 6 1921, and that death occurred on the date stated above, at 11 P.M.
The CAUSE OF DEATH* was as follows:
Mitral insufficiency.
(Duration) 2 Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) C. F. Pitman M. D.
7/14 1921 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Albion Idaho | DATE OF BURIAL: 7/16 1921
20. UNDERTAKER: Ellen Price | ADDRESS: Moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
AUG 6 1921
BUREAU OF VITAL STATISTICS

Registration District No. 61
Primary Registration District No. 1011
File No. 34878
Registered No. 36

1. PLACE OF DEATH
County of Latah
City of Moscow
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sylvinda A. Warren
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widowed (Write the word.)

6. DATE OF BIRTH: March 3 1834 (Month) (Day) (Year)

7. AGE: 87 Yrs. 4 Mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer): At home with children

9. BIRTHPLACE (State or Country): Penn

10. NAME OF FATHER: Rogers

11. BIRTHPLACE OF FATHER (State or Country): Penn

12. MAIDEN NAME OF MOTHER: Not known here

13. BIRTHPLACE OF MOTHER (State or Country): Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) N. F. Warren
(Address) Moscow Wash

15. Filed 7/9 1921 N. H. Gaither Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July 8 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 8th 1921, to July 8 1921, that I last saw h. Ex. alive on July 8 1921, and that death occurred on the date stated above, at 10 20 P.M.

The CAUSE OF DEATH* was as follows:

Senility —

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Myocarditis

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Virgil M. Gilchrist M. D.

7/9 1921 (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Moscow Cem
DATE OF BURIAL: 7/10 1921

20. UNDERTAKER: Allen Funeral Home
ADDRESS Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 24880

Registered No. .....

1. PLACE OF DEATH.

County of Latah

City of Princeton

(No. ..... St.)

Registration District No. 65

Primary Registration District No. 2145

RECEIVED
AUG 10 1921
BUREAU OF VITAL STATISTICS

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME W. H. Daughs.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Jan. (Month) 25 (Day) 1909 (Year)

7. AGE: 12 Yrs. 7 Mos. 4 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: School boy.

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Montana

10. NAME OF FATHER: W. H. Daughs.

11. BIRTHPLACE OF FATHER (State or Country): Germany.

12. MAIDEN NAME OF MOTHER: L. Cunningham

13. BIRTHPLACE OF MOTHER (State or Country): Kansas.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W. H. Daughs

(Address) Princeton

15. Filed July 29th 1921 J. H. Thompson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 29 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 28 1921, to July 29 1921, that I last saw him alive on July 29 1921, and that death occured on the date stated above, at 6 A M.

The CAUSE OF DEATH* was as follows:

Laryngeal Diphtheria

(Duration) ..... Yrs. ..... mos. 5 ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. H. Thompson M. D.

7/29/1921 (Address) Potlatch

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Palouse - wash. DATE OF BURIAL: July 31 1921

20. UNDERTAKER: E. Irwin. ADDRESS: Palouse

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SVMB - YORK CO., PTRS. & BORS. 24854

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34881
Registered No. .....

RECEIVED
AUG 10 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH.
County of Latah
City of Potlatch
(If death occurs away from usual residence, give facts called for under special information.)
Registration District No. 65
Primary Registration District No. 2145
(No. ..... St.)

2. FULL NAME Morton Schroeder Foss.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): School Boy.
6. DATE OF BIRTH. Oct (Month) 22 (Day) 1907 (Year)
7. AGE: 14 Yrs. ..... Mos. ..... ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work... School Boy
(b) General nature of industry, business, or establishment in which employed (or employer).....
9. BIRTHPLACE (State or Country): Oregon
10. NAME OF FATHER: Henry Foss.
11. BIRTHPLACE OF FATHER (State or Country): Illinois
12. MAIDEN NAME OF MOTHER: Longaway.
13. BIRTHPLACE OF MOTHER (State or Country): California.
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) H. A. Foss
(Address) Potlatch Ida.
15. Filed July 13th 1921 — D. Jr. Thompson, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 13th (Day) 1921 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Dec. 1st 1920, to July 13 1921, that I last saw him alive on July 13. 1921, and that death occured on the date stated above, at 11:55 A.M.
The CAUSE OF DEATH* was as follows:
Osteo-sarcoma of head of left Tibia
(Duration) ..... Yrs. 6 mos. 10 ds.
Contributory (Secondary) unknown
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) Ernest A Hess M. D.
7/15 1921 (Address) Potlatch Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Palouse Wash. — DATE OF BURIAL: July 16 1921
20. UNDERTAKER: E. M. Irwin. — ADDRESS: Palouse.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SDRS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 24882

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Latah.

City of Potlatch, I.D.

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 65

Primary Registration District No. 2145

(No. ..... St.)

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BUREAU OF VITAL STATISTICS

2. FULL NAME Charles Rowly Cromwell.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married.

6. DATE OF BIRTH. Jan (Month) 17 (Day) 1857 (Year)

7. AGE: 67 Yrs. 4 Mos. 13 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Georgia.

10. NAME OF FATHER Andrew Cromwell.

11. BIRTHPLACE OF FATHER (State or Country) Georgia.

12. MAIDEN NAME OF MOTHER Lowery.

13. BIRTHPLACE OF MOTHER (State or Country) Not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. C. B. Cromwell
(Address) Palouse.

15. Filed July 6th 1921. J. W. Thompson, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 1 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 1 1921, to July 1 1921, that I last saw him alive on June 25 1921, and that death occured on the date stated above, at 2:45 A.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of liver and uremia

(Duration) 2 Yrs. mos. ds.

Contributory (Secondary) Carcinoma of lip

(Duration) 2 yrs. mos. ds.

(Signed) J. C. Nuzum M. D.

July 3 1921 (Address) Pullman Wash

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Palouse Wash. DATE OF BURIAL: July 3 1921

20. UNDERTAKER: L. M. Irwin ADDRESS: Palouse

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 24654

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BUREAU OF VITAL STATISTICS

Form V. S. No. 5. 10M. 6-21

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH — Registration District No. 68

County of Latah — Primary Registration District No. ____ — File No. 24882

City of Kendrick — (No. ____, ____ St.) — Registered No. ____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Maude Elton Stanton

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: July (Month) 7th (Day) 1886 (Year)

7. AGE: 34 yrs. 11 mos. 19 ds. — IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: J. C. Bibb

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Elizabeth Tate

13. BIRTHPLACE OF MOTHER (State or Country): Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Hugh D. Stanton
(Address) Kendrick Idaho

15. Filed June 27 1921 — R F Pepple, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 26th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from January 1st 1919, to June 26 1921 that I last saw h[illegible] alive on June 26 1921, and that death occurred on the date stated above, at 5 P M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 2 yrs. — mos. — ds.

Contributory (Secondary) ____ (Duration) ____ yrs. ____ mos. ____ ds.

(Signed) W. G. R Cotterell M. D.

June 27 1921 (Address) Kendrick Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and 2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. — In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Kendrick Idaho	June 27 1921
20. UNDERTAKER	ADDRESS
E. E. Brethal	Kendrick Idaho

N. B.—Every item of information should be given if possible. PHYSICIANS should state CAUSE OF DEATH fully and accurately. Correct statement of OCCUPATION is very important.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

Juliaetta Ida

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED
JUL 13 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34884
Registered No. 11

1. PLACE OF DEATH
County of Lemhi — Registration District No. 42
City of Leadore — Primary Registration District No. 2153
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John H. Clark

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	single

6. DATE OF BIRTH
Born Aug. (Month) 22 (Day) 1854 (Year)

7. AGE
64 Yrs. ..... Mos. 11 ds. 16
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country) Bates Co. Mo

10. NAME OF FATHER Geo. W. Clark

11. BIRTHPLACE OF FATHER (State or Country) Virginia

12. MAIDEN NAME OF MOTHER E. A. Stevenson

13. BIRTHPLACE OF MOTHER (State or Country) Maryland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Elizabeth Clark
(Address) Leadore Idaho

15. Filed 7/10 1921 Chas Bellamy Local Registrar
By Deputy

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
July (Month) 6 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 5th 1921, to July 6th 1921, that I last saw h~~im~~ alive on July 6th 1921, and that death occurred on the date stated above, at 24 M.

The CAUSE OF DEATH was as follows:
Cancer of the Bladder.

(Duration) One Yrs. ..... mos. ..... ds.

Contributory (Secondary) none

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Irvin B. Keller M. D.
7/7 1921 (Address) Leadore Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Gimetion Cemetery — DATE OF BURIAL: 7-7 1921

20. UNDERTAKER: Jno C Tocker — ADDRESS: Salmon Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34885
Registered No. .....

RECEIVED
JUL 13 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of ..... Registration District No. .....
City of Ogden (Utah) Primary Registration District No. .....
If death occurs away from usual residence, give facts called for under special information. (No. ....., ... St.)

2. FULL NAME Rhoda A. Spahn

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH. February 15 (Month) (Day) 1845 (Year)

7. AGE: 76 Yrs. 4 Mos. 12 ds.
IF LESS than 1 day how many .... hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) At Home

9. BIRTHPLACE (State or Country) Ohio

10. NAME OF FATHER Barthem Brown

11. BIRTHPLACE OF FATHER (State or Country) Vermont

12. MAIDEN NAME OF MOTHER Joanna A. Leach

13. BIRTHPLACE OF MOTHER (State or Country) Vermont

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Josephine Seaman
(Address) 706-21 St. St

15. Filed June 30 1921 ..... Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 28" 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 15" 1921 to June 28" 1921
that I last saw her alive on June 27" 1921
and that death occurred on the date stated above, at 8 a.m.

The CAUSE OF DEATH* was as follows:
Cerebral Apoplexy
.....(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) old age and Arteriosclerosis
.....(Duration) 2 Yrs. ..... mos. ..... ds.
(Signed) Edward L. Rich M. D.
6/27 1921 (Address) Ogden Utah

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence Salmon Idaho

19. PLACE OF BURIAL OR REMOVAL Salmon Cemetery DATE OF BURIAL July 2" 1921

20. UNDERTAKER W. C. Jacobs ADDRESS Salmon Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-12 M. 6-15-17.

RECEIVED
JUL 13 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34886
Registered No. .....

Registration District No. 41
Primary Registration District No. 2116

1. PLACE OF DEATH
County of Lemhi
City of Salmon (If not in incorporated limits, give township) St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sarah Hyde

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): widowed
6. DATE OF BIRTH: April (Month) 21 (Day) 1849 (Year)
7. AGE: 72 Yrs. 1 Mos. 27 ds. IF LESS than 1 day how many .... hrs. or .... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: House Keeper
(b) General nature of industry, business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Wis.
10. NAME OF FATHER: Minert
11. BIRTHPLACE OF FATHER (State or Country): Wis
12. MAIDEN NAME OF MOTHER:
13. BIRTHPLACE OF MOTHER (State or Country):
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jessie Black
(Address) Salmon Ida
15. Filed 7/10 1921 Clio Bellamy deputy Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Died June 18 (Month) (Day) 1921 (Year)
17. I HEREBY CERTIFY, That I attended deceased from June 1920 to June 15 1921
that I last saw h[illegible] alive on June 17 1921
and that death occurred on the date stated above, at 8 a.m.
The CAUSE OF DEATH* was as follows:
Mitral regurgitation
(Duration) One Year mos. ds.
Contributory (Secondary) Parenchymatous nephritis
(Duration) One Year mos. dc.
(Signed) F B Wright M. D.
7/8 1921 (Address) Salmon

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Salmon Cemetery — DATE OF BURIAL: 6-21-1921
20. UNDERTAKER: [illegible] Doolittle — ADDRESS: Salmon, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-12 M. 6-15-17.

N. B. MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

Registration District No. 41

Primary Registration District No. 2116

(No. [redacted] St.)

RECEIVED
AUG 15 1921
BUREAU OF VITAL

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 24888
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Lemhi
City of [redacted]
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Alice Livermore

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH: July (Month) 31 (Day) 1921 (Year)

7. AGE: .....Yrs.....Mos.....ds.
IF LESS than 1 day how many 4 hrs. or 30 min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Grover C. Livermore

11. BIRTHPLACE OF FATHER (State or Country) Iowa

12. MAIDEN NAME OF MOTHER Annie Ryan

13. BIRTHPLACE OF MOTHER (State or Country) North Dakota

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mariane Booth
(Address) Salmon Idaho

15. Filed 8/10 1921
Clio Billows
Deputy Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July 31st (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 31 1921 to July 31 1921 that I last saw h[redacted] alive on July 31 1921 and that death occurred on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:
Premature birth
(7 months)
2 hours
.....(Duration) ..... Yrs..... mos..... ds.

Contributory (Secondary) .....
.....(Duration) ..... Yrs..... mos..... ds.

(Signed) Chas F. Hammon M. D.
8/9 1921 (Address) Salmon

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Salmon Cemetery — DATE OF BURIAL: Aug 1st 1921

20. UNDERTAKER: Jno C Jacobs — ADDRESS: Salmon Ida.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 41
Primary Registration District No. 2116
File No. 34889
Registered No.

1. PLACE OF DEATH
County of Lemhi
City of Salmon
(No. St.)
If death occurs away from usual residence, give facts called for under special information.

RECEIVED AUG 1921 VITAL STATISTICS

2. FULL NAME J. Johnson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widowed (Write the word.)

6. DATE OF BIRTH: Not known (Month) (Day) 1 (Year)

7. AGE: about 78 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired Rancher
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Not known

10. NAME OF FATHER: " "

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wm C Doebler
(Address) Salmon Ida.

15. Filed 8/10 1921 Chas Bellamy Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 17th (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 13 1921, to June 17 1921, that I last saw h[illegible] alive on June 16th 1921, and that death occurred on the date stated above, at 10 A M.

The CAUSE OF DEATH* was as follows:
Myocarditis
Ending Rheumatism
5 D 4th
(Duration) Yrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) George A Kinney M. D.
6/18 1921 (Address) Salmon Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Salmon Cemetery
DATE OF BURIAL: 6-18 1921

20. UNDERTAKER: Wm C Doebler
ADDRESS: Salmon Ida.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34890
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

RECEIVED
AUG 15 1921
BUREAU OF VITAL STATISTICS

Registration District No. 41
Primary Registration District No. 2116
(No. ..... St.)

1. PLACE OF DEATH
County of Lemhi
City of North Fork
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME H J Wanick

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Not known ..... 1 ..... (Month) (Day) (Year)

7. AGE: about 37 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many .... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Quartz Mining
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Penn.

10. NAME OF FATHER: Not known

11. BIRTHPLACE OF FATHER (State or Country): Not known

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wm C Doebler
(Address) Salmon Ida

15. Filed 8/10 - 1921 Clio Bellamy Deputy Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July 10th (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..... to ..... 191...
that I last saw h.....alive on ..... 191....
and that death occurred on the date stated above, at .....M.
The CAUSE OF DEATH* was as follows:
..... Drowned
in Salmon River in boat
.....
.....(Duration) ..... Yrs..... mos. ..... ds.
Contributory (Secondary) .....
.....(Duration) ..... Yrs..... mos. ..... ds.
(Signed) William C Doebler Coroner
7-16" 1921 (Address) Salmon Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Salmon Cemetery — DATE OF BURIAL: 7-17" 1921

20. UNDERTAKER: W C Doebler — ADDRESS: Salmon Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34691
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

Registration District No. 41
Primary Registration District No. 2116
(No. ..... St.)

AUG 1 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Lemhi
City of Lemhi
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Edward DEAN Wolfe

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. October (Month) 19th (Day) 1845 (Year)

7. AGE: 76 Yrs. 8 Mos. 26 ds.
IF LESS than 1 day how many .... hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: Maurice Wolfe

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Johanna Downey

13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. E. D. Wolfe
(Address) Lemhi Idaho

15. Filed 8/10 - 21 Chas. Bellamy Deputy Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 14" (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..... to .....191...
that I last saw h.....alive on .....191....
and that death occurred on the date stated above, at .....M.
The CAUSE OF DEATH* was as follows:
.....Valvulor heart
Incidt
.....
.....(Duration) ..... Yrs..... mos. ..... ds.
Contributory (Secondary) .....
.....(Duration) ..... Yrs..... mos. ..... ds.
(Signed) William C. Doebb Coroner
7-18" 1921 (Address) Salmon Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Lemhi Idaho — DATE OF BURIAL: 7-18" 1921

20. UNDERTAKER: William C Doebb — ADDRESS: Salmon Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

V. S. No. 3 7M

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registrar's No. .....

Original Record for State Registrar

STANDARD CERTIFICATE OF DEATH

STATE OF ~~MONTANA~~ Idaho,

State File No. .....

Bureau of Vital Statistics

This Margin Reserved for Binding
WRITE PLAINLY WITH UNFADING INK

1. PLACE OF DEATH:
(a) County Lemhi
(b) City or town Rural.
(If outside city or town limits write Rural)
(c) Name of hospital or institution:
(If not in hospital or institution write street number or location)
(d) Length of stay: In hospital or institution ..... (Specify whether
In this community ..... years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Idaho (b) County Lemhi
(c) City or town Rural.
(If outside city or town limits write Rural)
(d) Street No. .....
(If rural give location)
(e) If foreign born, how long in U. S. A.? ..... years

3 (a) FULL NAME Edward Dean Wolfe

3 (b) If veteran, name war —

3 (c) Social Security No. —

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced Married

6 (b) Name of husband or wife Margaret E. Wolfe,

6 (c) Age of husband or wife if alive 85 years

7. Birth date of deceased ..... (Month) (Day) (Year) 1853

8. AGE: Years	Months	Days	If less than one day
68			..... hr. ..... min.

9. Birthplace Streator Ill
(City, town or county) (State or foreign country)

10. Usual occupation Rancher

11. Industry or business .....

Mother / Father

12. Name not known
13. Birthplace " "
(City, town or county) (State or foreign country)
14. Maiden name not known
15. Birthplace " "
(City, town or county) (State or foreign country)

16 (a) Informant's own signature Mamie E Wolfe
(b) Address Dell Mont

17 (a) Burial (b) Date thereof July 1921
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Dillon Mont

18 (a) Signature of funeral director Wm C Knobler
(b) Address Salmon Ida

19 (a) ..... (b) .....
(Date rec'd. local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. Date of death: Month July day 14
year 1921 hour ..... minute .....

21. I hereby certify that I attended the deceased from ..... 19..... to ..... 19.....; that I last saw h..... alive on ..... 19.....; and that death occurred on the date and hour stated above.

	DURATION
Immediate cause of death Heart attack	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) .....
(b) Date of occurrence .....
(c) Where did injury occur? ..... (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? .....
(Specify type of place)
While at work? ..... (e) Means of injury Corona

23. Signature W C Knobler (M. D. or other)
Address Salmon Ida Date signed .....

THE UNITED PUBLISHERS, HAVRE, MONTANA.

FORM V. S. No. 5-12 M. 6-15-17.

34892

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. .....
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

Registration District No. 41
Primary Registration District No. 2116

RECEIVED
AUG 15 1921
BUREAU OF VITAL STATISTICS
STATE OF IDAHO

1. PLACE OF DEATH
County of Lemhi
City of Salmon
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Chandler

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: (Month) Not known (Day) ..... (Year) .....

7. AGE: about 75 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many .... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: County Charge
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Not known

10. NAME OF FATHER: " "

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) William C Doebler
(Address) Salmon Idaho

15. Filed 8/10 ..... 191.... Chas Bellows
Local Registrar.
deputy

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July 17th (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..... to ..... 191...
that I last saw h.....alive on ..... 191....
and that death occurred on the date stated above, at .....M.
The CAUSE OF DEATH* was as follows:
..... Natural
Causes Due to Valvular heart
trouble
.....
.....(Duration) ..... Yrs..... mos. ..... ds.
Contributory (Secondary) .....
.....(Duration) ..... Yrs..... mos. ..... ds.
(Signed) William C Doebler Coroner D.
7-18" 1921 (Address) Salmon Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the State....yrs.....mos....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Johnson Cemetery
DATE OF BURIAL: 7-18" 1921
20. UNDERTAKER: Wm C Doebler
ADDRESS: Salmon Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

RECEIVED
AUG 15 1921
BUREAU OF VITAL STATISTICS
STATE OF IDAHO

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 41
Primary Registration District No. 2116
File No. 34894
Registered No.

1. PLACE OF DEATH.
County of Lemhi
City of Salmon Ida (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Daniel McInerny

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH Not Known (Month) 1 (Day) (Year)

7. AGE 62 about yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Quartz Miner
(b) General nature of industry business, or dstablishment in which employed (or employer) "

9. BIRTHPLACE (State or Country) Not Known

10. NAME OF FATHER " "

11. BIRTHPLACE OF FATHER (State or Country) " "

12. MAIDEN NAME OF MOTHER " "

13. BIRTHPLACE OF MOTHER (State or Country) " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) William C. Doebler
(Address) Salmon Ida

15.
Filed 8/10- 191 21 Chas Bellamy Deputy Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Aug (Month) 7th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 7 1921, to Aug 8 1921, that I last saw h in alive on Aug 8 1921 and that death occurred on the date stated above, at 7P M.

The CAUSE OF DEATH* was as follows:
Apoplexy
12 hours
(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas F. Hammel M. D.
8/9 1921 (Address) Salmon

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Salmon Cemetery	8-9 191
20. UNDERTAKER	ADDRESS
W. C. Doebler	Salmon Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34895

Registration District No. 49
Primary Registration District No. 2428

RECEIVED
AUG 13 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH.
County of Kootenai
City of Kamiah
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ransom J Badger

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. Nov (Month) 14 (Day) 1850 (Year)

7. AGE: 70 Yrs. 8 Mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: — McKinley

11. BIRTHPLACE OF FATHER (State or Country): Don't Know

12. MAIDEN NAME OF MOTHER: Caroline Adams

13. BIRTHPLACE OF MOTHER (State or Country): Don't Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Jennie M Baldwin
(Address) Kamiah Idaho

15. Filed 7/29 1921
C J Johnson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 29 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 23 1921, to Cherrial 191..., that I last saw her alive on July 29 1921, and that death occured on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
(Duration) ..... Yrs. ..... mos. 7 ds.
Contributory (Secondary) Myocardial Insufficiency
(Duration) 7 yrs. ..... mos. ..... ds.
(Signed) C. J. Bryan M. D.
7/29 1921 (Address) Kamiah

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Clarkston Wash. DATE OF BURIAL: 7/31 1921

20. UNDERTAKER: C J Johnson ADDRESS: Kamiah Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34896
Registered No. .....

1. PLACE OF DEATH.

County of Lewis
City of Kamiah
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elizabeth Cabell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

RECEIVED
AUG 6 1921
BUREAU OF VITAL STATISTICS

Registration District No. .....
Primary Registration District No. .....

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. July (Month) 13 (Day) 1848 (Year)

7. AGE: 72 Yrs. 11 Mos. 29 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House-keeper
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: John McClane

11. BIRTHPLACE OF FATHER (State or Country): Don't know

12. MAIDEN NAME OF MOTHER: Susan Armstrong

13. BIRTHPLACE OF MOTHER (State or Country): Don't know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Ruby Mosher
(Address) Kooskia Idaho.

15. Filed 8/13 1921
J J Johnson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
July (Month) 12 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 1921, to June 1921, that I last saw her alive on July 12th 1921, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Cancer of Stomach

(Duration) Yrs. 7 mos. 7 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C H Bruyere M. D.
7/15 1921 (Address) Kooskia

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Willow Hill Cem, Idaho Co Ida — DATE OF BURIAL: 7/14 1921

20. UNDERTAKER: C J Johnson — ADDRESS: Kamiah Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34897

Registered No. 12

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Lincoln

City of Shoshone

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No. ..... St.)

2. FULL NAME Ellen Jane Orr

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. July 12 1879 (Month) (Day) (Year)

7. AGE: 42 Yrs. ____ Mos. 8 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Wife

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: William Dice

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Anna Mary Walgamott

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant): L. H. Dell

(Address): Shoshone Ida

15. Filed July 21 1917

J. L. Turner
Local Registrar

SYMS-YORK CO., PTG. & STNS. 24853

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 20 (Day) 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 10 1917, to July 20 1917, that I last saw h[illegible] alive on July 20 1917, and that death occured on the date stated above, at 11 20 M.

The CAUSE OF DEATH* was as follows:

An encephalitis
from Amebic infection.

(Duration) Yrs. 3 mos. ..... ds.

Contributory (Secondary): Not Given

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) L. H. Dell M. D.

7/21 1917 (Address) Shoshone Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos 30 days. In the State ..... yrs ..... mos 30 days

Where was disease contracted if not at place of death? Echo Nevada

Former or usual residence: Echo Nevada

19. PLACE OF BURIAL OR REMOVAL: Shoshone Ida — DATE OF BURIAL ..... 191...

20. UNDERTAKER: O. J. Brannan — ADDRESS: Shoshone

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

RECEIVED AUG 6 19[illegible] BUREAU OF VITAL STATISTICS

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34898

Registered No. 56

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No. 100

Primary Registration District No. 2178

County of Madison

City of Sugar (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary V. Cook

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F	W	Married

6. DATE OF BIRTH: April (Month) 29 (Day) 1846 (Year)

7. AGE: 75 yrs. 7 mos. 4 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Pensylvania

10. NAME OF FATHER: Henry O. Donell

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Dilla [illegible]

13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W F Cook
(Address) Sugar

15. Filed 7/4 1921 G G Gage Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: July (Month) 3 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1st 1921 to July 3 1921 that I last saw h[illegible] alive on July 2nd 1921 and that death occurred on the date stated above, at 7.30 a. M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ..... yrs. ..... mos. 3 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F. B. Evans M. D.

7-5 1921 (Address) Sugar City, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Sugar | DATE OF BURIAL: 7/6 1921

20. UNDERTAKER: J Rigney | ADDRESS: Rigby

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

RECEIVED
AUG 6 1921
BUREAU OF VITAL STATISTICS

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 100
Primary Registration District No. 2178
File No. 34899
Registered No. 57.

1. PLACE OF DEATH.
County of Madison
City of Rigby
(No. ....., ...)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary J. Neville

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Aug (Month) 2 (Day) 1872 (Year)

7. AGE: 48 yrs. 11 mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Thomas Whitehead

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Mary J. Woodcock

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Joseph E. Neville
(Address): R F D 3

15.
Filed 7/6 1921
G G Estes
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: July (Month) 5 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 25 1921, to July 5 1921, that I last saw her alive on July 5 1921, and that death occurred on the date stated above, at 11 55 A.M.

The CAUSE OF DEATH* was as follows:
Diabetes Mellitus

(Duration) few yrs. mos. ds.
Contributory (Secondary) Diabetic Coma
(Duration) yrs. mos. ds.

7/6/1921 (Signed) Lorin A. Rich M. D.
(Address) Rexburg Idaho,

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Burton | DATE OF BURIAL: ..... 191..

20. UNDERTAKER: Rigby | ADDRESS: Rigby

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

RECEIVED AUG 6 1921 BUREAU OF VITAL STATISTICS

34900

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 100

Primary Registration District No. 2178

File No.

County of Madisom

City of Rexburg. (No. ....., ... St.)

Registered No. 58

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Edwin. W. Buttler.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.): Married

6. DATE OF BIRTH: April (Month) 25 (Day) 1868 (Year)

7. AGE: 53 yrs. 2 mos. 3 ds.

IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Edwin Buttler.

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Louise Buttler

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Buttler (E. W.)
(Address) Thornton

15. Filed 6/29 1921 G. E. Egbert Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June (Month) 28 (Day) 1921. (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1919, to June 28th 1921, that I last saw him alive on May 1921 and that death occurred on the date stated above, at 1a M.

The CAUSE OF DEATH* was as follows:
Carcinoma of Face

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) 8 yrs. ..... mos. ..... ds.

(Signed) Parley Nelson M. D.

June 29, 1921 (Address) Rexburg Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Archer

DATE OF BURIAL: 6/30/21 191

20. UNDERTAKER: J. R. Young

ADDRESS: Rexburg

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-19.

34901

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
AUG 6 - 1921
BUREAU OF VITAL STATISTICS

Registration District No. 6
Primary Registration District No. 6
File No. 7
Registered No. 39

1. PLACE OF DEATH
County of Fremont
City of Ashton
(No.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Albert Lowell Ellsworth

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widower

6. DATE OF BIRTH: Sept (Month) 21 (Day) 1856 (Year)

7. AGE: 63 Yrs. 9 Mos. 21 ds.
IF LESS than 1 day how many..... hrs. or.....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Edmund Ellsworth

11. BIRTHPLACE OF FATHER (State or Country): Vermont

12. MAIDEN NAME OF MOTHER: Mary Ann Dudley

13. BIRTHPLACE OF MOTHER (State or Country): Vermont

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Emma Smyth
(Address) Rexburg Idaho

15. Filed 7/10 1921

E G Peake
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 6 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from did not 19 see deceased 19, that I last saw him alive on death 19, and that death occurred on the date stated above, at .....M.

The CAUSE OF DEATH* was as follows:

Heart trouble

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Heart trouble

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A G Meacham M. D.

7-6 1921 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rexburg Ida. — DATE OF BURIAL: 7-8 1921

20. UNDERTAKER: David Young — ADDRESS: Rexburg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY; PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34902
Registered No. 60

RECEIVED
1921 AUG 6
BUREAU OF VITAL STATISTICS

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of MADISON.
City of REXBURG
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 100
Primary Registration District No. 2178
(No. ....., ...)

2. FULL NAME GEORGE HENRY STATHAM

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: MARRIED (Write the word.)

6. DATE OF BIRTH: NOVEMBER 6st (Month) 1 (Day) 1855 (Year)

7. AGE: 65 Yrs. 8 Mos. 12 ds.
IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: FARMER.
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE: ENGLAND (State or Country)

10. NAME OF FATHER: SAMUEL STATHAM

11. BIRTHPLACE OF FATHER: ENGLAND (State or Country)

12. MAIDEN NAME OF MOTHER: MARY WILLIAMS.

13. BIRTHPLACE OF MOTHER: ENGLAND (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Fred R Statham
(Address) Thornton

15. Filed 7/20 1921 — G H Cope, Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July 18 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug- 1917 to April 1921
that I last saw him alive on July 16- 1921
and that death occurred on the date stated above, at 2: P. M.
The CAUSE OF DEATH* was as follows:
Acute Dilatation of Heart
(Duration) Yrs. mos. 1 ds.
Contributory (Secondary) Arterio-sclerosis
(Duration) few Yrs. mos. ds.
(Signed) Lorin F Rich M. D.
7/20 1921 (Address) Rexburg Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rex Cemetery — DATE OF BURIAL: 7-21- 1921

20. UNDERTAKER: [illegible] — ADDRESS: Rexburg

Form V. S. No. 5 20M.1-16-12

Cafe.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34903

RECEIVED
AUG 6 1921
BUREAU OF VITAL STATISTICS

Registration District No. 100
Primary Registration District No. 2178
Registered No. 61

1. PLACE OF DEATH.
County of Madison
City of Sugar
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Masawo Aizawa

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: Japanese
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH: Feb (Month) 17 (Day) 1921 (Year)

7. AGE: ..... yrs. 5 mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Shinji Aizawa

11. BIRTHPLACE OF FATHER (State or Country) Japan

12. MAIDEN NAME OF MOTHER Tomiwo Fujimoto

13. BIRTHPLACE OF MOTHER (State or Country) Japan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Kyunojio Satow
(Address) Rexburg

15. Filed 7/18 1921 G. H. Espe
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 7 (Month) 18 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 7/17 1921, to 7/18 1921, that I last saw h[illegible] alive on 7/17 1921, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Acute Intestinal Obstruction

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G. H. Espe M. D.

19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rexburg — DATE OF BURIAL: 7/19 1921

20. UNDERTAKER: John R Phillips — ADDRESS: Rexburg

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & SDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

M.

RECEIVED AUG 6 1921 BUREAU OF VITAL STATISTICS

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 100

Primary Registration District No. 2178

(No. ....., ...)

Registered No. 34904

County of Madison

City of Rexburg

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jane Bitton Poole

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): widowed

6. DATE OF BIRTH. Sept (Month) 3 (Day) 1836 (Year)

7. AGE: 84 Yrs. 8 Mos. 20 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: William Bitton

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Jane Evington

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C.W. Poole

(Address) Rexburg

15. Filed 7/25 1921 G.L. Espe Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24854

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 23 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 21 1921, to July 23 1921, that I last saw h[illegible] alive on July 21 1921, and that death occured on the date stated above, at 11.50 P.M.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) ..... Yrs. ..... mos. 3 ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) O.C. Martin M. D.

July 23 1921 (Address) Rexburg, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Menan, Ida. DATE OF BURIAL: 7-26 1921

20. UNDERTAKER: David Young ADDRESS: Rexburg.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 100

Primary Registration District No. 2178

RECEIVED AUG 6 1921 BUREAU OF VITAL STATISTICS

File No. 34905

Registered No. 63

County of Madison

City of Sugar

(No. ....., ...)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Joseph Smith Ingram

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH.

August (Month) 16 (Day) 1846 (Year)

7. AGE

74 Yrs. 11 Mos. 0 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION

(a) Trade, profession or particular kind of work... Farmer

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country) England

10. NAME OF FATHER

Edward Ingram

11. BIRTHPLACE OF FATHER

(State or Country) England

12. MAIDEN NAME OF MOTHER

Ann Smith

13. BIRTHPLACE OF MOTHER

(State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Melissa Ingram

(Address) Sugar City, Ida.

15. Filed 7/17 1921

G B Espe
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July (Month) 16th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 7th 1921, to July 15 1921, that I last saw h alive on July 15th 1921, and that death occured on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Cirhosis of Liver

(Duration) 1 Yrs. 2 mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) F B. Wauer M. D.

19 ..... (Address) Sugar City

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Sugar City	7-18 1921
20. UNDERTAKER	ADDRESS
David Young	Rexburg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SVMB - YORK CO., PTRS. & SONS. 24854

FORM V. S. No. 5-12 M. 6-15-17.

Dr Evans

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. .....
Registered No. 64
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

Registration District No. 100
Primary Registration District No. 2178 3496
(No. ....., ... St.)

RECEIVED
DEC 6 1921

1. PLACE OF DEATH
County of Madison
City of Sugar
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Juanita Cortez

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: Mexican

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1888 (Year)

7. AGE: 33 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many .... hrs. or ..... min.?'

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Mexico

10. NAME OF FATHER: Mr Perez

11. BIRTHPLACE OF FATHER (State or Country): Mexico

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): Mexico

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Cortez
(Address) Sugar

15. Filed 7/30 1921 G. H. Cooper Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 29 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191.... to ..... 191..
that I last saw h.....alive on ..... 191....
and that death occurred on the date stated above, at ....., ...M.

The CAUSE OF DEATH* was as follows:

Puerperal Sepsis

(Duration) ..... Yrs. 1 mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) F. B. Evans M. D.
8-2 1921. (Address) Sugar Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the ,State....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Sugar — DATE OF BURIAL: 7/30 1921

20. UNDERTAKER: J Lyons — ADDRESS: Rigby

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

34907

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
AUG 6 1921
BUREAU OF VITAL STATISTICS

File No. .....
Registered No. 65

1. PLACE OF DEATH
County of Madison
City of Rexburg
If death occurs away from usual residence, give facts called for under special information.

Registration District No. .....
Primary Registration District No. .....
(No. .....)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Dellis E. Beattie

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M.	W	Bale

6. DATE OF BIRTH. July 27 (Month) (Day) 1921 (Year)

7. AGE ..... Yrs. ..... Mos. 5 ds.
IF LESS than 1 day how many .... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Still Born
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Rexburg

10. NAME OF FATHER Earl Beattie

11. BIRTHPLACE OF FATHER (State or Country) Rexburg

12. MAIDEN NAME OF MOTHER Susan Munns

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Earl Beattie
(Address) .....

15. Filed 8/2 1921 Geo Epps
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 31st 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 27 1921 to August 1st 1921 that I last saw h-im alive on July 31st 1921 and that death occurred on the date stated above, at Noon M.

The CAUSE OF DEATH* was as follows:

Prematurity

(Duration) ..... Yrs. ..... mos. 4 ds.

Contributory (Secondary) .....

(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) H. B. Ware M. D.

8-2 1921 (Address) Teton City

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Burton — DATE OF BURIAL 8/2 1921

20. UNDERTAKER O'Leary — ADDRESS Rexburg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34908

Registered No. 66

1. PLACE OF DEATH.

County of Madison

City of Rexburg

If death occurs away from usual residence, give facts called for under special information.

Registration District No.....

Primary Registration District No.....

(No. ....., ...)

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AUG 6 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME John Eckersoll

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. January (Month) 1st (Day) 1921 (Year)

7. AGE: ---Yrs. 7 Mos. --ds.

IF LESS than 1 day how many.....hrs. or .....min.)

8. OCCUPATION

(a) Trade, profession or particular kind of work: (Child)

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: John Eckersoll

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Marjorie Holbert

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Eckersoll

(Address) Rexburg, Idaho

15. Filed 8/2 1921

J. L. Eskelsen
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 31 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 30 1921, to July 31 1921, that I last saw h/M alive on July 31 1921, and that death occured on the date stated above, at 9 PM M.

The CAUSE OF DEATH* was as follows:

Convulsions

Epileptiform (Bilateral)

(Duration) Yrs. mos. 1 ds.

Contributory (Secondary)

(Duration yrs. mos. ds.

(Signed) Lorin L. Rich M. D.

8/2 1921 (Address) Rexburg Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
REXBURG IDAHO	8-2 1921

20. UNDERTAKER	ADDRESS
David Young	Rexburg Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & ENGS. 24654

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 19
Primary Registration District No. 2015
File No. 34909
Registered No. 30

1. **PLACE OF DEATH**
County of Minidoka
City of Rupert
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. **FULL NAME** Anna M. Hadley
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

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BUREAU OF VITAL STATISTICS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. **SEX** F
4. **COLOR OR RACE** White
5. **SINGLE, MARRIED, WIDOWED OR DIVORCED** Married
(Write the word.)

6. **DATE OF BIRTH** Dec 2 1849
(Month) (Day) (Year)

7. **AGE** 30 Yrs. 6 Mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. **OCCUPATION**
(a) Trade, profession or particular kind of work House Wife
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. **BIRTHPLACE** (State or Country) Ireland

10. **NAME OF FATHER** Thomas J. Blackmore

11. **BIRTHPLACE OF FATHER** (State or Country) Ireland

12. **MAIDEN NAME OF MOTHER** Mary J. Jourdan

13. **BIRTHPLACE OF MOTHER** (State or Country) Ireland

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**
(Informant) Mary J. Blackmore
(Address) Deer Lodge Montana

15. Filed July 29 1921 E. O. Elmore Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH** June (Month) 7 (Day) 1921 (Year)

17. **I HEREBY CERTIFY**, That I attended deceased from May 1" 1921, to June 7 1921, that I last saw her alive on June 7 1921, and that death occurred on the date stated above, at 1.55 M.

The **CAUSE OF DEATH*** was as follows;

Mitral Insufficiency and Puerperal Septicemia

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Chronic Salpingitis

..... (Duration) 9 yrs. ..... mos. ..... ds.

(Signed) E. O. Elmore M. D.

7-29-1921 (Address) Rupert, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. **PLACE OF BURIAL OR REMOVAL** Catholic Cemetery — **DATE OF BURIAL** June 10 1921

20. **UNDERTAKER** W. G. Goodman — **ADDRESS** Rupert Idaho

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

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JUL 14 1923
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34910

Registered No.

1. PLACE OF DEATH

County of Nez Perce

City of Peck

(No. ..... St.)

Registration District No. .....

Primary Registration District No. 2371

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME W H Steele

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Widowed

6. DATE OF BIRTH: July (Month) 3 (Day) 1848 (Year)

7. AGE: 72 Yrs. 11 Mos. 9 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: Eli Hugh Trimble

11. BIRTHPLACE OF FATHER (State or Country): Kentucky

12. MAIDEN NAME OF MOTHER: P Baker

13. BIRTHPLACE OF MOTHER (State or Country): Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W H Steele
(Address) Peck Ida.

15. Filed 6/13 1921 Dan Lyle
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 12 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from September 1920, to June 12 1921
that I last saw her alive on June 12 1921
and that death occurred on the date stated above, at 9.30 P.M.
The CAUSE OF DEATH* was as follows:
Chronic valvular heart disease

(Duration) ? Yrs. ? mos. ? ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Jas. A Wood Gore M. D.
6/12 1921 (Address) Pierce, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Angel Ridge — DATE OF BURIAL: June 14 1921

20. UNDERTAKER Stoddard — ADDRESS Kiffford

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

Registration District No. 128

Primary Registration District No.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34911

Registered No.

1. PLACE OF DEATH

County of Nez Perce

City of Culdesac Ida

(No. Culdesac Prairie St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William Stephen Shoemaker

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: March (Month) 12 (Day) 1915 (Year)

7. AGE: 6 Yrs. 4 Mos. 22 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Washington

10. NAME OF FATHER: Samuel S. Shoemaker

11. BIRTHPLACE OF FATHER (State or Country): Washington

12. MAIDEN NAME OF MOTHER: Bertha Scott

13. BIRTHPLACE OF MOTHER (State or Country): Minnesota

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Samuel S. Shoemaker

(Address) Culdesac Ida

15. Filed July 19 21 George Gaignard Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 28 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 25 1921 to July 28 1921

that I last saw him alive on July 28 1921

and that death occurred on the date stated above, at 7.55 P.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ..... Yrs. ..... mos. 7 ds.

Contributory (Secondary)

(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) George Gaignard M. D.

7/29/1921 (Address) Culdesac Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Clarkston Wash. DATE OF BURIAL: July 30 1921

20. UNDERTAKER: Hooper Gormly H. R. Merchant ADDRESS: Lewiston Clarkston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

34912

State of Idaho
BOARD of HEALTH
Bureau of Vital Statistics

File No. 5

Registered No. 27

RECEIVED
AUG 5 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH. Registration District No. 92
Primary Registration District No. 2170
County of Nez Perce
City of Gifford (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lawrence Hawley

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. Sept (Month) 7 (Day) 1864 (Year)

7. AGE: 56 Yrs. 10 Mos. 11 ds. IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Oregon

10. NAME OF FATHER: Nyran Hawley

11. BIRTHPLACE OF FATHER (State or Country): Ill

12. MAIDEN NAME OF MOTHER: Arminta —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant): Mrs L Hawley
(Address): Gifford

15. Filed 7-18 1921 E E Watts, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 18 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from — 191—, to — 191—, that I last saw him alive on 7-18 1921, and that death occured on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:
Apoplexy
(Duration) — Yrs. — mos. 15 min ds.
Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) E. E. Watts M. D.
7-18 1921 (Address) Gifford Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston Ida
DATE OF BURIAL ..... 191...

20. UNDERTAKER: Vassar and Co
ADDRESS: Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

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SYMS - YORK CO., PTRS. & BOKS. 24653

Form V. S. No. 5 20M.1-16-12

RECEIVED JUL 15 1921 BUREAU OF VIT STATIST

CERTIFICATE OF DEATH

34915

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 97

County of Nez Perce

Primary Registration District No. 2174

File No. 3

City of Lapwai (No. ....., ... St.)

Registered No. 3

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William Siegrist

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (If married, widowed or divorced, write the word.): Married

6. DATE OF BIRTH: Jan. (Month) 16th (Day) 1860 (Year)

7. AGE: 61 yrs. 4 mos. 29 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Flour miller
(b) General nature of industry business, or dstablishment in which employed (or employer): Flour mill

9. BIRTHPLACE (State or Country): Columbia Co. Wis.

10. NAME OF FATHER: Henry Siegrist

11. BIRTHPLACE OF FATHER (State or Country): Switzerland

12. MAIDEN NAME OF MOTHER: Not remembered

13. BIRTHPLACE OF MOTHER (State or Country): Switzerland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Sanford Siegrist
(Address) Lapwai, Idaho.

15.
Filed June 15 1921
L.D. Riggs
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June (Month) 14th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 14 1921, to June 14 1921, that I last saw h..... alive on ..... 191..., and that death occurred on the date stated above, at 8:3a A.M.

The CAUSE OF DEATH* was as follows:

Coronary thrombosis heart disease

(Duration) Sudd yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) L.D. Riggs M. D.

6/15 1921 (Address) Lapwai Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Lewiston Ida — DATE OF BURIAL: June 16 1921

20. UNDERTAKER: L.B. Wann — ADDRESS: Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED
AUG 5 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34916
Registered No. 662

1. PLACE OF DEATH
County of Nez Perce — Registration District No. 96
City of Lewiston — (No. ..... St.) — Registration District No. 1009
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Joyner

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1 (Year)

7. AGE: 37 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer Farm
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Texas

10. NAME OF FATHER: Not Known

11. BIRTHPLACE OF FATHER (State or Country): Not Known

12. MAIDEN NAME OF MOTHER: Not Known

13. BIRTHPLACE OF MOTHER (State or Country): - -

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A. L. Bruce
(Address) Genesee Ida.

15. Filed July 31 1921 — Dean E. Bruce, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 3rd (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 3 1921 to June 3 1921 that I last saw h.[illegible] alive on June 3 1921 and that death occurred on the date stated above, at 9:35 P.M.

The CAUSE OF DEATH* was as follows:
Acute endo & myo Ca[illegible]
Hypostatic C[illegible]
& Chronic Nephritis
..... (Duration) ..... Yrs. 2 mos. ..... ds.
Contributory (Secondary) June
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Edgar L. White M.D.
June 4 1921 (Address) Lewiston Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Genesee, Idaho — DATE OF BURIAL ..... 19.....

20. UNDERTAKER: VASSAR UNDERTAKING CO. — ADDRESS Lewiston, Idaho

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 24917

Registered No. 663

RECEIVED
AUG 5 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Nez Perce

City of Lewiston (No. ..... St.)

Registration District No. 96

Primary Registration District No. 1009

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James W. Akers

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widower

6. DATE OF BIRTH: July (Month) 6 (Day) 1859 (Year)

7. AGE: 61 Yrs. 11 Mos. 3 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Engineer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ill.

10. NAME OF FATHER: [illegible]

11. BIRTHPLACE OF FATHER (State or Country): Ill

12. MAIDEN NAME OF MOTHER: Sampson

13. BIRTHPLACE OF MOTHER (State or Country): Ill

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Florence Akers

(Address) .....

15. Filed July 31 1921 Susan E Bruce Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 9th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1st 1921, to June 8 1921, that I last saw h[illegible] alive on June 8 1921, and that death occurred on the date stated above, at 7 A.M.

The CAUSE OF DEATH* was as follows:

Shock

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Acute diffused gastritis

..... (Duration) ..... yrs. 6 mos. ..... ds.

(Signed) L.D. Perkins M. D.

6/10 1921. (Address) Lewiston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston — DATE OF BURIAL: June 11 1921

20. UNDERTAKER: [illegible] UNDERTAKING CO — ADDRESS: Lewiston Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-A—25 M. 1-19.

White

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34918

Registered No. 664

RECEIVED AUG 5 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 96

Primary Registration District No. 1009

County of Nez Perce

City of Lewiston (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ada Summers

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Married

6. DATE OF BIRTH: Oct (Month) 23 (Day) 1895 (Year)

7. AGE: 25 Yrs. 7 Mos. 16 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): W. Va

10. NAME OF FATHER: W. Va. Chas. Long

11. BIRTHPLACE OF FATHER (State or Country): W. Va.

12. MAIDEN NAME OF MOTHER: Virginia Teaters

13. BIRTHPLACE OF MOTHER (State or Country): W. Va

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. C. W. O'Bryan.
(Address) 2721 Main St City

15. Filed July 31 1921 Susan E. Bruce Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 9 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 4 1921, to June 9 1921, that I last saw h..... alive on ..... 19....., and that death occurred on the date stated above, at 11 a. M.

The CAUSE OF DEATH* was as follows: General Peritonitis following Operation for suppurating Cystic Ovary

(Duration) 1 Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. J. Clark M. D.

June 9 1921. (Address) Lewiston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Greer Ida.	6/10 1921

20. UNDERTAKER: WASSAR UNDERTAKING CO. ADDRESS: Lewiston, Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

RECEIVED
AUG 5 1921
BUREAU OF VITAL STATISTICS

Registration District No. 96
Primary Registration District No. 1002
File No. 34919
Registered No. 665

County of Nez Perce
City of Lewiston (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of the street and number.

2. FULL NAME Sister Mary Alphonsus Vanderpool

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: May 3 1903
~~June 11 1921~~ (Month) (Day) (Year)

7. AGE: 18 Yrs. — Mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Catholic Nun
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kentucky

10. NAME OF FATHER: George Vanderpool

11. BIRTHPLACE OF FATHER (State or Country): Kentucky

12. MAIDEN NAME OF MOTHER: Margaret Lowe

13. BIRTHPLACE OF MOTHER (State or Country): Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mother M. Adelaide
(Address) St Joseph's Hosp. Lewiston

15. Filed July 31 1921 Susan E Bruce Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 6 (Month) 11 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1-2 1921, to 6-11 1921
that I last saw h.e.v. alive on 6 11 1921,
and that death occurred on the date stated above, at 10:15 M.
The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis
..... (Duration) ..... Yrs. 4 mos. ..... ds.
Contributory (Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) E G Bradbrook M. D.
6/13 1921 (Address) Lewiston, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: City Cemetery — DATE OF BURIAL: 6/13 1921

20. UNDERTAKER — ADDRESS: Lewiston Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED AUG 3 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Alley

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 34921
Registered No. 667

1. PLACE OF DEATH
County of Nez Perce
City of Lewiston (St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

FULL NAME Edith C. Dickson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	Indian	Married

6. DATE OF BIRTH: Sept — 1886 (Month) (Day) (Year)

7. AGE: 34 Yrs. Mos. ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Silas Corbett

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Ellen

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) James G. Dickson
(Address) Stites, Idaho.

15. Filed July 31 1921 Susan E. Bruce Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 21 20 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 15 1921, to June 21 1921 that I last saw h[illegible] alive on June 21 1921, and that death occurred on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:

Nephritis

(Duration) Yrs. 5 mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) John H. Alley M. D.

6-24-1921 (Address) Lewiston

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Moscow, Idaho | DATE OF BURIAL 19

20. UNDERTAKER: [illegible] UNDERTAKING CO. | ADDRESS Lewiston, Id

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34922

Registered No. 668

1. PLACE OF DEATH

County of Nez Perce

City of Lewiston (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
AUG 5 1921
BUREAU OF VITAL STATISTICS

Registration District No. 96

Primary Registration District No. 1009

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lawrence Gastaw Galtz

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Male	White	~~(Write word.)~~

6. DATE OF BIRTH: ~~Nov~~ Oct 13 1920
(Month) (Day) (Year)

7. AGE: ~~Yrs.~~ 8 Mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ida.

10. NAME OF FATHER: A. G. Galtz

11. BIRTHPLACE OF FATHER (State or Country): Wash

12. MAIDEN NAME OF MOTHER: Ollie Oakes

13. BIRTHPLACE OF MOTHER (State or Country): Wash.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A G Galtz
(Address) 1228 18th St.

15. Filed July 31 1921 Susan E Bruce
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 15 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 14 1921, to June 15 1921
that I last saw h~~is~~er alive on June 6 1921,
and that death occurred on the date stated above, at 8 P M.

The CAUSE OF DEATH* was as follows:
Intussception, Gangrene
(Duration) ..... Yrs. ..... mos. 1 ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W D Clark M. D.
June 15 1921 (Address) Lewiston Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Lewiston Ida.	6/17 1921
20. UNDERTAKER	ADDRESS Lewiston Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Nez Perce

City of Lewiston

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 96

Primary Registration District No. 1009

No. 34923

Registered No. 669

RECEIVED AUG 6 BUREAU OF VITAL STATISTICS

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Herman Hammond

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH ..... (Month) ..... (Day) 1 (Year)

7. AGE 59 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business or establishment in which employed (or employer) Common

9. BIRTHPLACE (State or Country) Unknown

10. NAME OF FATHER "

11. BIRTHPLACE OF FATHER (State or Country) "

12. MAIDEN NAME OF MOTHER "

13. BIRTHPLACE OF MOTHER (State or Country) "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ewe Brower

(Address) Lewiston Ida

15. Filed Aug 3 1921 Susan E. Brue Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH ..... 7 (Month) ..... 1 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 5 1921, to July 1 1921 that I last saw h alive on July 1 1921 and that death occurred on the date stated above, at 10:30 P.M.

The CAUSE OF DEATH* was as follows:

Aortic Regurgitation

(Duration) 1 Yrs. ..... mos. ..... ds.

Contributory (Secondary) Unknown

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John H Alley M. D.

7-2- 1921 (Address) Lewiston Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Farmington Wash	Aug 3 1921

20. UNDERTAKER WASSAR UNDERTAKING CO ADDRESS Lewiston Idaho

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

34924

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
AUG 6 1921
BUREAU OF VITAL STATISTICS

Registration District No. 96
Primary Registration District No. 1009
(No. ..... St.)

File No. 574

1. PLACE OF DEATH

County of Nez Perce
City of Lewiston

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Francis E. Millay

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH June 26 (Month) (Day) 1879 (Year)

7. AGE 42 Yrs. 5 Mos. 11 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Teacher

(b) General nature of industry, business or establishment in which employed (or employer): Normal School

9. BIRTHPLACE (State or Country) Mo.

10. NAME OF FATHER W. L. Millay

11. BIRTHPLACE OF FATHER (State or Country) Ill.

12. MAIDEN NAME OF MOTHER Mary E. Kearns

13. BIRTHPLACE OF MOTHER (State or Country) Del.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Emil Bowers

(Address) Lewiston Idaho

15. Filed July 8 & Aug 3 1921

Emma E Bruce
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 7 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 1920, to July 7 1921, that I last saw h.. alive on July 7 1921, and that death occurred on the date stated above, at 2:45 P.M.

The CAUSE OF DEATH* was as follows:

Sarcoma (Intra abdominal)

(Duration) ..... Yrs. 11 mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Paul W. Johnson M. D.

July 8 1921 (Address) Lewiston Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Chewelah Wn. | **DATE OF BURIAL** ..... 19.....

20. UNDERTAKER | **ADDRESS** Lewiston Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

A. K. Millay

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 34925
Registered No. 671

1. PLACE OF DEATH

County of Nez Perce
City of Lewiston
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Christene Peterson

If death occurred in a hospital, institution or camp, give NAME instead of street and number.

RECEIVED
AUG 6 1921
BUREAU OF VITAL STATISTICS

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Widow

6. DATE OF BIRTH

..... (Month) ..... (Day) 1..... (Year)

7. AGE

60 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country) Norway

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (State or Country) ,,

12. MAIDEN NAME OF MOTHER ,,

13. BIRTHPLACE OF MOTHER (State or Country) ,,

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ernest Brower

(Address) Lewiston Idaho

15. Filed July 8 — 1921 — By — Susan E Bruce, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

7 (Month) 8 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 7 1921, to July 7 1921, that I last saw h.. alive on July 7 1921, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows: Cerebral Hemorrhage

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John K Alley M. D.

..... 19.. (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Lewiston Cemetery — **DATE OF BURIAL** 7/9 1921

20. UNDERTAKER ..... **ADDRESS** Lewiston Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

Registration District No. 96 — 3492

Primary Registration District No. 1009

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. RECEIVED AUG 6 1921 VITAL

Registered No. 66

1. PLACE OF DEATH

County of Nez Perce

City of Lewiston

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Walter C. Kennedy

If death occurred in a hospital, institution or camp, give the NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Oct (Month) 24 (Day) 1882 (Year)

7. AGE: 38 Yrs. 8 Mos. 15 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Mechanic (Auto)

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wash.

10. NAME OF FATHER: L. A. Kennedy

11. BIRTHPLACE OF FATHER (State or Country): Pennsylvania

12. MAIDEN NAME OF MOTHER: Alice Dall

13. BIRTHPLACE OF MOTHER (State or Country): Georgia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Earl Brown

(Address) Lewiston Ida

15. Filed July 11th 1921 — Aug 3 - 21 — Susan E. Bruce, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 9th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 9 1921, to July 9 1921 that I last saw h.. alive on July 9 1921 and that death occurred on the date stated above, at 10 P M.

The CAUSE OF DEATH* was as follows:

Accidental Burns over entire surface of body from neck to wrists over both arms & hands (Duration) ..... Yrs. ..... mos. 1 ds.

Contributory (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Edward G Braddock M. D.

July 11 1921 (Address) Lewiston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston Cemetery — DATE OF BURIAL: 7/12 1921

20. UNDERTAKER — ADDRESS: Lewiston Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

34927

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
AUG 6 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Nez Perce

City of Lewiston

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 96

Primary Registration District No. 1009

(No. ..... St.)

Filed ..... Registered No. 1923

If death occurred in a hospital, institution or camp, state this instead of street and number.

2. FULL NAME James F. Atkinson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: May (Month) 24th (Day) 1912 (Year)

7. AGE: 9 Yrs. 1 Mos. 16 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: School Boy

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: John W. Atkinson

11. BIRTHPLACE OF FATHER (State or Country): Kans

12. MAIDEN NAME OF MOTHER: Missouri Webb

13. BIRTHPLACE OF MOTHER (State or Country): Tenn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. C A Tennerich

(Address) Moscow, Ida

15. Filed Aug 3 1921 Susan E Bruce Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 10 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 10 1921, to July 10 1921, that I last saw h. alive on July 10 1921, and that death occurred on the date stated above, at 9:30 P.M.

The CAUSE OF DEATH* was as follows:

Fracture base of Skull

(Automobile accident)

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W D Clark M. D.

July 10 1921 (Address) Lewiston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Gifford Ida

DATE OF BURIAL ..... 19.....

20. UNDERTAKER

ADDRESS Lewiston Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

34929

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
AUG 6 1921
BUREAU OF VITAL STATISTICS

Registration District No. 96
Primary Registration District No. 1009
File No. 1927
Registered No. 3

1. PLACE OF DEATH
County of Nez Perce
City of Lewiston
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lewis Vivian Knight
If death occurred in a hospital, institution or camp, state the NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6. DATE OF BIRTH: May 25 1905 (Month) (Day) (Year)

7. AGE: 16 Yrs. 1 Mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: William H. Knight

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Flora E. Culberson

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. H. Knight
(Address) Grangeville Idaho

15. Filed 7/15 1921
Aug 3. 21
Susan E. Bruce
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 15 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 7th 1921, to July 15 1921, that I last saw h.. alive on July 15 1921, and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Sub Phrenic Abscess
Appendicitis
(Duration) ..... Yrs. ..... mos. 14 ds.
Contributory (Secondary) Post O. Peritonitis
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) W. H. Squires M. D.
7/15 1921 (Address) Lewiston, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
[illegible] Idaho	July 19 21

20. UNDERTAKER: [illegible] UNDERTAKING CO. ADDRESS Lewiston, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 24830
Registered No. 1716
RECEIVED
AUG

1. PLACE OF DEATH
County of Nez Perce
City of Lewiston
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James Lambert
If death occurred in a hospital, institution, or camp, GIVE NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the Word.)

6. DATE OF BIRTH: April (Month) 5 (Day) 1848 (Year)

7. AGE: 73 Yrs. 3 Mos. 17 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer): Retired

9. BIRTHPLACE (State or Country): N. Y.

10. NAME OF FATHER: Peter Lambert

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Susan E Bruce
(Address) Lewiston Ida

15. Filed Aug 3 1921 Susan E Bruce
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 22nd (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 20, 1921, to July 22 1921
that I last saw h[illegible] alive on July 22 1921
and that death occurred on the date stated above, at 6 45 A.M.
The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis
Arteriosclerosis.
(Duration) Yrs. 2 mos. ds.
Contributory (Secondary) Chronic Interstitial Nephritis
(Duration) 2 yrs. mos. ds.

(Signed) E. L. White M. D.
July 25 1921 (Address) Lewiston Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston Cemetery | DATE OF BURIAL: July 24 1921

20. UNDERTAKER | ADDRESS: Lewiston Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

34931 Braddock.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No.
Registered No. 677

RECEIVED
AUG 6 1921
BUREAU OF VITAL STATISTICS
STATE OF IDAHO

1. PLACE OF DEATH

County of Nez Perce

City of Lewiston

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 96

Primary Registration District No. 1007

(No. ....., ... St.)

If death occurred in a hospital, institution or camp, GIVE NAME instead of street and number.

2. FULL NAME Susan Jane Neahr.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Widow

6. DATE OF BIRTH

..... (Month) ..... (Day) 1 (Year)

7. AGE

66 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): N. Y.

10. NAME OF FATHER: unknown.

11. BIRTHPLACE OF FATHER (State or Country): N. Y.

12. MAIDEN NAME OF MOTHER: unknown.

13. BIRTHPLACE OF MOTHER (State or Country): N. Y.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mary Blomquist

(Address) 1025 - 8th St.

15.

Filed Aug 3 1921 Susan E Burns Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 23rd (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1 1921, to July 23 1921, that I last saw h.er alive on July 23 1921, and that death occurred on the date stated above, at 6.45 P.M.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

..... (Duration) ..... Yrs. 6 mos. 23 ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E G Braddock M. D.

July 23 1921 (Address) Lewiston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Lewiston Ida

DATE OF BURIAL: 7/25 1921

20. UNDERTAKER

ADDRESS: Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

34932

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
AUG 6 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Nez Perce

City of Lewiston

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 9b

Primary Registration District No. 1009

(No. ..... St.)

File No. .....

Registered No. 678

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Wm B. Kiser

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH

Dec (Month) 1 (Day) 1898 (Year)

7. AGE

23 Yrs.) Mos. 23 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Barber

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) North Carolina

10. NAME OF FATHER Edwin Kiser

11. BIRTHPLACE OF FATHER (State or Country) ✓

12. MAIDEN NAME OF MOTHER ✓

13. BIRTHPLACE OF MOTHER (State or Country) ✓

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Cecelia Walzer

(Address) Wallace, Idaho

15.

Filed Aug 3 1921

Susan E. Bruce
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 24 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 24 1921, to July 24 1921, that I last saw h.. alive on July 24 1921, and that death occurred on the date stated above, at 12 30 P.M.

The CAUSE OF DEATH* was as follows:

Auto accident.
Crushed right Chest
Basil Skull fracture, shock

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) E. H. White M. D.

July 24 21 (Address) Lewiston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Kellogg Idaho	19

20. UNDERTAKER ..... ADDRESS Lewiston Id

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

34933

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. .....

Registered No. 5/5

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

RECEIVED
AUG 6 1921
BUREAU OF VITAL STATISTICS

Registration District No. 96

Primary Registration District No. .....

1. PLACE OF DEATH.

County of Nez Perce

City of Lewiston

(No. ....., St. Joseph Hospital, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Reuben Walter Reggeno

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Wht

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. July (Month) 23rd (Day) 1921 (Year)

7. AGE: ..... Yrs. ..... Mos. 7 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... none

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho St Joseph Hospital

10. NAME OF FATHER Carlisle Reggeno

11. BIRTHPLACE OF FATHER (State or Country) Germany

12. MAIDEN NAME OF MOTHER Elizabeth Ollendorf

13. BIRTHPLACE OF MOTHER (State or Country) Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) R. Reggeno

(Address) Lewiston Idaho

15. Filed 7/25 1921 Aug 3 - 1921 Susan E. Bruce Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 25 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 23rd 1921, to July 25 1921, that I last saw h[illegible] alive on July 25 1921, and that death occured on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:

Thrombosis

(Duration) ..... Yrs. ..... mos. 1 ds.

Contributory (Secondary) Pernicious Anemia

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. E. Cameron M. D.

19..... (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Gifford Ida — DATE OF BURIAL: ..... 191.....

20. UNDERTAKER: Vassar Undertaking Co. — ADDRESS: Lewiston Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY; PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24853

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 109
(No. ..... , ...)

RECEIVED
AUG 6, 1921
BUREAU OF VITAL STATISTICS

File No. 34934
Registered No. 650

1. PLACE OF DEATH

County of W. N. Hill

City of Ney Perce

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William N. Hill

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Male	white	married (Write the word.)

6. DATE OF BIRTH: July (Month) 25 (Day) 1921 (Year)

7. AGE: 82 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Platte Co. Mo

10. NAME OF FATHER Manuel Hill

11. BIRTHPLACE OF FATHER (State or Country) Not known

12. MAIDEN NAME OF MOTHER Not known

13. BIRTHPLACE OF MOTHER (State or Country) Not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. W. Hill

(Address) Lewiston Ida

15. Filed Aug 3 1921 Susan E. Bruce Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 26 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 10 1921, to July 20 1921, that I last saw h— alive on July 10 1921, and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Senility

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) L. G. Perkins M. D.

7/26 1921 (Address) Lewiston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Lewiston Ida	7/26 1921
20. UNDERTAKER	ADDRESS
	Lewiston Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers,* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL *septicemia,*" "PUERPERAL *peritonitis,*" etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

1 5 2 #6

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 86
Primary Registration District No.
(No. 4 St.)

RECEIVED
AUG 9 1921
BUREAU OF VITAL STATISTICS

File No. 34935
Registered No. 681

1. PLACE OF DEATH
County of Nez Perce
City of Lewiston
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Katherine McPherren

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	married

6. DATE OF BIRTH
(Month) (Day) (Year)

7. AGE
54 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Ill.

10. NAME OF FATHER Lewis Clink

11. BIRTHPLACE OF FATHER (State or Country) Germany

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (State or Country) N. Y.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Lou Person
(Address) Lapwai Nash

15. Filed Aug 3 1921 3:05 P.M. Susan E Bruce Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 28 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 24 1921, to July 28 1921
that I last saw h[illegible] alive on July 28 1921
and that death occurred on the date stated above, at 5-30 P.M.
The CAUSE OF DEATH* was as follows:

Haemorrhage (secondary)
Post operative 4 days.
1 hr.
(Duration) Yrs. mos. ds.
Contributory (Secondary) Dermoid Cyst of Left Ovary + Carcinoma of sigmoid
(Duration) 3 yrs. mos. ds.

(Signed) E. L. White M. D.
July 28 1921 (Address) Lewiston Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Lewiston Cemetery DATE OF BURIAL July 30 1921

20. UNDERTAKER ADDRESS Lewiston Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
AUG 6 1921
BUREAU OF VITAL STATISTICS

Registration District No. 96
Primary Registration District No. 100
File No. 34936
Registered No. 682

1. PLACE OF DEATH

County of Nez Perce
City of Lewiston
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Elsie May Gibbs

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	single

6. DATE OF BIRTH: Feb (Month) 14 (Day) 1921 (Year)

7. AGE: Yrs. 5 Mos. 16 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Arrow N. P. Co.

10. NAME OF FATHER: B R. Gibbs

11. BIRTHPLACE OF FATHER (State or Country): Tenn

12. MAIDEN NAME OF MOTHER: Carrie Abbutton

13. BIRTHPLACE OF MOTHER (State or Country): Tenn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Bennie B Gibbs
(Address) Juliaetta R.F.D. No. 2.

15. Filed Aug 3 1921 Susan E Bruce, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 30th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 28 1921, to July 30 1921, that I last saw h[illegible] alive on Friday July 29 1921, and that death occurred on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:
Gastro-enterocolitis

(Duration) ..... Yrs. ..... mos. 10 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John H Alley M. D.
Aug 1921 (Address) Lewiston

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston Cemetery | DATE OF BURIAL: July 31 1921

20. UNDERTAKER | ADDRESS: Lewiston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 26
Primary Registration District No. 2069
File No. 34937
Registered No. 23

RECEIVED
AUG 10 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Oneida
City of Malad
(No. ____ St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Thomas Bolingbroke

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Divorced

6. DATE OF BIRTH: April (Month) 18 (Day) 1848 (Year)

7. AGE: 73 Yrs. 3 Mos. 19 ds.
IF LESS than 1 day how many ____ hrs. or ____ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: Thomas J Bolingbroke

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Mary C

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) D. L. Bolingbroke
(Address)

15. Filed Aug 4 1921 R T Mauer M.D.
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 8 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 2 1921, to July 8 1921
that I last saw h im alive on July 8 1921,
and that death occurred on the date stated above, at 6 P. M.
The CAUSE OF DEATH* was as follows:
aortic regurgitation

(Duration) 6 Yrs. ____ mos. ____ ds.
Contributory (Secondary)
(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) R. T. Mauer M. D.
July 10 1921 (Address) Malad Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Malad Cem
DATE OF BURIAL: 7-10 1921
20. UNDERTAKER: D. E. Johnson
ADDRESS: Malad

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34938
Registered No. .....

Registration District No. .....
Primary Registration District No. .....

1. PLACE OF DEATH.
County of Owyhee
City of Stone Ida
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

RECEIVED
AUG 10 1921

2. FULL NAME Helena Ophelia Cottle

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married
6. DATE OF BIRTH. April (Month) 29 (Day) 1885 (Year)
7. AGE: 35 Yrs. 7 Mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): Farr West Weber Co Ut
10. NAME OF FATHER: Nels Peter Lee
11. BIRTHPLACE OF FATHER (State or Country): Denmark
12. MAIDEN NAME OF MOTHER: Helena Mickelson
13. BIRTHPLACE OF MOTHER (State or Country): Denmark
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Walter Cottle
(Address) Stone Idaho
15. Filed Aug 4 1921 R. M. Lauer Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH. July (Month) 7 (Day) 1921 (Year)
17. I HEREBY CERTIFY, That I attended deceased from July 6 1921, to July 7 1921, that I last saw her alive on July 7 1921, and that death occured on the date stated above, at 4 P. M.
The CAUSE OF DEATH* was as follows:
Myocarditis
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Cholecystitis - Acute -
(Duration) ..... yrs. ..... mos. 2 ds.
(Signed) Chas Sandleigh MD M. D.
July 7 1921 (Address) Snowville Utah

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 2 yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence Stone Ida

19. PLACE OF BURIAL OR REMOVAL: Snowville Utah — DATE OF BURIAL: July 10 1921
20. UNDERTAKER: Jos. J. Larkin. — ADDRESS: Snowville

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. RECEIVED

Primary Registration District No. AUG 10 1921

File No. 34939

County of Kootenai

City of St. Maries (No. ..., ... St.)

Registered No. ...

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Evan D. Jones

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH: Aug (Month) 12 (Day) 1866 (Year)

7. AGE: 54 yrs. 11 mos. 2 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) Farmer

9. BIRTHPLACE (State or Country) Kootenai Co Ida

10. NAME OF FATHER John M Jones

11. BIRTHPLACE OF FATHER (State or Country) Wales

12. MAIDEN NAME OF MOTHER Sarah Jones

13. BIRTHPLACE OF MOTHER (State or Country) Wales

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Rosalie Jones

(Address) ...

15.

Filed ..... 191 ..... Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: July (Month) 14 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 10 1921, to July 14 1921, that I last saw him alive on July 13 1921, and that death occurred on the date stated above, at ... M.

The CAUSE OF DEATH* was as follows:

Cerebritis

(Duration) ... yrs. ... mos. ... ds.

Contributory (Secondary) ...

(Duration) 1 yrs. ... mos. ... ds.

(Signed) H Elton M. D.

19 21 (Address) Malad

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs ... mos ... days. In the State ... yrs ... mos ... days.

Where was disease contracted if not at place of death? ...

Former or usual residence ...

19. PLACE OF BURIAL OR REMOVAL: St. Mary's DATE OF BURIAL: July 17 1921

20. UNDERTAKER: J. Ray Dawson ADDRESS: Malad

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-18

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District RECEIVED AUG 10 1921 BUREAU OF VITAL STATISTICS

Primary Registration District No. Doc

File No. 3490

Registered No. 22

County of Owyhee

City of Silver

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Sparks

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Dec (Month) 9th (Day) 1838 (Year)

7. AGE: 82 Yrs. 7 Mos. 11 Ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Blacksmith
(b) General nature of industry, business, or establishment in which employed (or employer): Mined

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: Wm. Sparks -

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Elizabeth Chapel

13. BIRTHPLACE OF MOTHER (State or Country): England.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Lester J. Sparks -
(Address) Stone Idaho

15. Filed Aug 4 1921 R. M. Maxwell Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July - (Month) 19 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July - 10 1921 to July 19 1921 that I last saw him alive on July - 19 1921 and that death occured on the date stated above, at 9a M.

The CAUSE OF DEATH was as follows:*
Arteriosclerosis

(Duration) 15 Yrs. mos. ds.
Contributory (Secondary) Hernia
(Duration) yrs. mos. ds.

(Signed) Chas Faraday Mc M. D.
19 (Address) Snowville Utah

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 28 yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Snowville Utah — DATE OF BURIAL: July 21 1921

20. UNDERTAKER: Jos J Larkin — ADDRESS: Snowville

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BOOK. 24658

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
AUG 5 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 5
Primary Registration District No. 2009
File No. 34941
Registered No. 4

1. PLACE OF DEATH

County of Payette
City of Mrs Reymouth (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Infant Colleman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
F.	W	Infant (Write the word.)

6. DATE OF BIRTH July (Month) 5 (Day) 1921 (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many 1 hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE Idaho - (State or Country)

10. NAME OF FATHER Clyde G. Colleman

11. BIRTHPLACE OF FATHER Iowa (State or Country)

12. MAIDEN NAME OF MOTHER Sophia M. Patterson

13. BIRTHPLACE OF MOTHER Ohio - (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Clyde G Colleman

(Address) Mrs Reymouth Ida

15. Filed July 7 1921 — Wm J. Dysdale, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 5 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from at birth 19..., to ..... 19....., that I last saw her alive on July 5 1921, and that death occurred on the date stated above, at 2 P.M. The CAUSE OF DEATH* was as follows:

Insufficient Fetal Development

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Premature Birth

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Wm J. Dysdale M. D.

7-7-1921 (Address) Mrs Reymouth Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Mrs Reymouth — **DATE OF BURIAL** July 5 1921

20. UNDERTAKER Father of infant — **ADDRESS** Mrs Reymouth Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

Form V. S. No. 5 20M.1-16-12

34942

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

25 AUG 10 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH.

Registration District No. 25

Primary Registration District No. 2012 STATE No. 3

County of Power

City of ~~American Falls~~ Roy, Idaho (St.)

Registered No. 130

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Do. Jake H. Clark

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)
Male	White	Married

6. DATE OF BIRTH: March (Month) 4 (Day) 1870 (Year)

7. AGE: 51 yrs. 4 mos. 13 ds. IF LESS than 1 day how many ..... *hrs.* or ..... *mins.*

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): ~~XXX~~ Ind Ore

10. NAME OF FATHER: Jacob Clark

11. BIRTHPLACE OF FATHER (State or Country): Ind.

12. MAIDEN NAME OF MOTHER: Johana Commins

13. BIRTHPLACE OF MOTHER (State or Country): Ind.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John L. Cook
(Address) Roy, Idaho

15. Filed ~~July 19~~ 8 - 8, 1921 — R. 1 noth
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: July (Month) 17th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at 3 P.M.
The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) V. G. Fagan M. D.
7/18 1921 (Address) American Falls,

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rockland, Idaho | DATE OF BURIAL: ..... 191...

20. UNDERTAKER: A.W.Davis | ADDRESS: American Falls,

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

34943

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 23

Primary Registration District No. 9672

File No. 3

Registered No. 131

RECEIVED
AUG 10 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH.

County of Power

City of American Falls, Idaho

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Angelina DeJulis

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. July (Month) 8 (Day) 1921 (Year)

7. AGE: 15 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho ~~Italy~~

10. NAME OF FATHER: Rocco DeJulis

11. BIRTHPLACE OF FATHER (State or Country): Itley

12. MAIDEN NAME OF MOTHER: Mary Dicenzo

13. BIRTHPLACE OF MOTHER (State or Country): Itley

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rocco DeJulis

(Address) American Falls, Box 157

15. Filed July 23 1921 Aug 5

R. F. Mock
Local Registrar

SVMS - WMK CO., PTRS. 24853

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 23 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 12 1921, to 191, that I last saw h alive on July 12 1921, and that death occured on the date stated above, at 7a M.

The CAUSE OF DEATH* was as follows:

Acute
Enter-colitis

(Duration) Yrs. mos. 2 wks ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) C. F. DeJulis M. D.

7/23 1921 (Address) Amer. Falls Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Pocatello, Idaho — DATE OF BURIAL: July 24 1921

20. UNDERTAKER: A.W.Davis — ADDRESS: American Falls, Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34944

Registered No. 2120

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AUG 10 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Teton

City of Victor

(No. ..... St.)

Registration District No. 77

Primary Registration District No. 2176

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Leroy Kersley

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	white	Single

6. DATE OF BIRTH: August - 1 - 1905 (Month) (Day) (Year)

7. AGE: 15 Yrs. 11 Mos. 18 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: E. N. Kersley.

11. BIRTHPLACE OF FATHER (State or Country): Salt Lake City Utah

12. MAIDEN NAME OF MOTHER: Lucy Stevens

13. BIRTHPLACE OF MOTHER (State or Country): Huntington Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ruby Stevens
(Address) Victor, Idaho

15. Filed Aug 27th 1921 Martha Marker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July 18 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at 4:30 P.M.
The CAUSE OF DEATH* was as follows:

Killed by Lightning.

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. A. Breeden M. D.

7/18/1921 (Address) Victor Idaho

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Victor Cemetery	July 22 1921

20. UNDERTAKER: Hoffman ADDRESS: Driggs, Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34945
Registered No. 5

1. PLACE OF DEATH

County of Teton

City of Driggs.

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 77

Primary Registration District No. 2176

(No. ..... St.)

RECEIVED AUG 15 1921 BUREAU OF VITAL STATISTICS

2. FULL NAME Infant Nelson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	white	single

6. DATE OF BIRTH: February - 24 - 1920 (Month) (Day) (Year)

7. AGE: 1 Yrs. 5 Mos. 7 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant.
(b) General nature of industry, business or establishment in which employed (or employer): Infant.

9. BIRTHPLACE (State or Country): Teton County, Idaho.

10. NAME OF FATHER: Dan Nelson.

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Rosuca Nickle

13. BIRTHPLACE OF MOTHER (State or Country): Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Louis E. Nickson
(Address) Driggs, Idaho.

15. Filed July 27th 1921 Martha Marker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July - 25 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 23 1921, to July - 25 1921 that I last saw her alive on July 25 1921. and that death occurred on the date stated above, at 7 A. M.

The CAUSE OF DEATH* was as follows:
Acute Gastro Enteritis

(Duration) 0 Yrs. ..... mos. 3 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. H. Culbertson M. D.
7/26/1921 (Address) Driggs Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Darby Cemetery DATE OF BURIAL: July 27 1921

20. UNDERTAKER: W. King ADDRESS: Driggs, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34946

Registered No. 4

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AUG 10 1921
BUREAU OF VITAL STATISTICS

Registration District No. 77

Primary Registration District No. 2176

1. PLACE OF DEATH

County of Teton

City of Tetonia

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Dallas Frank Harrop.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
	White	Single

6. DATE OF BIRTH June 3 1921
(Month) (Day) (Year)

7. AGE Yrs. 1 Mos. 22 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Infant.
(b) General nature of industry, business or establishment in which employed (or employer) Infant.

9. BIRTHPLACE (State or Country) Teton County. Idaho

10. NAME OF FATHER Frank B. Harrop

11. BIRTHPLACE OF FATHER (State or Country) Idaho.

12. MAIDEN NAME OF MOTHER Minnie M. Howard

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Frank B. Harrop
(Address) Tetonia, Idaho

15. Filed July 27th 1921 Martha Marker Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51068

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 24 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 10 1921, to July 24 1921
that I last saw him alive on July 23 1921,
and that death occurred on the date stated above, at 7 A.M.
The CAUSE OF DEATH* was as follows:
Dermatitis Herpetiformis

(Duration) Yrs: ..... mos. 14 ds.

Contributory (Secondary) None

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D. H. Culbertson M. D.

19..... (Address) Driggs Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Tetonia Idaho | DATE OF BURIAL July 25 1921

20. UNDERTAKER Eggleston | ADDRESS Driggs, Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 77
Primary Registration District No. 2176
File No. 34017
Registered No. Three

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BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Teton
City of Tetonia (St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs. Mary Adams.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Dec. (Month) 4 (Day) 1861 (Year)

7. AGE: 59 Yrs. 7 Mos. 6 ds.
IF LESS than 1 day: how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): West. Virginia

10. NAME OF FATHER: E. C. Adams.

11. BIRTHPLACE OF FATHER (State or Country): West Virginia

12. MAIDEN NAME OF MOTHER: Dean.

13. BIRTHPLACE OF MOTHER (State or Country): West Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) M. R. Adams
(Address) Tetonia Idaho

15. Filed July 27th 1921 Martha Marker Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 10 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 4 1921, to July 10 1921, that I last saw her alive on July 10 1921, and that death occurred on the date stated above, at 2 P. M.
The CAUSE OF DEATH* was as follows:
Apoplexy

..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Chas. J. Martin M. D.
July 11 1921 (Address) Driggs, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rigby, Idaho | DATE OF BURIAL: July 14 1921

20. UNDERTAKER: [illegible] | ADDRESS: Driggs Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

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MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34948

Registered No. 6

RECEIVED
AUG 10 1921
BUREAU OF VITAL STATISTICS

Registration District No. 77

Primary Registration District No. 2176

1. PLACE OF DEATH

County of Teton

City of Cache

(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Wendell H. Rawlings

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH: July (Month) 6 (Day) 1919 (Year)

7. AGE: 1 Yrs. 11 Mos. 22 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business or establishment in which employed (or employer): Infant.

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: Willard Rawlings

11. BIRTHPLACE OF FATHER (State or Country): Fairview Idaho.

12. MAIDEN NAME OF MOTHER: Norma Burton

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Tacy H. Burton
(Address) Tetonia Ida

15. Filed Aug 7th 1921 Martha Marker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 25 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July - 20 - 1921, to July - 25 - 1921
that I last saw him alive on July - 21 - 1921
and that death occurred on the date stated above, at 3 A.M.

The CAUSE OF DEATH* was as follows:
Acute Gastro Enterities

(Duration) ..... Yrs. ..... mos. 5 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. F. Culbertson M. D.

19 ..... (Address) Driggs Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Tetonia Cemetery | DATE OF BURIAL: July - 30 19 21

20. UNDERTAKER: W. Rees | ADDRESS: Driggs.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registrar's District No. 77
Primary Registration District No. 2176
File No. 34949
Registered No. 7

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AUG 10 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Teton
City of Tetonia
(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Joseph A. Deceased Hochstrasser

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	white	Single

6. DATE OF BIRTH: April - 16 - 1 (Month) (Day) (Year)

7. AGE: 19 Yrs. 3 Mos. 21 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer): Farming

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: J. Hochstrasser

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Alice Fuerner

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Joseph A. Hochstrasser
(Address) Tetonia, Idaho

15. Filed Aug 7th 1921 Martha Marker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August 7 — 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Drowning
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) H L Hoopes M. D.
8-8-1921 (Address) Tetonia Teton Co, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Tetonia, Ida	Aug 10 1921
20. UNDERTAKER	ADDRESS
[illegible]	Tetonia

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

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Form V. S. No. 5 20M.1-16-12

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CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34950
Registered No.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
Registration District No. 38
County of Twin Falls Primary Registration District No. 2086
City of Twin Falls, Ida. (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Richard H. Bostic

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: May (Month) 23 (Day) 1852 (Year)

7. AGE: 69 yrs. 1 mos. 28 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) Farmer.

9. BIRTHPLACE (State or Country) Kentucky.

10. NAME OF FATHER Gabriel Bostic.

11. BIRTHPLACE OF FATHER (State or Country) Kentucky.

12. MAIDEN NAME OF MOTHER Mary Taylor.

13. BIRTHPLACE OF MOTHER (State or Country) Kentucky.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Mamie.
(Address) Twin Falls Idaho.

15.
Filed July 22 1921 A. A. Rockwood Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: July (Month) 21 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 11 1921, to July 21 1921 that I last saw h[illegible] alive on July 20 1921 and that death occurred on the date stated above, at 2:00 P.M.

The CAUSE OF DEATH* was as follows:

Uremic Coma.
..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Obstruction of Bowels.
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A. W. Sawyer M. D.
7/21 1921 (Address) Twin Falls.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Grenola, Kas. DATE OF BURIAL: 1921

20. UNDERTAKER: W. E. Drake. ADDRESS: Twin Falls Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-12 M. 6-15-17.

RECEIVED AUG 3 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEAL
Bureau of Vital Statis
File No. 3495
Registered No. .....

Registration District No. .....
Primary Registration District No. .....

1. PLACE OF DEATH
County of Twin Falls
Filer
City of .....
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Baby Cunningham

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. March (Month) 12 (Day) 1921 (Year)

7. AGE: 8 hours
..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER R. D. Cunningham

11. BIRTHPLACE OF FATHER (State or Country) Iowa

12. MAIDEN NAME OF MOTHER Essie Oderkirk

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Myrtle Cunningham
(Address) Filer

15. Filed 2-13-21 A. A. Newberry Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH at 8:30
March (Month) 12 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar. 12 '21 to Mar. 12 '21
that I last saw h/m alive on Mar. 12 '21
and that death occurred on the date stated above, at 8:30 P.M.

The CAUSE OF DEATH* was as follows:

Bleed - Hemorrhage from umbilical Cord.

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory .....
(Secondary)

..... (Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) A. A. Newberry M. D.
3-14-21 (Address) Filer Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: I.O.O.F. Cemetery — DATE OF BURIAL: Mar 14 1921

20. UNDERTAKER: F E Deake — ADDRESS: Filer

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34952
Registered No. .....

1. PLACE OF DEATH
County of Twin Falls
City of Filer,
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 95
Primary Registration District No. 2086
(No. ....., ... St.)

2. FULL NAME J. M. Darrow

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married
6. DATE OF BIRTH. Oct (Month) 29 (Day) 1876 (Year)
7. AGE: 44 Yrs. 8 Mos. 18 ds. IF LESS than 1 day how many .... hrs. or .... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) Farmer
9. BIRTHPLACE (State or Country) Kansas
10. NAME OF FATHER Ewell Darrow
11. BIRTHPLACE OF FATHER (State or Country) N Y
12. MAIDEN NAME OF MOTHER Mary McCracken
13. BIRTHPLACE OF MOTHER (State or Country) Ill
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. J. M. Darrow
(Address) Filer
15. Filed July 18 1921. G. A. Spurlock Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 18 (Day) 1921 (Year)
17. I HEREBY CERTIFY, That I attended deceased from July 3 1921 to July 18 1921
that I last saw him alive on July 18 1921
and that death occurred on the date stated above, at 12:55 A.M.

The CAUSE OF DEATH* was as follows:

Cardiac Paralysis
(Duration) ..... Yrs ..... mos. 24 hrs. ds.
Contributory (Secondary) Cerebral Hemorrhage
(Duration) ..... Yrs. ..... mos. 15 ds.

(Signed) Frank A. Wright M. D.
July 19 1921. (Address) Filer, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: I.O.O.F. Cemetery — DATE OF BURIAL: July 19 1921.
20. UNDERTAKER: E. Drake — ADDRESS: Filer

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WHITE PAPER, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-12 M. 6-15-17.

RECEIVED AUG 3 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4393
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
Registration District No. .....
Primary Registration District No. .....
County of Twin Falls
City of Filer
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Callie M. Davis

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Apr. (Month) 30 (Day) 1867 (Year)

7. AGE: 54 Yrs. 7 Mos. 20 ds.
IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Missouri

10. NAME OF FATHER Joseph M Moore

11. BIRTHPLACE OF FATHER (State or Country) Missouri

12. MAIDEN NAME OF MOTHER Sarah Baker

13. BIRTHPLACE OF MOTHER (State or Country) Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Joseph M. Newport
(Address) Nampa Ida.

15.
Filed ..... 191....
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 12-40
June (Month) 20 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 22 1921 to June 18 1921
that I last saw her alive on May 22 1921
and that death occurred on the date stated above, at .... M.
The CAUSE OF DEATH* was as follows:
Carcinoma (General) involving lungs, Abdomenal Viscera
.....
(Duration) 2 Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... Yrs. ..... mos. ..... ds.
(Signed) H. W. Wilson M. D.
June 23 1921. (Address) Twin Falls Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: T.F. Cemetery — DATE OF BURIAL: June 23 1921

20. UNDERTAKER: F. E. Drake — ADDRESS: Filer

Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34954

Registered No.

1. PLACE OF DEATH

Registration District No. 37

Primary Registration District No. 1085

County of Twin Falls

City of " "

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

RECEIVED
JUL 22 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME Harry F Allen.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Jan (Month) 21 (Day) 1873 (Year)

7. AGE: 48 Yrs. 5 Mos. 6 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Oil

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mo.

10. NAME OF FATHER: Wm K Allen

11. BIRTHPLACE OF FATHER (State or Country): New Jersey.

12. MAIDEN NAME OF MOTHER: Mary Hill.

13. BIRTHPLACE OF MOTHER (State or Country): Ind.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wendle Allen

(Address) Twin Falls.

15.

Filed ..... 19.....

John H Haugen Jr
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 27 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 6-24, 1921, to 6-27 1921 that I last saw h. ~~was~~ alive on 6-27 1921 and that death occurred on the date stated above, at 2:40 M.

The CAUSE OF DEATH* was as follows:

Acute Myocarditis

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Fracture Base of Skull

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J H Haugen M. D.

6-1 1921 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls,

DATE OF BURIAL: 6/28 1921

20. UNDERTAKER: P. J. Grossman.

ADDRESS: Twin Falls

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34955

RECEIVED JUL 22 1921 BUREAU OF VITAL STATISTICS

Registration District No. 37
Primary Registration District No. 1086

1. PLACE OF DEATH
County of Twin Falls
City of
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Gerrald A. Berry

(No. St.)

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: May 5 (Month) (Day) 1919 (Year)

7. AGE: 2 Yrs. 1 Mos. 23 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Arthur Berry

11. BIRTHPLACE OF FATHER (State or Country): Ore

12. MAIDEN NAME OF MOTHER: Lila Stevenson

13. BIRTHPLACE OF MOTHER (State or Country): Ore

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Arthur Berry
(Address)

15. Filed June 27 1921 John A. Coughlin Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 27 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 6/23/1921, to 6/27/1921, that I last saw him alive on 6/27/1921, and that death occurred on the date stated above, at 12 Noon

The CAUSE OF DEATH* was as follows:
Acute intestinal intoxication

(Duration) ..... Yrs. ..... mos. 5 ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. H. Pike M. D.
6/29/1921 (Address) Twin Falls Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Ida. DATE OF BURIAL: 7-28 1921

20. UNDERTAKER: L. E. Ward ADDRESS: Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34956

Registered No.

RECEIVED
JUL 22 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Twin Falls Registration District No. 37

Primary Registration District No. 1085

City of ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Harriet A Salonde

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write one word.): Widow

6. DATE OF BIRTH: Aug 11 (Month) (Day) 1852 (Year)

7. AGE: 68 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: House ward

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Stockland

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Eliza Allen

13. BIRTHPLACE OF MOTHER (State or Country): Pennsylvania

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) Twin Falls

15.

Filed ..... 19.....

John P. Dugan
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 23 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 13 1921, to June 23 1921, that I last saw her alive on June 23 1921, and that death occurred on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Gastro enterstinal intoxication

.....(Duration) ..... Yrs. ..... mos. 11 ..... ds.

Contributory (Secondary) Intestinal Stasis

.....(Duration) ..... yrs. ..... mos. 10 ..... ds.

(Signed) G. S. Murphy M. D.

6/24 1921 (Address) Twin Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. 10 days. In the State 4 yrs. 7 mos. 2 days

Where was disease contracted if not at place of death? ✓

Former or usual residence Kimberly Ida

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Idaho — DATE OF BURIAL: 7-24 1921

20. UNDERTAKER: L E Rowell — ADDRESS: Twin Falls

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JUL 29 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Milford.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34957

Registered No.

1. PLACE OF DEATH

County of Twin Falls Registration District No. 37

City of " " Primary Registration District No. 1085

(If outside limits of city or village give township) (Name of hospital or institution. If not in hospital or institution, give street address or location. St.)

Twin Falls Merced Hospital

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elizabeth Eleanor Curtis

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Single

6. DATE OF BIRTH: Nov (Month) 24 (Day) 1914 (Year)

7. AGE: 6 Yrs. 5 Mos. 22 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Dee.

10. NAME OF FATHER: W. G. Curtis

11. BIRTHPLACE OF FATHER (State or Country): Dee

12. MAIDEN NAME OF MOTHER: Nellie Tatro

13. BIRTHPLACE OF MOTHER (State or Country): Dee.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. G. Curtis
(Address) Hansen, Ida

15. Filed June 18 1921 J. M. D. Coughlin Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 16 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 6-14 1921, to 6-16 1921 that I last saw h..... alive on ..... 19....., and that death occurred on the date stated above, at 1:10 P M.

The CAUSE OF DEATH* was as follows:

Diphtheria

(Duration) ..... Yrs. ..... mos. 6 ds.

Contributory (Secondary): Tonsilitis

(Duration) ..... yrs. ..... mos. 7 ds.

(Signed) C. S. Milford M. D.

6-14 1921 (Address) Twin Falls Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. 2 days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? Hansen, Ida

Former or usual residence Hansen, Ida.

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Twin Falls Ida	6/18 1921

20. UNDERTAKER	ADDRESS
S. J. Grossman	Twin Falls Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JUL 22 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1885
File No. 24958
Registered No.

1. PLACE OF DEATH

County of Twin Falls
City of Twin Falls (If outside city limits, write "Rural.")
No. Mercy Hospital (If in hospital or institution, give its name instead of street and number.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Marguerite Leighton

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Married

6. DATE OF BIRTH: March (Month) 27 (Day) 1894 (Year)

7. AGE: 26 Yrs. 4 Mos. 25 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Colorado

10. NAME OF FATHER: C. E. Edwards

11. BIRTHPLACE OF FATHER (State or Country): Kentucky

12. MAIDEN NAME OF MOTHER: Maggie Friend

13. BIRTHPLACE OF MOTHER (State or Country): [redacted]

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. E. Edwards
(Address) 457 - 4th avenue east Twin Falls

15. Filed June 24 1921 John F. Coughlin Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 21 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 21 1921, to June 21 1921
that I last saw h.r alive on June 21 1921
and that death occurred on the date stated above, at 3:20 P.M.
The CAUSE OF DEATH* was as follows:

Burn from oil explosion

(Duration) ..... Yrs. ..... mos. 1 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. N. Leete M. D.
6/22 1921 (Address) Twin Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Ida | DATE OF BURIAL ..... 19.....

20. UNDERTAKER: P. J. Grossman | ADDRESS: Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

Ida

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
JUL 22 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 37

County of Twin Falls Primary Registration District No. 1085

File No. 34959

City of [illegible] St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Denby Wetsel

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6. DATE OF BIRTH: June 23 1921 (Month) (Day) (Year)

7. AGE: ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many 3 hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business or establishment in which employed (or employer) Mechanic

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER D M Wetsel

11. BIRTHPLACE OF FATHER (State or Country) Indiana.

12. MAIDEN NAME OF MOTHER Ora Maddock

13. BIRTHPLACE OF MOTHER (State or Country) Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C. A. Werner

(Address) Twin Falls

15. Filed June 24 1921 John T. Coughlin Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 23 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 23 1921, to June 24 1921, that I last saw h[illegible] alive on June 24 1921, and that death occurred on the date stated above, at 7:00 A.M.

The CAUSE OF DEATH* was as follows:

Premature Birth

3 hrs

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. H. Leete M. D.

6/24 1921 (Address) Twin Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls | DATE OF BURIAL: June 25 1921

20. UNDERTAKER: J. F. Goossen | ADDRESS: Twin Falls Ida

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JUL 22 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34960

Registration District No. 37

Primary Registration District No. 1085

Registered No.

1. PLACE OF DEATH

County of Twin Falls

City of " " (If outside limits of city or village, write the word "Outside.") St. Mercy Hospital

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary M Tubbs

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: June (Month) 21 (Day) 1893 (Year)

7. AGE: 28 Yrs. 11 Mos. 25 ds.

IF LESS than 1 day: how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Minn.

10. NAME OF FATHER: Geo Brundage

11. BIRTHPLACE OF FATHER (State or Country): Wis

12. MAIDEN NAME OF MOTHER: Alice E. Adams

13. BIRTHPLACE OF MOTHER (State or Country): Pa.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John D Tubbs
(Address) Jerome Ida

15. Filed ..... 19 ..... John P. Quigley Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 16 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 15 1921, to June 16 1921 that I last saw her alive on June 16 1921, and that death occurred on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

General septic peritonitis

(Duration) About yrs. mos. 3 ds.

Contributory (Secondary) Acute appendicitis

(Duration) yrs. mos. 6 ds.

(Signed) G.S. Murphy M. D.

June 18 1921 (Address) Twin Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. 1 days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? Jerome Idaho

Former or usual residence Jerome Idaho

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Ida — DATE OF BURIAL: 6/18 1921

20. UNDERTAKER: F.J. Grossman — ADDRESS: Twin Falls Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

RECEIVED AUG 10 1921 BUREAU OF VITAL STATISTICS

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 39
Primary Registration District No. 2-087
File No. 34961
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of Twin Falls
(No. St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charles A. Bauer
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH July 29TH 1871 (Month) (Day) (Year)

7. AGE 49 Yrs. 11 Mos. 25 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Darke, Ill.

10. NAME OF FATHER Chas. Edward Bauer

11. BIRTHPLACE OF FATHER (State or Country) Penna.

12. MAIDEN NAME OF MOTHER Barbara Wright

13. BIRTHPLACE OF MOTHER (State or Country) Ohio.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Chas A. Bauer
(Address) Burke Ida

15. Filed July 5 1921 J. N. Murphy Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 4 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 18 1921, to July 4 1921, that I last saw h.. alive on July 3 1921, and that death occurred on the date stated above, at 5 A.M.
The CAUSE OF DEATH* was as follows:

Streptococcus Pneumonitis
(Duration) Yrs. mos. 5 ds.
Contributory (Secondary) Chronic Arthritis mitralis
(Duration) 20 yrs. mos. ds.
(Signed) A. Engelhardt M. D.
7/5 1921 (Address) Burke Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Burke Ida DATE OF BURIAL July 6 1921

20. UNDERTAKER Homer B. Evans ADDRESS Burke

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 39
Primary Registration District No. 2087
File No. 34962
Registered No.

1. PLACE OF DEATH

County of Twin Falls
City of Clover
(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
JUL 20 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME William [illegible] Wavara Jr

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Bohemia

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Sept. (Month) 10 (Day) 1903 (Year)

7. AGE: 17 Yrs. 10 Mos. 2 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: farm laborer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Minn.

10. NAME OF FATHER: William [illegible] Wavara.

11. BIRTHPLACE OF FATHER (State or Country): Minn.

12. MAIDEN NAME OF MOTHER: Agnes Dvorak

13. BIRTHPLACE OF MOTHER (State or Country): Bohemia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) William [illegible] Wavara

(Address) Clover Ida.

15. Filed July 13 1921

J. H. Meeuwsen
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July 12 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....

that I last saw h..... alive on ..... 19.....

and that death occurred on the date stated above, at 6:30 P.M.

The CAUSE OF DEATH* was as follows:

Drowned (accidental)

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. F. Freeman Coroner

7/13 1921 (Address) Twin Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Twin Falls Cemetery — **DATE OF BURIAL** July 14 1921

20. UNDERTAKER [illegible] — **ADDRESS** Twin Falls

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 39
Primary Registration District No. 2087
File No. 34963
Registered No.

RECEIVED
AUG 10 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Twin Falls
City of Buhl
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Flora Bertalot

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Female	White	Married

6. DATE OF BIRTH Feb. - 11 - 1879
(Month) (Day) (Year)

7. AGE 42 Yrs. 5 Mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Housewife.
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Neb.

10. NAME OF FATHER Mort. Engles

11. BIRTHPLACE OF FATHER (State or Country) Ill.

12. MAIDEN NAME OF MOTHER Elizabeth Heckman

13. BIRTHPLACE OF MOTHER (State or Country) Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Geo. Bertalot
(Address) Buhl, Ida.

15. Filed 7-21 1921 J. N. Murphy Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 21 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 15 1921, to July 21 1921 that I last saw h[illegible] alive on July 21 1921 and that death occurred on the date stated above, at 9:30 A.M.

The CAUSE OF DEATH* was as follows:
Suppression of Urine due to Pregnancy, & Heart Failure
(Duration) ..... Yrs. ..... mos. 6 ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G. A. Marsh M. D.
July 21 1921 (Address) Buhl. Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Buhl Cemetery — DATE OF BURIAL July 22 1921

20. UNDERTAKER Fowler & Lloyd — ADDRESS Buhl Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 34
Primary Registration District No. 8 7
File No. 34964
Registered No.

RECEIVED
AUG 10 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Twin Falls.
City of Burke
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME [redacted] Morris Patterson
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widowed

6. DATE OF BIRTH: Nov (Month) 29 (Day) 1841 (Year)

7. AGE: 79 Yrs. 7 Mos. 29 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER: John Morris

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Lovina Patterson

13. BIRTHPLACE OF MOTHER (State or Country): New York.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. E. Estes
(Address) Laramie, Wyo.

15. Filed 7-28 1921 J. N. Murphy Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 28 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 19 1921, to July 28 1921, that I last saw h[illegible] alive on July 27 1921, and that death occurred on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:
Senility.
(Duration) Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) J. N. Murphy M. D.
7-28 1921 (Address) Burke Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mackin's Junction Wy. DATE OF BURIAL 19

20. UNDERTAKER: [illegible] ADDRESS Burke Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 39
Primary Registration District No. 2087
File No. 34965
Registered No.

RECEIVED
AUG 10 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Wendell
City of Gooding
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Ellen Murray.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Widow, Div'd.)

6. DATE OF BIRTH: Dec (Month) 26 (Day) 1895 (Year)

7. AGE: 25 Yrs. 7 Mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: ✓
(b) General nature of industry, business or establishment in which employed (or employer): ✓

9. BIRTHPLACE (State or Country): Ill.

10. NAME OF FATHER: Thos. Murray.

11. BIRTHPLACE OF FATHER (State or Country): Scotland

12. MAIDEN NAME OF MOTHER: Mary Desroe.

13. BIRTHPLACE OF MOTHER (State or Country): France.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Herman Brand.
(Address) Wendell Ida

15. Filed Augt 1921
J. W. Murphy
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 30 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 7/11 1921, to 7/30 1921, that I last saw h. alive on 7/11 1921, and that death occurred on the date stated above, at 11:30 P.M.

The CAUSE OF DEATH* was as follows:

Acute dilatation of heart
(Duration) Few hrs Yrs. ..... mos. ..... ds.
Contributory (Secondary) Gaseous Indigestion
(Duration) ..... yrs. ..... mos. 2 ds.

(Signed) A. Inglusky M. D.
7/31 1921 (Address) Burl Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Verden Ill. | DATE OF BURIAL ..... 19.....

20. UNDERTAKER: Melville & Rugg | ADDRESS: Burl, Idaho

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
JUL 22 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 39
Primary Registration District No. 3087
File No. 34966
Registered No.

1. PLACE OF DEATH

County of Twin Falls
City of Buhl (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Baby Gifts

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female

4. COLOR OR RACE White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.) Single

6. DATE OF BIRTH June (Month) 6 (Day) 1921 (Year)

7. AGE — Yrs. — Mos. 1 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Buhl

10. NAME OF FATHER J. M. Gifts

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Myrtle Steers

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jas. M. Gifts

(Address) .....

15. Filed 6-8 1921 J. N. Wrigley Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 7 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 6 1921, to June 7 1921, that I last saw her alive on June 7 1921, and that death occurred on the date stated above, at 7.30 P.M.

The CAUSE OF DEATH* was as follows:

Premature birth.

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. N. Wrigley M. D.

6-8 1921 (Address) Buhl Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Buhl Cemetery — **DATE OF BURIAL** June 8 1921

20. UNDERTAKER Neville & Gregg H. F. — **ADDRESS** Buhl Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
JUL 22 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 39
Primary Registration District No. 2087
File No. 34967
Registered No.

County of Twin Falls
City of Burke (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William J. Ince

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widower

6. DATE OF BIRTH: July (Month) IX (Day) 1 (Year)

7. AGE: 76 Yrs. 10 Mos. 1 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: Dont Know

11. BIRTHPLACE OF FATHER (State or Country): England.

12. MAIDEN NAME OF MOTHER: Dont Know

13. BIRTHPLACE OF MOTHER (State or Country): England.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. N. Hanson
(Address) Burke, Ida.

15.
Filed 6-14 1921
J. H. Murphy
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 13 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 6/11 1921 to 6/13 1921 that I last saw h.. alive on 6/13 1921 and that death occurred on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

(a) Cardiac Arrhythmia

(Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary) Uremia Salaries

(Duration) 2 yrs. ..... mos. ..... ds.

(Signed) A. Chris Clarke M. D.

6/14 1921 (Address) Burke Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Salt Lake City — DATE OF BURIAL ..... 19.....

20. UNDERTAKER: Thomas B. Evans — ADDRESS: Burke Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
JUL 22 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 39
Primary Registration District No. 2087
File No. 34968
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of Burley (No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary B Clark
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: April (Month) 12 (Day) 1879 (Year)

7. AGE: 42 Yrs. 2 Mos. 4 ds.
IF LESS than 1 day how many..... hrs. or.....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: John Walker

11. BIRTHPLACE OF FATHER (State or Country): Scotland

12. MAIDEN NAME OF MOTHER: Mary Blaine

13. BIRTHPLACE OF MOTHER (State or Country): Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): John Walker
(Address): Filer

15. Filed 6-17 1921 J. H. Murphy Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 16 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 6-13-1921, to 6-16-1921, that I last saw her alive on 6-16-1921, and that death occurred on the date stated above, at 5 P. M.
The CAUSE OF DEATH* was as follows:

Organic Heart disease
during labor.
(Duration) Yrs. mos. 2 hrs ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) Geo. Jennings M. D.
6-17 1921 (Address) Burley, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Filer Ida. DATE OF BURIAL: 6-18 1921

20. UNDERTAKER: Homer B Evans ADDRESS: Burley

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
JUL 22 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 39

Primary Registration District No. 2077

File No. 24069

County of Twin Falls

City of Burke (No. ....., ... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Walter Freeman Jr

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	

6. DATE OF BIRTH June 30 1921
(Month) (Day) (Year)

7. AGE — Yrs. — Mos. 2 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work X

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Burke Idaho

10. NAME OF FATHER Walter Freeman

11. BIRTHPLACE OF FATHER (State or Country) Switzerland

12. MAIDEN NAME OF MOTHER Ella Wetherbee

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Walter Freeman

(Address) Burke Ida

15. Filed 6-23 1921 J. H. Murphy Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 22 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 20 1921, to June 22 1921, that I last saw him alive on June 21 1921, and that death occurred on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Guardian.

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. H. Murphy M. D.

6-22 1921 (Address) Burke

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Filer Idaho DATE OF BURIAL June 23 1921

20. UNDERTAKER Homer B Evans ADDRESS Burke

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
JUL 22 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 34
Primary Registration District No. 2087
File No. 34970
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of Burke (No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Bedrich Egerendorf
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Nov. 13 1912 (Month) (Day) (Year)

7. AGE: 8 Yrs. 7 Mos. 13 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: School boy
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Texas

10. NAME OF FATHER: James Egerendorf

11. BIRTHPLACE OF FATHER (State or Country): Bohemia

12. MAIDEN NAME OF MOTHER: Mary Straupika

13. BIRTHPLACE OF MOTHER (State or Country): Bohemia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) James Egerendorf
(Address) Burke Ida

15. Filed June 26 1921 J. A. Murphy Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 25 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ____ 19__, to ____ 19__, that I last saw h__ alive on ____ 19__, and that death occurred on the date stated above, at 12:30 P.M.
The CAUSE OF DEATH* was as follows:

Drowned (Accidental)

(Duration) Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) J. J. Swanson Coroner
June 27 1921 (Address) Twin Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Burke Ida | DATE OF BURIAL: June 27 1921

20. UNDERTAKER: Homer B Evans | ADDRESS: Burke

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-12 M. 6-15-

RECEIVED AUG 3 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34971
Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Twin Falls

City of Filer

If death occurs away from usual residence, give facts called for under special information.

Registration District No. .....

Primary Registration District No. .....

(No. ..... St.)

2. FULL NAME Charlet May Carlson

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female

4. COLOR OR RACE white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. ~~Single~~ (Write the word.)

6. DATE OF BIRTH. June (Month) 22 (Day) 1920 (Year)

7. AGE ..... Yrs. 11 Mos. 21 ds. IF LESS than 1 day how many .... hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Arthur A. Carlson

11. BIRTHPLACE OF FATHER (State or Country) Nebraska

12. MAIDEN NAME OF MOTHER Edna May Nelson

13. BIRTHPLACE OF MOTHER (State or Country) Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A. A. Carlson

(Address) Filer

15. Filed June 14 1921 T. A. Newberry Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 13 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 4 1921 to June 13 1921 that I last saw h.. alive on June 13 1921 and that death occurred on the date stated above, at 2:30 P. M.

The CAUSE OF DEATH* was as follows:

.....

.....

Auto intoxication

(Duration) ..... Yrs. ..... mos. 4 ds.

Contributory (Secondary) Substitional Paralysis

(Duration) ..... Yrs. ..... mos. 24 hrs

(Signed) Frank A. Douglas M. D.

June 15-21 (Address) Filer, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs....mos....days. In the State....yrs....mos....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Twin Falls Cemetery — **DATE OF BURIAL** June 15 1921

20. UNDERTAKER J E Burke — **ADDRESS** Filer

FORM V. S. No. 5-25 M. 1-19.

RECEIVED SEP 6 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34932
Registered No. 8

1. PLACE OF DEATH
County of Ada Registration District No. 2
City of Boise (If outside limits, give township) Ada Registration District No. 1004
(No. 418 State St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Adie Alice Stephens

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Jan (Month) 3 (Day) 1890 (Year)

7. AGE: 31 Yrs. 7 Mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mont

10. NAME OF FATHER: Matt Current

11. BIRTHPLACE OF FATHER (State or Country): Mo.

12. MAIDEN NAME OF MOTHER: Mrs Alice Current

13. BIRTHPLACE OF MOTHER (State or Country): Mont

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Susan J. Stephens
(Address) Kuna Ida

15. Filed Aug 1 1921 R. H. Pratt Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 29 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 10 1921 to July 30 1921 that I last saw h— alive on July 30 1921 and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Uterine hemorrhage

(Duration) ..... Yrs. ..... mos. ..... ds.

*Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo Collett M. D.
19 ..... (Address) Boise Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Meridian Cemetery
DATE OF BURIAL: Aug. 1 1921

20. UNDERTAKER: Schreiber & Sidenfaden
ADDRESS: Boise

Falls

FORM V. S. No. 5-25 M. 1-19.

RECEIVED SEP 6 - 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 2

County of Ada

Primary Registration District No. 1054

City of Boise Idaho (No. 1315 Franklin St.)

File No. 34933

Registered No. 2299

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Olene Vivian Polley

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	

6. DATE OF BIRTH: May (Month) 27 (Day) 1921 (Year)

7. AGE: Yrs. 2 Mos. 5 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Nampa Idaho

10. NAME OF FATHER: Earl Ross W. E. Polley, adopted

11. BIRTHPLACE OF FATHER (State or Country): American

12. MAIDEN NAME OF MOTHER: Rosalia Don't Know Agnes Polley, adopted

13. BIRTHPLACE OF MOTHER (State or Country): American

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. E. Polley
(Address)

15. Filed Aug. 1 1921 R. H. Coad Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 1st (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 1st 1921, to Aug 1st 1921, that I last saw h.e.r. alive on Aug 1st 1921, and that death occurred on the date stated above, at 7a M.

The CAUSE OF DEATH* was as follows:
Congenital Heart Disease
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Olen Bacon M. D.
8. 1 1924 (Address) Boise Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery | DATE OF BURIAL: 8/2 1921

20. UNDERTAKER: Schmuhs Undertaking Parlors | ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

Stewart

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED SEP 6 - 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Ada — Registration District No. 2

City of Boise — Primary Registration District No. 1004

(If outside limits, give township) — (Ward) — (St. Bethesda Lutheran Hospital)

If death occurs away from usual residence, give facts called for under special information.

File No. 24654

Registered No. 2150

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Charles J. Berg.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M.	White.	Married

6. DATE OF BIRTH: June 6 (Month) (Day) 1862 (Year)

7. AGE: 59 Yrs. 1 Mos. 24 ds. — IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER: Johnson

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Oscar Berg
(Address) ...

15. Filed Aug 1 1921 — R. H. Pratt, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 30 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 25 1921, to July 30 1921, that I last saw h... alive on July 30 1921, and that death occurred on the date stated above, at 10a M.

The CAUSE OF DEATH* was as follows:

Post Operative Pneumonia

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary) Chr. Myocarditis

(Duration) ... yrs. ... mos. ... ds.

7/30 1921 (Signed) James L. Stewart M. D.
(Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death? ...

Former or usual residence ...

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Nampa Idaho.	Aug 2 1921
20. UNDERTAKER	**ADDRESS**
Funeral Directors Assn.	Boise, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED SEP 6 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Ada — Registration District No. 9 — File No. 4075

City of ... (If outside limits, give township) — Primary Registration District No. 1 4 — Registered No. 223

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William F. Huftle

If death occurred in a hospital, institution or camp, give its NAME instead of street and number. Soldiers Home

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M.	White	Widower

6. DATE OF BIRTH — (Month) ... (Day) 1 (Year) 1841

7. AGE — 80 Yrs. ... Mos. ... ds. — IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Veteran Civil War.
(b) General nature of industry, business or establishment in which employed (or employer): ...

9. BIRTHPLACE (State or Country) Unknown

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (State or Country) Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Clyde E. Summers
(Address) Boise Ida

15. Filed August 4 1921 — R. H. Pratt, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH — (Month) August ... (Day) 3 ... (Year) 1921

17. I HEREBY CERTIFY, That I attended deceased from Jan 1 1921, to Aug 3 1921
that I last saw h. im alive on July 1 1921,
and that death occurred on the date stated above, at 6 P.M.
The CAUSE OF DEATH* was as follows:
Senility

.....(Duration) ... Yrs. ... mos. ... ds.
Contributory (Secondary) ...
.....(Duration) ... yrs. ... mos. ... ds.

(Signed) Roscoe C Ward M. D.
8/5 1921 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death? ...
Former or usual residence ...

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Morris Hill Cemetery	Aug 4 1921
20. UNDERTAKER	ADDRESS
Summers & Trebs	Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED SEP 6 - 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 2

Primary Registration District No. 1004

File No. 34976

Registered No. 226

County of Ada

City of Boise (No. 514 St. Alphonsus St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Amos Newton Null

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH: July (Month) 28 (Day) 1856 (Year)

7. AGE: 65 Yrs. Mos. 9 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: City Blacksmith
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: Sampson

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: unknown

13. BIRTHPLACE OF MOTHER (State or Country): unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Walter Null
(Address) 2103 N. 14th St.

15. Filed August 6 1921 K. H. Pratt Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 8 (Month) 6 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 6, 1921, to Aug 6 1921
that I last saw h[illegible] alive on 8/6 1921
and that death occurred on the date stated above, at 10:30 A M.

The CAUSE OF DEATH* was as follows:
Lympho: Sarcoma.

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Fred. A. Young Jr. M. D.

8/6 1921 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Morris Hill	Aug. 7 1921
20. UNDERTAKER	**ADDRESS**
Wm. Mc. Bratney	Boise, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19

RECEIVED
SEP 6 - 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34977
Registered No. 227

1. PLACE OF DEATH
County of Ada
Registration District No. 2
Primary Registration District No. 1004
City of Boise (No. 2324 Fairview Ave.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Arch Matthews

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widowed
6. DATE OF BIRTH: Feb. (Month) 20 (Day) 1 (Year)
7. AGE: 69 Yrs. 5 Mos. 14 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Blacksmith
(b) General nature of industry, business or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Missouri
10. NAME OF FATHER: David Crockett
11. BIRTHPLACE OF FATHER (State or Country): Ireland
12. MAIDEN NAME OF MOTHER: Mc. Donald
13. BIRTHPLACE OF MOTHER (State or Country): Ohio
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Pearl Shangle
(Address) 2324 Fairview Ave.
15. Filed August 6 1921 R N Pratt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 6th (Day) 1921 (Year)
17. I HEREBY CERTIFY, That I attended deceased from June 3d 1921, to Aug 6 1921 that I last saw him alive on Aug 4th 1921, and that death occurred on the date stated above, at 8 A M.
The CAUSE OF DEATH* was as follows:
Cancer of Stomach
(Duration) One Yrs. 6 mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) J W Cannon M. D.
19 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Ada, Idaho — DATE OF BURIAL: Aug 7 1921
20. UNDERTAKER: Wm. E. Bratney — ADDRESS: Boise, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-25 M. 1-19.

RECEIVED SEP 6 - 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 1004
File No. 34978
Registered No. 228

1. PLACE OF DEATH
County of Ada
City of Boise (No. 110 E. Bannock St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Edgar Leroy Searey

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: July (Month) 10 (Day) 1901 (Year)

7. AGE: 20 Yrs. 0 Mos. 26 ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: H. C. Searey

11. BIRTHPLACE OF FATHER (State or Country): Illinois

12. MAIDEN NAME OF MOTHER: Jessie O. Coe

13. BIRTHPLACE OF MOTHER (State or Country): Wisconsin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Harry C. Searey
(Address) Eagle Idaho R.F.D. #1

15. Filed August 8 1921 R. N. Smith Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 6 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 5 1921, to Aug 6 1921, that I last saw him alive on Aug 6 1921, and that death occurred on the date stated above, at 11 M.

The CAUSE OF DEATH* was as follows:
Surgical shock
(Duration) ... Yrs. ... mos. ... ds.
Contributory (Secondary) Hemorrhage L. K. Wound
(Duration) ... yrs. ... mos. 1 ds.

(Signed) O. H. Parker M. D.
19... (Address) ...

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Aug 7 1921
20. UNDERTAKER: Summers & Trobe — ADDRESS: Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED SEP 6 - 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 2

Primary Registration District No. 1604

File No. 24980

County of Ada

City of Boise (No. 411 Washington Ave St.)

Registered No. 2 10.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sarah E Clemons

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	African	Married

6. DATE OF BIRTH: Oct (Month) ..... (Day) 1893 (Year)

7. AGE: 27 Yrs. 9 Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housekeeper

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Virginia

10. NAME OF FATHER: John Campbell

11. BIRTHPLACE OF FATHER (State or Country): Not known Virginia

12. MAIDEN NAME OF MOTHER: Not known

13. BIRTHPLACE OF MOTHER (State or Country): Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) R. M. Clemons

(Address) Boise Ida

15. Filed August 8 19 21 R. H. Pratt Local Registrar

SYMS-YORK CO. PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug. (Month) 6 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 4 1921, to Aug 6 1921, that I last saw her alive on Aug 6 1921, and that death occurred on the date stated above, at 11:30 A.M.

The CAUSE OF DEATH* was as follows:

Puerperal Eclampsia

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo Callicat M. D.

8/7 1921 (Address) Boise Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Amsbury Virginia	8/9 1921

20. UNDERTAKER	ADDRESS
Schreiber & Sidenfaden	Boise

Callister

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 5381

Registered No. 231

1. PLACE OF DEATH

Registration District No. 2

Primary Registration District No. 1004

County of Ada

City of Boise (If outside limits, give township.) No. 410 State St.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED SEP 6 - 1921 BUR. OF VITAL STATISTICS

2. FULL NAME Alice B. Winter

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: May (Month) 19 (Day) 1887 (Year)

7. AGE: 34 Yrs. 2 Mos. 21 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): North Dakota

10. NAME OF FATHER: John Spence

11. BIRTHPLACE OF FATHER (State or Country): Am.

12. MAIDEN NAME OF MOTHER: Margarete Anderson

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Archie T. Winter

(Address) Mtn Home Idaho

15. Filed Aug. 11 1921 R. H. Pond Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug. (Month) 9 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 5 1921, to Aug 9 1921 that I last saw h..... alive on Aug 9 1921 and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of Heart

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Chronic Endocarditis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) James L. Stewart M. D.

8/10 1921 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence Mountain Home 2 Idaho Shipment

19. PLACE OF BURIAL OR REMOVAL: Mountain Home DATE OF BURIAL: 8/10 1921

20. UNDERTAKER: Schreiber & Hidenfaden ADDRESS: Boise Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED SEP 6 - 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Ada — Registration District No. 2

City of Boise — Primary Registration District No. 1904

(No. 1807 Bannock St.)

File No. 34082

Registered No. 233

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Joseph B. Fickle.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
M.	White.	Married (widower)

6. DATE OF BIRTH: Apr 17 (Month) (Day) 1882 (Year)

7. AGE: 39 Yrs. 3 Mos. 26 ds. — IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Switchman
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Kansas.

10. NAME OF FATHER: Robert W. Fickle.

11. BIRTHPLACE OF FATHER (State or Country): Virginia

12. MAIDEN NAME OF MOTHER: Sarah Harris.

13. BIRTHPLACE OF MOTHER (State or Country): Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. J. B. Fickle
(Address) .....

15. Filed Aug 15 1921 — R. V. Pratt, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug. (Month) 12 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 5 1921, to Aug 12 1921, that I last saw him alive on Aug 11 1921, and that death occurred on the date stated above, at 1 A.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) 6 Yrs. ..... mos. ..... ds.

Contributory (Secondary): Endocarditis

(Duration) 1 yrs. ..... mos. ..... ds.

(Signed) J. B. Smith M. D.

19..... (Address) Boise, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cem — DATE OF BURIAL: Aug 15 1921

20? UNDERTAKER: Summers & Keb. — ADDRESS: Boise Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED SEP 6 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34983
Registered No. 233

1. PLACE OF DEATH
County of Ada — Registration District No. 2
City of Boise — Primary Registration District No. 1004
(No.) 313 Thatcher St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William W. Abrams

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: May (Month) 16 (Day) 1847 (Year)

7. AGE: 73 Yrs. 8 Mos. 27 ds.
IF LESS than 1 day: how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Carpenter
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ind.

10. NAME OF FATHER: Not obtainable

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): American

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A. S. Abrams
(Address) 313 Thatcher St. Boise Ida

15. Filed Aug 16 1921 — P. M. Pratt, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 13 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 18 1921, to Aug 13 1921, that I last saw h[illegible] alive on July 1 1921, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Cancer of stomach
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) M. H. Fallman M. D.
8/15 1921 (Address) Boise

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 8/16 1921

20. UNDERTAKER: Schreiber & Redemann — ADDRESS: Boise

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

Sutton

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34984
Registered No. 234

RECEIVED
SEP 6 - 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Ada Registration District No. 2

City of Boise Primary Registration District No. 1004

(No. 410 W State St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elisha Smith Miller

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: June (Month) 14 (Day) 1857 (Year)

7. AGE: 64 Yrs. 6 Mos. 0 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa.

10. NAME OF FATHER: William Miller.

11. BIRTHPLACE OF FATHER (State or Country): Unknown.

12. MAIDEN NAME OF MOTHER: Minerva Clark.

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mary M. Smith

(Address) 425½ S. 15 St.

15. Filed Aug 16 - 1921 R. H. Pratt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August (Month) 14 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 7 1921, to Aug-14 1921, that I last saw him alive on Aug 13 - 1921 and that death occurred on the date stated above, at 6 A.M.

The CAUSE OF DEATH* was as follows:

Pyaemia —

"Originated from Abscess

Mouth (Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary) Pneumonia" —

(Duration) ... yrs. ... mos. ... ds.

(Signed) R. L. Sutton M. D.

19 ..... (Address) 425½ S. 15 St.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Aug 16 1921

20. UNDERTAKER: Summers & Trube — ADDRESS: Boise Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED SEP 6 - 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH — Registration District No. 2
County of Ada — Primary Registration District No. 1004
City of Boise — 410 State St.)
File No. 34985
Registered No. 235
If death occurs away from usual residence, give facts called for under special information.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ida E. Syra

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: June (Month) 13th (Day) 1881 (Year)

7. AGE: 40 Yrs. 8 Mos. 2 ds.
IF LESS than 1 day how many..... hrs. or.....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housekeeper
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Sheffield, Iowa

10. NAME OF FATHER: G. J. Beck

11. BIRTHPLACE OF FATHER (State or Country): Iowa.

12. MAIDEN NAME OF MOTHER: Francis Cook

13. BIRTHPLACE OF MOTHER (State or Country): ~~Iowa~~, Wis

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant)
(Address) Nam. Idaho

15. Filed Aug 17 1921 — R. N. Pratt, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug. (Month) 15 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 30 1921, to Aug 15 1921, that I last saw h alive on Aug 15 1921, and that death occurred on the date stated above, at 3 P. M.
The CAUSE OF DEATH* was as follows:
Pulmonary embolism
(Duration) ..... Yrs. ..... mos. 1 ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) M. H. Tallman M. D.
8/15 1921 (Address) Boise, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence Kuna, Idaho

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 8/21 1921

20. UNDERTAKER: Schreiber & Siebenfaden — ADDRESS: Boise, Ida

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED SEP 6 - 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Ada — Registration District No. 2

City of Boise — Primary Registration District No. 1004

(No. 2014 N. 17th St.)

File No. 34986

Registered No. 236

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Chas E. Sanderson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widower (Write the word.)

6. DATE OF BIRTH: Mar (Month) 1st (Day) 1845 (Year)

7. AGE: 76 Yrs. 5 Mos. 16 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Carpenter

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Niagara Falls, Can

10. NAME OF FATHER: Thos Sanderson

11. BIRTHPLACE OF FATHER (State or Country): Canada

12. MAIDEN NAME OF MOTHER: Julia Sanderson

13. BIRTHPLACE OF MOTHER (State or Country): Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John L Green

(Address) Boise

15. Filed Aug 17 1921 — R. H. Pratt, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 16th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 3 1921, to Aug 16 1921, that I last saw h[im] alive on Aug 1st 1921, and that death occurred on the date stated above, at 7 A.M.

The CAUSE OF DEATH* was as follows:

Arterio sclerosis

(Duration) 10 Yrs. ..... mos. ..... ds.

Contributory (Secondary): Myocarditis

(Duration) ..... yrs. 6 mos. ..... ds.

(Signed) M. H. Tallman M. D.

8/16 1921 (Address) Boise. Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 8/18 1921

20. UNDERTAKER: Schreiber & Siebenfreden — ADDRESS: Boise Ida

Dr. Tallman

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-2a M. 1-19.

Parker.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Ada. RECEIVED SEP 6 - 1921 BUREAU OF VITAL STATISTICS

Registration District No. 2

Primary Registration District No. 1 or 4

City of Boise. (No.) 2724 Idaho St.)

File No. 02301

Registered No. 237

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Martha J. Carver.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F.	White	Widow

6. DATE OF BIRTH: Nov 26 (Month) (Day) 1849 (Year)

7. AGE: 71 Yrs. 8 Mos. 21 ds. IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Penn.

10. NAME OF FATHER: William Coharles.

11. BIRTHPLACE OF FATHER (State or Country): Unknown.

12. MAIDEN NAME OF MOTHER: Amanda Walls

13. BIRTHPLACE OF MOTHER (State or Country): Penn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs S B McAlvey
(Address)

15. Filed Aug 17 1921 R. H. Pratt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 16 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 11 1921, to Aug 16 1921, that I last saw her alive on Aug 14 1921, and that death occurred on the date stated above, at 3 P M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ... Yrs. ... mos. 6 ds.

Contributory (Secondary) Hyp[illegible] Blood Pressure

(Duration) ... yrs. ... mos. ... ds.

(Signed) O. H. Parker M. D.

19... (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cem. DATE OF BURIAL: Aug 18 1921

20. UNDERTAKER: Summers & Co. ADDRESS: Boise Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34988
Registered No. 238

RECEIVED SEP 6 - 1921 BUREAU OF VITAL STATISTICS STATE OF IDAHO

1. PLACE OF DEATH

County of Ada Registration District No. 2

City of Boise Primary Registration District No. 1 ag 4

(No. Mitchell Hotel St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Harriet T. Burnet

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (write the word.)

6. DATE OF BIRTH: Oct (Month) 18 (Day) 1848 (Year)

7. AGE: 72 Yrs. 9 Mos. 29 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ill

10. NAME OF FATHER: Moses Arnold

11. BIRTHPLACE OF FATHER (State or Country): Mass

12. MAIDEN NAME OF MOTHER: Adelia B. Brown

13. BIRTHPLACE OF MOTHER (State or Country): New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E. G. Burnet

(Address) Dedrick Hotel

15. Filed Aug 17 1921 R. H. Pratt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 8 (Month) 17 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 8/14 1921, to 8/17 1921 that I last saw her alive on 8/16 1921 and that death occurred on the date stated above, at 11A M.

The CAUSE OF DEATH* was as follows:

Senility

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. H. Edwards M. D.

8/17 1921 (Address) Owsley Bldg

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Aug 19 1921

20. UNDERTAKER: Summers & Trebo — ADDRESS: Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

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FORM V. S. No. 5-2f. M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34089
Registered No. 248

RECEIVED SEP 6 - 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 2
Primary Registration District No. 1 1 0 0 4

County of Ada
City of Boise (If outside limits of city or village, give township.) No. 412 So. 12th St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jose Iraolabeitia

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	

6. DATE OF BIRTH: August (Month) 16th (Day) 1921 (Year)

7. AGE: ....Yrs. ....Mos. 4 ds. IF LESS than 1 day how many....hrs. or....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Juan Iraolabeitia

11. BIRTHPLACE OF FATHER (State or Country): Marquina, Vizaya Spain

12. MAIDEN NAME OF MOTHER: Maria Jurista

13. BIRTHPLACE OF MOTHER (State or Country): Motrico Spain

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ignacio Aregui
(Address) 418 Ida. St. Boise Ida.

15. Filed August 20 21 R. H. Pond Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 19th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 16 1921 to Aug 19th 1921 that I last saw h.im alive on Aug 19th 1921 and that death occurred on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:
Bronchopneumonia Following Measles
(Duration) ....Yrs. ....mos. ....ds.

Contributory (Secondary)
(Duration) ....yrs. ....mos. ....ds.

(Signed) Hans Burk M. D.
8-21 1921 (Address) Boise Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death....yrs....mos....days. In the State....yrs....mos....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
St Johns Cemetery	8/20 1921
20. UNDERTAKER: Schreiber & Sidenfaden	ADDRESS: Boise Ida

Boeck

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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FORM V. S. No. 5-25 M. 1-19.

RECEIVED SEP 6 - 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34990
Registered No. 342

1. PLACE OF DEATH
Registration District No. 2
Primary Registration District No. 1004
County of Ada
City of Boise (No. 410 West State St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Corwin James McRee
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Oct 12 (Month) (Day) 1885 (Year)

7. AGE: 35 Yrs. 10 Mos. 7 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Bank Cashier
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: Charles H. McRee

11. BIRTHPLACE OF FATHER (State or Country): Illinois

12. MAIDEN NAME OF MOTHER: Melora Spencer

13. BIRTHPLACE OF MOTHER (State or Country): Wisconsin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Edith W. McRee
(Address) Boise Idaho

15.
Filed Aug 22 1921
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August (Month) 19th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 13th 1921, to Aug. 19th 1921, that I last saw h.im alive on Aug. 19th 1921, and that death occurred on the date stated above, at 3:10 P.M.

The CAUSE OF DEATH* was as follows:
Encephalitis
autopsy - pathologic exam
matters not yet completed
(Duration) Yrs. mos. 5 ds.

Contributory (Secondary) —
(Duration) yrs. mos. ds.

(Signed) J. M. Taylor M. D.
Aug 19th 1921 (Address) Boise Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cem — DATE OF BURIAL: Aug 22 1921

20. UNDERTAKER: Summers & Kibbe — ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY; PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

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FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34991

Registered No. 243

RECEIVED SEP 6 - 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Ada Registration District No. 2

City of Boise Primary Registration District No. 1004

(No. 1418, Grant Ave St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Fred F Lloyd

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: May (Month) 25th (Day) 1859 (Year)

7. AGE: 62 Yrs. 2 Mos. 27 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: News Paper

(b) General nature of industry, business or establishment in which employed (or employer): Publishers

9. BIRTHPLACE (State or Country): Roseburg Oregon

10. NAME OF FATHER: Creed Lloyd

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Sarah Anna Lane

13. BIRTHPLACE OF MOTHER (State or Country): Ind.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mitta Lloyd

(Address) .....

15. Filed August 24 1921 R. W. Pratt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 22nd (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from January 3rd 1921, to aug 22 1921, that I last saw h.... alive on aug 22 1921 and that death occurred on the date stated above, at 8:30 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

.....(Duration) .....Yrs. .....mos. .....ds.

Contributory (Secondary) Arteris - Sclerosis

.....(Duration) .....yrs. .....mos. .....ds.

(Signed) J S Springer M. D.

Aug 25 1921 (Address) Boise Ida

*State the *Disease Causing Death*; or in deaths from **Violent Causes**, state (1) **Means of Injury**; and (2) whether **Accidental**, **Suicidal** or **Homicidal**.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs. .....mos. .....days. In the State .....yrs. .....mos. .....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
St Johns Cemetery	8/25 1921
20. UNDERTAKER	ADDRESS
Pierce Funeral Parlors	Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED SEP 6 - 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Ada — Registration District No. 2

City of Boise — Primary Registration District No. 1 — (No. 1900 N. 14th St.)

File No. 34992

Registered No. 34992/1

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs. Carrie A. Scott

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Feb, 24, 1872 (Month) (Day) (Year)

7. AGE: 49 Yrs. 5 Mos. 29 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wisconsin

10. NAME OF FATHER: George Prentiss

11. BIRTHPLACE OF FATHER (State or Country): N. Y.

12. MAIDEN NAME OF MOTHER: Nancy Skidmore

13. BIRTHPLACE OF MOTHER (State or Country): N. Y.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm McBratney

(Address) Boise Idaho

15. Filed August 24 19 21 — R. H. Pratt, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug. 23 - 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 17 1921 to Aug 23 1921 that I last saw h[illegible] alive on Aug 23 1921 and that death occurred on the date stated above, at 3a M.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) 1 yrs. ..... mos. ..... ds.

(Signed) W Slaters M. D.

8/23 1921 (Address) Boise, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Caldwell Idaho — DATE OF BURIAL: 8/23 1921

20. UNDERTAKER: W McBratney — ADDRESS: Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED SEP 6 - 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 2

County of Ada

Primary Registration District No. 1094

City of Boise (No. 411 Washington St.)

File No. 34993

Registered No. 245

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Viola Mare Yapp

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Aug (Month) 29 (Day) 1921 (Year)

7. AGE: Yrs. Mos. ds.

IF LESS than 1 day how many 7 hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Boise

10. NAME OF FATHER: R. G. Yapp

11. BIRTHPLACE OF FATHER (State or Country): Kas.

12. MAIDEN NAME OF MOTHER: Lena J. Topliff

13. BIRTHPLACE OF MOTHER (State or Country): Kas.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) R. G. Yapp

(Address) 411 Boise Ida

15. Filed August 30 1921 R. H. Pratt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 29 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 8-29 1921, to 8-29 1921 that I last saw h.r alive on 8-29 1921 and that death occurred on the date stated above, at 8:15 P.M.

The CAUSE OF DEATH* was as follows:

Premature + Imm. births

Immediate Cause of Death

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) D P Heyns M. D.

8-29 1921 (Address) 1612 Walnut Boise

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 8/31 1921

20. UNDERTAKER: Schneider & Siddoway — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED
SEP 6 - 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 8
Primary Registration District No. 2005
File No. 34994
Registered No. 57

1. PLACE OF DEATH
County of Ada
City of Boise.
(No. 6 miles S.W. of City St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elmer E. Emerson
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Sept (Month) 29 (Day) 1861 (Year)

7. AGE: 59 Yrs. 10 Mos. 12 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Asa Emerson

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Sarah Jones.

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wm McBratney
(Address) Boise Idaho

15. Filed Aug 13 1921 R. H. Pratt Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 11 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 10 1921, to Aug 11 1921
that I last saw him alive on Aug 11 1921,
and that death occurred on the date stated above, at 8 P. M.
The CAUSE OF DEATH* was as follows: Cancer of Liver and Stomach

(Duration) 5 Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) H. F. Neal M. D.
8-12 1921 (Address) Meridian Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery
DATE OF BURIAL: 8/14 1921

20. UNDERTAKER: W. McBratney
ADDRESS: Boise Idaho

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19

RECEIVED
SEP 6 - 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
Registration District No. 8
County of Ada
Primary Registration District No. 2008
City of Boise (No. U.S.P.H.S.Hospital #52 St.)
File No.
Registered No. 34985

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME David G. Harner

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Oct. 20, 1900 (Month) (Day) (Year)

7. AGE: 20 Yrs. 10 Mos. 5 ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Soldier, World War
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Port Ludlow, Wash.

10. NAME OF FATHER: D.I.Harner

11. BIRTHPLACE OF FATHER (State or Country): Canada

12. MAIDEN NAME OF MOTHER: Eva Sparks

13. BIRTHPLACE OF MOTHER (State or Country): Port Ludlow, Wash.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W.McBratney
(Address) Boise, Idaho.

15. Filed Aug 26 1921
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug. 25, 1921. (Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 26, 1920 19 ..., to Aug. 25, 1921 19 ...
that I last saw h...im... alive on Aug. 25, 1921 19 ..., 11:30 A. M.
and that death occurred on the date stated above, at ... M.

The CAUSE OF DEATH* was as follows:
Tuberculosis, chronic, pulmonary

Unknown (Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary) XX

XX (Duration) ... yrs. ... mos. ... ds.

J.A.P. (Signed) [signature] M. D.
USPHS Hosp. #52, Boise, Ida. Surgeon in Charge (R)
Aug. 26 19 21 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 1 yrs. 2 mos. 29 days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death? Unknown
Former or usual residence Ketchikan, Alaska

19. PLACE OF BURIAL OR REMOVAL: Montesano, Wash.
DATE OF BURIAL ... 19 ...

20. UNDERTAKER: W.McBratney
ADDRESS: Boise, Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED
SEP 6 - 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH — Registration District No. 8

County of Ada — Primary Registration District No. 3 and 4

City of Boise (No. 5 miles N. W. Boise St.)

File No. 24996

Registered No. 24996

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Henry Dazer.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M.	W.	Widower

6. DATE OF BIRTH — April 13 1830.
(Month) (Day) (Year)

7. AGE — 91 Yrs. 4 Mos. 18 ds.
IF LESS than 1 day how many ____ hrs. or ____ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) England.

10. NAME OF FATHER Robert Dazer.

11. BIRTHPLACE OF FATHER (State or Country) England.

12. MAIDEN NAME OF MOTHER Sophia Chapman.

13. BIRTHPLACE OF MOTHER (State or Country) England.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wm McBratney
(Address) Boise, Idaho.

15. Filed Sept 1 1921 — R. T. Pratt, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH — Aug 31 — 1921
(Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from August 23 1921, to August 31 1921 that I last saw h. alive on August 31 1921, and that death occurred on the date stated above, at ____ M.

The CAUSE OF DEATH* was as follows:
Arteriosclerosis, Senilis. Senile Bronchitis (Old age)

(Duration) ____ Yrs. ____ mos. ____ ds.

Contributory (Secondary)

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) L. P. McCalla M. D.
9/1/21 (Address) Boise, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL — Stella. Neb. — DATE OF BURIAL ____ 19

20. UNDERTAKER — W. McBratney — ADDRESS Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 84997
Registered No. 241

1. PLACE OF DEATH
County of Ada
City of Boise
(No. 410, Slate St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2
Primary Registration District No. 1004

2. FULL NAME Lina Hel Weiss
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F	White	Married

6. DATE OF BIRTH: Dec (Month) 25th (Day) 1885 (Year)

7. AGE: 35 Yrs. 8 Mos. 25 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Zurich Switzerland

10. NAME OF FATHER: Mr. Eichelsdinger

11. BIRTHPLACE OF FATHER (State or Country): Switzerland

12. MAIDEN NAME OF MOTHER: Dont Know

13. BIRTHPLACE OF MOTHER (State or Country): Switzerland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W Wm W Weiss
(Address)

15. Filed Aug 22 1921 R. H. Pratt Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 20th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from August 13th 1921, to August 20th 1921, that I last saw h[illegible] alive on August 20 1921, and that death occurred on the date stated above, at 5:30 P.M.

The CAUSE OF DEATH* was as follows:
Obstruction of bowel, following peritonitis
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) L. P. McCall M. D.
8/22 1921 (Address) Boise, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
St Johns Cemetery	8/23 1921
20. UNDERTAKER	ADDRESS
Johnson & Anderson	Boise

Dr. McCall.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED SEP 2 - 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bannock — Registration District No. 84

City of Kelly (No. ..... St.) — Primary Registration District No. 2161

File No. [illegible]

Registered No. 34998

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Martha Alice Smith

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write one word.)
F	white	single

6. DATE OF BIRTH: July 28, 1921 (Month) (Day) 1 (Year)

7. AGE: ..... Yrs. ..... Mos. 7 ds. — IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Bannock county

10. NAME OF FATHER: R.F. Smith

11. BIRTHPLACE OF FATHER (State or Country) Mapleton Utah

12. MAIDEN NAME OF MOTHER: Mary Ewell

13. BIRTHPLACE OF MOTHER (State or Country) Farmaquin Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Father

(Address) .....

15. Filed 9-1-21 19..... Walter L. Roach Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug 4 1921 (Month) (Day) 19..... (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....,
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Status Lymphaticus

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

..... 19..... (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Chesterfield	8-5 19.....
20. UNDERTAKER	ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
AUG 29 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 57
Primary Registration District No. 2022
File No. 34999
Registered No. 2299

1. PLACE OF DEATH
County of Blaine
City of Hailey, (Ward ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Alvin B. O'Neil.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.
4. COLOR OR RACE: White.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single.
6. DATE OF BIRTH: Feb. (Month) 27 (Day) 1870 (Year)
7. AGE: 51 Yrs. 4 Mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner.
(b) General nature of industry, business or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Kansas.
10. NAME OF FATHER: J. H. O'Neil.
11. BIRTHPLACE OF FATHER (State or Country): Ohio.
12. MAIDEN NAME OF MOTHER: Sophia Wendell.
13. BIRTHPLACE OF MOTHER (State or Country): Missouri.
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) X Mrs C. E. Preedy,
(Address) Leota, Idaho
15. Filed Aug 1 1921 R. H. Wright Local Registrar

MEDICAL CERTIFICATE OF DEATH

Dutton.
16. DATE OF DEATH: July. (Month) 1 (Day) 1921 (Year)
17. I HEREBY CERTIFY, That I attended deceased from June 9 1921 to July 1 1921
that I last saw h— alive on July 1 1921
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Gallstone Fever
Pulmonary T. B.
(Duration) ..... Yrs. ..... mos. 21 ds.
Contributory (Secondary)
(Duration) ..... Yrs. ..... ds.
(Signed) H. N. Dutton M. D.
19..... (Address) Hailey Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Hailey — DATE OF BURIAL: July 3 1921
20. UNDERTAKER: D. Harris — ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH — AUG 2 1921 — BUREAU OF VITAL STATISTICS — District No. 57
County of Blaine — Registration District No. 2022 — File No. 35001
City of Hailey (No. ..... St.) — Registered No. 23

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James M McPherson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	married.

6. DATE OF BIRTH — Dec. (Month) 13 (Day) 1852 (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds. — IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Mining Engineer.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Missouri

10. NAME OF FATHER —

11. BIRTHPLACE OF FATHER (State or Country) —

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER (State or Country) —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Elizabeth E McPherson
(Address) Hailey Ida.

15. Filed Aug-1 1921 — R. H. Wright, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

Dutton.

16. DATE OF DEATH July (Month) 12 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1 1921 to July 15 1921 that I last saw h.. alive on July 12 1921 and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows: Myocardial Degeneration.

(Duration) ..... Yrs. ..... mos. 12 ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) R H Dutton M. D.
1921 (Address) Hailey Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Hailey.	July 14 1921
20. UNDERTAKER J D Harris	ADDRESS Hailey

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
AUG 29 1921
BUREAU OF VITAL STATISTICS

Registration District No. 57
Primary Registration District No. 2022
File No. 35902
Registered No. 24

1. PLACE OF DEATH
County of Blaine
City of Ketchum (If outside limits, give township) St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Doris Newland.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Dec. 22 1834
(Month) (Day) (Year)

7. AGE: 86 Yrs. 6 Mos. 16 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: ✓

11. BIRTHPLACE OF FATHER (State or Country): ✓

12. MAIDEN NAME OF MOTHER: ✓

13. BIRTHPLACE OF MOTHER (State or Country): ✓

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R. H. Wright
(Address) Ketchum, Idaho

15. Filed Aug. 1 1921 R. H. Wright
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July 7. 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1 1921 to July 6 1921, that I last saw h[illegible] alive on July 6 1921 and that death occurred on the date stated above, at 7 P M.
The CAUSE OF DEATH* was as follows:
Acute Gastritis & Senility
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Robert H. Wright M. D.
7-18 1921 (Address) Hailey, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Ketchum, Ida — DATE OF BURIAL: 7-9 1921

20. UNDERTAKER: R. D. Harris — ADDRESS: Hailey.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY; PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35008
Registered No. 24

1. PLACE OF DEATH

County of Bonner — Registration District No. 85

City of Priest River, Ida. — Primary Registration District No. 2185

(No. of ..... St.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED SEP 8 BUREAU OF STATISTICS

2. FULL NAME Jean Ellen Ragan

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Single

6. DATE OF BIRTH: Feb. (Month) 8 (Day) 1921 (Year)

7. AGE: ---- Yrs. 6 Mos. 18 ds. — IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: Sid Ragan

11. BIRTHPLACE OF FATHER (State or Country): Idaho.

12. MAIDEN NAME OF MOTHER: Amy Lemley

13. BIRTHPLACE OF MOTHER (State or Country): Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Sidney Ragan
(Address) Priest River, Ida.

15. Filed Sept. 1 1924 — E. P. Goetz — Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 26 (Day) 1921 (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from Aug 24 1921, to Aug 26 1921 19, that I last saw h.. or.. alive on Aug 26 1921 19, and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows: 12.M

Bronchial Pneumonia

(Duration) — Yrs. — mos. 3 ds.

Contributory (Secondary)

(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) E. P. Goetz M. D.

Sept 19 1921 (Address) Priest River, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Priest River, Ida. — DATE OF BURIAL: Aug 26 1921 (Sept)

20. UNDERTAKER: Wm. Dairs — ADDRESS: Newport, Wash.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED SEP 6 - 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 85

Primary Registration District No. 2185

File No. 35094

County of Bonner

City of Priest River (No. ..... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and numl

2. FULL NAME Katherine Elizabeth SChindler

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F.	White	Married

6. DATE OF BIRTH

Sept (Month) 15 (Day) 1879 (Year)

7. AGE

41 Yrs. 11 Mos. 15 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE

(State or Country) Miss.

10. NAME OF FATHER Frank Smith-Wilson

11. BIRTHPLACE OF FATHER

(State or Country) Scotland

12. MAIDEN NAME OF MOTHER Elizabeth Earl

13. BIRTHPLACE OF MOTHER

(State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Herman Schindler

(Address) priest iver

15. Filed Sept 1 1921 C. P. Gustoff Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug. (Month) 31 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 19 1921 to Aug 31 1921, that I last saw her alive on Aug 31 1921, and that death occurred on the date stated above, at 8.05 P.M.

The CAUSE OF DEATH* was as follows:

Peritonotis following pelvic abcess

(Duration) — Yrs. 1 mos. 12 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. P. Gustoff M. D.

Sept 1921 (Address) Priest River, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Priest River Ida. DATE OF BURIAL Sept 2 1921

20. UNDERTAKER Wm Howe ADDRESS Newport

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
SEP 6 - 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 85

Primary Registration District No. 285

File No. 35005

County of Bonner

City of Priest River (No. ....., ... St.)

Registered No. 76

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Francis Robert Ramari

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single.

6. DATE OF BIRTH: August 22 1921 (Month) (Day) (Year)

7. AGE: ..... Yrs. ..... Mos. 2 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Dominic Ramari.

11. BIRTHPLACE OF FATHER (State or Country): Italy.

12. MAIDEN NAME OF MOTHER: Louise Traio

13. BIRTHPLACE OF MOTHER (State or Country): Italy

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Dominic Traio

(Address) Priest River Ida.

15. Filed Sept. 1 1921

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug. 22 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 22 1921, to Aug. 24 1921, that I last saw h. alive on Aug. 24 1921, and that death occurred on the date stated above, at 3 A.M.

The CAUSE OF DEATH* was as follows:

Premature Birth at seven and a half months.

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. P. Gotcliff M. D.

Sept. 1 1921 (Address) Priest River Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Priest River, Ida. DATE OF BURIAL: Sept. 1 1921

20. UNDERTAKER: Gus Nauert & Friend ADDRESS: Priest River, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. .....
Primary Registration District No. .....
(No. Kopf, Ida. St. .....)
File No. 35006
Registered No. .....

RECEIVED
SEP 2 - 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Bonner
City of Sand Point
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Hoo Chew

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single
6. DATE OF BIRTH: Unknown (Month) 1854 (Year)
7. AGE: 67 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Section Employe
(b) General nature of industry, business or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): China
10. NAME OF FATHER: Unknown
11. BIRTHPLACE OF FATHER (State or Country): China
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (State or Country): China
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) .....
(Address) .....
15. Filed Aug 1st 1921 John Larson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 28, 1921 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to 1921
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows: Asthma
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Heart Failure
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) W. M. Knapp M. D.
June 30, 1921. (Address) Kopf, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Kopf Ida. DATE OF BURIAL: June 29, 1921
20. UNDERTAKER: E. Keough ADDRESS: Sand Point, Ida

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 5-1089

FORM V. S. No. 5-25 M. 1-19.

RECEIVED AUG 27 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bonneville — Registration District No. 73

City of Idaho Falls — Primary Registration District No. 2170 — File No. 35008

(St.) — Registered No. 34

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Henry C Fletcher

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write word.)
Male	White	Married

6. DATE OF BIRTH: Nov (Month) 5 (Day) 1848 (Year)

7. AGE: 73 Yrs. ... Mos. ... ds. — IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Maine

10. NAME OF FATHER: Omar Fletcher

11. BIRTHPLACE OF FATHER (State or Country): Maine

12. MAIDEN NAME OF MOTHER: Ruth Bartlett

13. BIRTHPLACE OF MOTHER (State or Country): Maine

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Henry C Fletcher
(Address) Idaho Falls

15. Filed 7/29 1921 — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July 27 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 30 1921, to June 30 1921, that I last saw h— alive on June 30 1921 and that death occurred on the date stated above, at ... M.

The CAUSE OF DEATH* was as follows:

Cirrhosis of Liver

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) J. C. Hallett M. D.

19... (Address) Idaho Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Vandalia Mo — DATE OF BURIAL 19 21

20. UNDERTAKER: Clifford C Hayes — ADDRESS: Idaho Fa

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
AUG 27 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35009

Registered No. 73

1. PLACE OF DEATH

County of Bannock

City of Ida Falls

(No. ..... St.)

Registration District No. 73

Primary Registration District No. 2170

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary Smith

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widowed

6. DATE OF BIRTH: July (Month) 30 (Day) 1830 (Year)

7. AGE: 91 Yrs. 0 Mos. 4 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: James Hibbert

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Hannah Beaon

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Smith

(Address) Morgan, Ut

15. Filed July 27 1921

Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 24 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....,

that I last saw h..... alive on ..... 19.....,

and that death occurred on the date stated above, at 10 a M.

The CAUSE OF ~~DEATH~~* was as follows:

Hypertension - No medical attendance

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. M. Hammond M. D.

7/27 1921 (Address) Ida Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence ship

19. PLACE OF BURIAL OR REMOVAL: Morgan, Ut

DATE OF ~~BURIAL~~: 7/29 1921

20. UNDERTAKER: E. L. Dunwoody

ADDRESS: Ida Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35011

Registered No. 91

RECEIVED
AUG 27 1921
BUREAU OF VITAL STATISTICS

Registration District No. 73

Primary Registration District No. 2170

1. PLACE OF DEATH

County of Bonneville

City of Ida Falls (If outside limits of city or village, give township.) St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME James A Collett

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH: May (Month) 25 (Day) 1921 (Year)

7. AGE: 0 Yrs. 0 Mos. 25 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Idaho Falls

10. NAME OF FATHER James A Collett

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER Ida L Tydeman

13. BIRTHPLACE OF MOTHER (State or Country) Georgia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) James A Collett
(Address) City

15. Filed July 12 1921 C M Linnard Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 19 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 15 1921, to June 18th 1921, that I last saw h~~im~~ alive on June 18th 1921, and that death occurred on the date stated above, at 10 P M.

The CAUSE OF DEATH* was as follows:

Pertussis

(Duration) — Yrs. — mos. 11 ds.

Contributory (Secondary) —— (Duration) — yrs. — mos. — ds.

(Signed) G W Pendleton M. D.

June 19 1921 (Address) Idaho Falls, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Ida Falls Ida — DATE OF BURIAL: 8/30 1921

20. UNDERTAKER: C C Dunwoody — ADDRESS: Ida Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

Geo. W. Pendleton

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35012
Registered No. 70

1. PLACE OF DEATH.
Registration District No. 73
Primary Registration District No. 21-0
County of Bonneville
City of Idaho Falls (If not in incorporated limits, give township) (Street) Hospital

RECEIVED
AUG 27 1921
BUREAU OF VITAL STATISTICS

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ida Corbitt

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. (Month) Aug (Day) 27 (Year) 1870.

7. AGE: 51 Yrs. 7 Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Home wife.
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mo.

10. NAME OF FATHER: Alexander Nickell

11. BIRTHPLACE OF FATHER (State or Country): Ohio.

12. MAIDEN NAME OF MOTHER: Ellen Dodson.

13. BIRTHPLACE OF MOTHER (State or Country): Ohio.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Harlon Corbitt
(Address) Irwin Ida

15. Filed 7/11 1921 [signature] Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar (Month) 26 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1 1920, to Mar 26 1921, that I last saw h[er] alive on March 26 1921, and that death occured on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:
Chronic Valvular Heart Disease

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration yrs. mos. ds.

(Signed) H. Spencer M. D.
July 9 1921 (Address) Idaho Falls Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Rose Hill.	7/8 1921
20. UNDERTAKER Cliff C Hayes	ADDRESS Idaho Falls

Dr. Spencer.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
AUG 27 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 73
Primary Registration District No. 21-0

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35013
Registered No. 67

1. PLACE OF DEATH
County of Bannock
City of Idaho Falls
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ethel L. Carson
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Dec 10 1910 (Month) (Day) (Year)

7. AGE: 10 Yrs. 6 Mos. [illegible] ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa, Ida

10. NAME OF FATHER: Charles N Carson

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Ella Nixon

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Edgar Carson
(Address) Idaho Falls

15. Filed 7/16 1921 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July 6 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 5 1921, to July 6 1921, that I last saw h.. alive on July 6 1921, and that death occurred on the date stated above, at 12 M.
The CAUSE OF DEATH* was as follows: Acute Gangrenous Appendicitis

(Duration) ..... Yrs. ..... mos. 2 ds.
Contributory (Secondary) Appendicitis ?
(Duration) ..... yrs. ..... mos. 5 ds.

(Signed) W. Ray Hatch M. D.
July 7, 1921 (Address) Idaho Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Iona, Ida — DATE OF BURIAL: 7-8 1921

20. UNDERTAKER: [illegible] — ADDRESS: Idaho Falls

Dr. Hatch

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
AUG 27 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 73
Primary Registration District No. 2150
File No. 35014
Registered No. 26

County of Fremont
City of Ida Falls (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Ellen Wilcock

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Married

6. DATE OF BIRTH: Dec. (Month) 8 (Day) 1857 (Year)

7. AGE: 63 Yrs. 6 Mos. 19 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: at Home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Wm Cook Mitchell

11. BIRTHPLACE OF FATHER (State or Country): ?

12. MAIDEN NAME OF MOTHER: Louisa Moore

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. Wilcock
(Address) Shelley, Ida

15. Filed 7/6 1921 [illegible] Local Registrar

SYMS-YORK CO. PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 27 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 1921 to June 1921 that I last saw h[illegible] alive on June 1921, and that death occurred on the date stated above, at 12 P M.

The CAUSE OF DEATH* was as follows:

Shock following operation for Gall stone obstruction of Common duct.

(Duration) Yrs. ..... mos. 1 ds.

Contributory (Secondary) Gall stones in common duct

(Duration) 2 yrs. ..... mos. ..... ds.

(Signed) W Ray Hatch M. D.

June 1921 (Address) Idaho Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Shelley, Ida	6/1 1921
20. UNDERTAKER	ADDRESS
C C Sunwoodey	Ida Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

Dr Hatch

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35015

Registered No. 67

RECEIVED
AUG 27 1921
BUREAU OF VITAL STATISTICS

Registration District No. 73

Primary Registration District No. 2140

1. PLACE OF DEATH

County of Jannevill

City of Ida Falls (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Andrew or W Eckersley

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Child

6. DATE OF BIRTH: January (Month) 4 (Day) 1920 (Year)

7. AGE: 1 Yrs. 3 Mos. 21 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Wm A. Eckersley

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Margaret Calahan

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm A Eckersley

(Address) Ida Falls

15. Filed 7/6 1921 [signature] Local Registrar

Dr Rogers

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 25 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1 1921, to May 25 1921, that I last saw h[illegible] alive on 25 May 1921, and that death occurred on the date stated above, at 6 P M.

The CAUSE OF DEATH* was as follows:

Measles. Complication Inflamation Bowels & Pneumonia

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D R Rogers M. D.

5/26 1921 (Address) Ida Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Idaho Falls	5/27 1921
20. UNDERTAKER C C Dunwoody	ADDRESS Ida Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
AUG 27 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35016
Registered No. 44

1. PLACE OF DEATH
County of Bonneville
City of Ida Falls
Registration District No. 73
Primary Registration District No. 2170
No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Matilda Holenberg
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: January 13 1857 (Month) (Day) (Year)

7. AGE: 64 Yrs. 5 Mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: at Home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER: Eric Anderson

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: ?

13. BIRTHPLACE OF MOTHER (State or Country): ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Peter Holenberg
(Address) Idaho Falls, Ida

15. Filed July 6 1921 [signature] Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 21 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....
and that death occurred on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:
Severing of radial artery & bleeding to death, accidental
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C G Dimwoodey Coroner
7/7 1921 (Address) Idaho Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Idaho Falls, Ida. DATE OF BURIAL: 5/25 1921

20. UNDERTAKER: C G Dimwoodey ADDRESS: Ida Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

RECEIVED
AUG 27 1921
BUREAU OF VITAL STATISTICS

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35017
Registered No. 64

1. PLACE OF DEATH.
Registration District No. 73
Primary Registration District No. 2154
County of Bonneville
City of Idaho Falls (If not in hospital give street address or location) Eastern Idaho Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Infant Eggers

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. March 18 1921
(Month) (Day) (Year)

7. AGE ..... Yrs. ..... Mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Idaho Falls

10. NAME OF FATHER Erich Eggers

11. BIRTHPLACE OF FATHER (State or Country) Germany

12. MAIDEN NAME OF MOTHER Mary Dirks

13. BIRTHPLACE OF MOTHER (State or Country) Iowa.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Erich Eggers
(Address) Idaho Falls Ida

15. Filed July 6 1921 W. Simmons
Local Registrar

SYMS-YORK CO., PTRS. & ENGS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
March 30 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 18 1921, to May 30 1921, that I last saw h... alive on May 30 1921, and that death occured on the date stated above, at 3 P M.

The CAUSE OF DEATH* was as follows:
Two months prematurity

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) H. R. Hatch M. D.
19 ..... (Address) Idaho Falls.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Rose Hill Idaho Falls — DATE OF BURIAL 3/31 191

20. UNDERTAKER Cliff Hayes — ADDRESS Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

Hospital

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35048
Registered No. 64

RECEIVED
AUG 27 1921
BUREAU OF VITAL STATISTICS

Registration District No. 73
Primary Registration District No. 2170

1. PLACE OF DEATH
County of Bonneville
City of Idaho Falls (If outside limits of city or village, write "Rural") St. Anthony's Hospital
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Oscar Sullivan

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Oct (Month) 15 (Day) 1864 (Year)

7. AGE: 57 Yrs. ... Mos. ... ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Tennessee.

10. NAME OF FATHER: J. H. Sullivan

11. BIRTHPLACE OF FATHER (State or Country): Tennessee.

12. MAIDEN NAME OF MOTHER: Georgia Latham

13. BIRTHPLACE OF MOTHER (State or Country): Tennessee.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Jennie Sullivan
(Address) Hayden Tennessee

15. Filed July 12 1921 — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 17, 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 25, 1921 to June 17, 1921, that I last saw him alive on June 16, 1921, and that death occurred on the date stated above, at 7A M.

The CAUSE OF DEATH* was as follows:

Gastric Carcinoma

(Duration) Indefinite Yrs. ... mos. ... ds.

Contributory (Secondary)
(Duration) ... yrs. ... mos. ... ds.

(Signed) John C. Mellar M. D.
19 (Address) Idaho Falls, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Palmyra Idaho — DATE OF BURIAL: June 1921

20. UNDERTAKER: Hayes — ADDRESS: Idaho Falls Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED AUG 27 1921 BUREAU OF STATISTICS

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35020
Registered No. 62

1. PLACE OF DEATH.

County of Bonneville Registration District No. 73
City of Idaho Falls (If outside limits of city or village, give township) Registration District No. 2170
(No. of house in which death occurred, or street and number, if in city or village) St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Infant Prince, Maude Hood.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. March 20 1921
(Month) (Day) (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many 4 hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) 1 mile east Idaho Falls.

10. NAME OF FATHER A R Prince.

11. BIRTHPLACE OF FATHER (State or Country) Wyo.

12. MAIDEN NAME OF MOTHER Clara Golden.

13. BIRTHPLACE OF MOTHER (State or Country) Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) A R Prince
(Address) Regent Idaho

15. Filed 7/12 1921 C Kinnaird Local Registrar

BYNS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 20 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 20 1921, to March 20 1921, that I last saw h er alive on March 20 1921, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Premature child, about 7 months, lived four hours.
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) A R Kellogg M. D.
3/15 1921 (Address) Idaho Falls Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL, REMOVAL Rose Hill Cemetery | DATE OF BURIAL 3/22 1921

20. UNDERTAKER Cliff Hayes. | ADDRESS Idaho Falls.

Dr. Wilson

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35021

Registered No. 61

1. PLACE OF DEATH

County of Bonneville

City of Idaho Falls

(No. 1056 Lawson, St.)

Registration District No. 73

Primary Registration District No. 21N-0

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
AUG 21 1926
BUREAU OF VITAL STATISTICS

2. FULL NAME Mrs Prewitt Bates.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: March 15 (Month) (Day) 1921 (Year)

7. AGE: ..... Yrs. Mos. 18 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: no.

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho Falls.

10. NAME OF FATHER: W P Bates.

11. BIRTHPLACE OF FATHER (State or Country): Mo.

12. MAIDEN NAME OF MOTHER: Agnes Sincke.

13. BIRTHPLACE OF MOTHER (State or Country): Wis

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W P Bates

(Address) Idaho Falls Ida

15. Filed July 6 1921 Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr. 2. (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 14 1921, to Apr 2 1921, that I last saw h.... alive on Apr. 2 1921 and that death occurred on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:

Uremia Nephritis

(Duration) ..... Yrs. ..... mos. 14 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C E Lemmon M. D.

July 6 1921 (Address) Idaho Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rose Hill Idaho — DATE OF BURIAL: Apr 4 1921

20. UNDERTAKER: Duff & Hayes — ADDRESS: Idaho Falls,

Dr. Kinnard

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35022
Registered No. 40

RECEIVED
AUG 27 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
Registration District No. 13
Primary Registration District No. 2110
County of Bonneville
City of Idaho Falls (No. if in hospital, give its NAME instead of street and number) General Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Wm Thiel

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married. (Write the word.)

6. DATE OF BIRTH: Dec 27 1874 (Month) (Day) (Year)

7. AGE: 46 Yrs. ... Mos. ... ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher.
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Wisconsin

10. NAME OF FATHER: Peter H Thiel

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Marthalena Teason

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Peter H Thiel
(Address) Idaho Falls Ida

15. Filed July 12 1921 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 27 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 12 1921 to June 27 1921 that I last saw h alive on June 27 1921 and that death occurred on the date stated above, at 8P M.

The CAUSE OF DEATH* was as follows:

Duodenal Ulcer

(Duration) 3 Yrs. ... mos. ... ds.

Contributory (Secondary) Pneumonia

(Duration) ... yrs. 7 mos. ... ds.

(Signed) [illegible] M. D.

19 ... (Address) Idaho Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL [illegible] DATE OF BURIAL July 2 1921

20. UNDERTAKER Jeff Hayes ADDRESS Idaho Falls Ida.

Dr Shaw.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35023

Registered No. 1-9

RECEIVED
AUG 27 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH. Registration District No. 73

County of Bannock Primary Registration District No. 21-0

City of Pocatello (No. Lee Hoop St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary E. Eggers

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Sept (Month) 25 (Day) 1890 (Year)

7. AGE: 30 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife.
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Iowa.

10. NAME OF FATHER: Friedrich Dunkel

11. BIRTHPLACE OF FATHER (State or Country): Germany.

12. MAIDEN NAME OF MOTHER: Margaret Bordike

13. BIRTHPLACE OF MOTHER (State or Country): Germany.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Erich Eggers.
(Address) Idaho Falls Ida.

15.
Filed ..... 191....
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Mar (Month) 30 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 3 1921, to Mar 30 1921, that I last saw h[illegible] alive on Mar 30 1921, and that death occured on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:
Extensive burns of trunk and body and both legs. (Scalds)
(Duration) ..... Yrs. ..... mos. 27 ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. R. Hatch M. D.
19..... (Address) Idaho Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Longworth Idaho — DATE OF BURIAL: Mar 1921

20. UNDERTAKER: Steffe Hayes — ADDRESS: Idaho Falls

Dr Hatch

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAIN — USE INDELIBLE INK—THIS IS A PERMANENT RECORD. — FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-19.

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BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35024

Registered No. 1-2

1. PLACE OF DEATH

Registration District No. 73

County of Bannock

Primary Registration District No. 21-0

City of Pocatello (If outside city limits, give township) Pocatello (or Hunter) St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James Waldon.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH: May (Month) 2 (Day) 1845 (Year)

7. AGE: 75 Yrs. 11 Mos. 8 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ill.

10. NAME OF FATHER: Solomon K Waldon

11. BIRTHPLACE OF FATHER (State or Country): Ill.

12. MAIDEN NAME OF MOTHER: Mary Reed.

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Katherine Waldon
(Address) Idaho Falls Ida

15. Filed July 12 1921 [signature] Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 10 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 9 1921, to June 10 1921, that I last saw h[illegible] alive on June 10 1921, and that death occurred on the date stated above, at 7:30 A.M.

The CAUSE OF DEATH* was as follows:

Mitral insufficiency

(Duration) One Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo. A. Asheperle M. D.

June 13 1921 (Address) Idaho Falls, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Kansas City Mo.	11 1921

20. UNDERTAKER	ADDRESS
C. F. Hayes	Idaho Falls

Dr. Asheperle

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35025

Registered No. 1-7

1. PLACE OF DEATH

County of Bonneville Registration District No. 73

City of Idaho Falls (If outside limits of city or village, give township) Primary Registration District No. 21 V-2

(St.) Kettering Sanitarium

If death occurs away from usual residence, give facts called for under special information.

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BUREAU OF VITAL STATISTICS

2. FULL NAME Mary Gibbs

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED: Widow (Write the word.)

6. DATE OF BIRTH: Sept (Month) 9 (Day) 1864 (Year)

7. AGE: 57 Yrs. ... Mos. ... ds.

IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Home wife.

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: A A Harmon.

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Margaret Scott

13. BIRTHPLACE OF MOTHER (State or Country): Ohio.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E M Gibbs

(Address) Ryby Idaho

15. Filed 7/12 1921 [illegible] Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 27 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 20 1921, to May 27 1921, that I last saw h[illegible] alive on May 27 1921, and that death occurred on the date stated above, at 9.45 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ... Yrs. 9 mos. ... ds.

Contributory (Secondary) Bright's

(Duration) 2 yrs. ... mos. ... ds.

(Signed) W A Kettering M. D.

May 29 1921 (Address) Idaho Falls Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Providence Utah — DATE OF BURIAL: 5/30 1921

20. UNDERTAKER: Cliff Hayes — ADDRESS: Idaho Falls

Dr. Kettering

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
AUG 27 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bonneville Registration District No. 73

City of Idaho Falls (No. 4 Spencer Hosp. St.) Primary Registration District No. 21 V-6

File No. 35026

Registered No. V 6

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Joe Alarcon

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: Brown

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: March 19 1901 (Month) (Day) (Year)

7. AGE: 20 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mexico.

10. NAME OF FATHER: Jasous Alarcon.

11. BIRTHPLACE OF FATHER (State or Country): Mexico.

12. MAIDEN NAME OF MOTHER: Don't Know.

13. BIRTHPLACE OF MOTHER (State or Country): Mexico.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Esquil DeLeon Alarcon
(Address) Firth Ida

15. Filed 7/12 1921 [signature] Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 21 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5-21-1921, to 5-21-1921, that I last saw h[illegible] alive on 5-21-1921, and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Shock following injury

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) T. C. Hollister M. D.

19 (Address) Idaho Falls, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

(Former) or usual residence

19. PLACE OF BURIAL OR REMOVAL: Firth Ida — DATE OF BURIAL: May 23 1921

20. UNDERTAKER: Cliff Hayes — ADDRESS: Idaho Falls

Dr. Hatcher

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

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FORM V. S. No. 5-25 M. 1-19.

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BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bonneville — Registration District No. 73

City of Idaho Falls (No. ..... St.) — Primary Registration District No. 2110

File No. 35028

Registered No. 4

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Nina Stevens

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	married

6. DATE OF BIRTH: June (Month) 18 (Day) 1894 (Year)

7. AGE: 27 Yrs. ..... Mos. ..... ds. — IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) N. C.

10. NAME OF FATHER Creatas R Platt

11. BIRTHPLACE OF FATHER (State or Country) N. C.

12. MAIDEN NAME OF MOTHER Ada Young

13. BIRTHPLACE OF MOTHER (State or Country) N. C.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jno A Stevens
(Address) Idaho Falls Ida

15. Filed July 12 1921 — Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr. (Month) 1 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 24 1921, to Apr 1 1921, that I last saw h.. alive on March 31 1921, and that death occurred on the date stated above, at 4 A.M.

The CAUSE OF DEATH* was as follows:
Broncho Pneumonia

..... (Duration) ..... Yrs. ..... mos. 6 ds.
Contributory (Secondary) Measles
..... (Duration) ..... yrs. ..... mos. 10 ds.

(Signed) W R Hatch M. D.
..... 19..... (Address) Idaho Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rose Hill Idaho Falls — DATE OF BURIAL: Apr 3 1921

20. UNDERTAKER: Jeff Hayes — ADDRESS: Idaho Falls,

Dr. Hatch,

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35030

Registered No. 1-2

1. PLACE OF DEATH

Registration District No. 73

Primary Registration District No. 21 N - 0

County of Bonneville

City of Idaho Falls (or Village, or Township, or Town) St.)

If death occurs away from usual residence, give facts called for under special information.

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2. FULL NAME Fredrick Wells

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH: May (Month) 19 (Day) 1918 (Year)

7. AGE: 3 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Noo

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Samuel Earl Wells

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Martha Carter

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Earl Wells.

(Address) Aurora. Ida.

15. Filed July 12 1921 C. E. Kinnaird Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 16 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 9th, 1921, to May 16th, 1921, that I last saw him alive on May 16, 1921, and that death occurred on the date stated above, at 5 A.M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) Yrs. mos. 9 ds.

Contributory (Secondary) Measles followed by Pneumonia

(Duration) yrs. mos. ds.

(Signed) W. F. Kellenberg & Co. M. D.

May 19 21 (Address) Idaho Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Aurora Ida. DATE OF BURIAL: May 18 1921

20. UNDERTAKER: Jeff Haynes ADDRESS: Idaho Falls.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

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FORM V. S. No. 5-25 M. 1-19.

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BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 2 1 N 0
File No. 35031
Registered No. 71

1. PLACE OF DEATH
County of Bonneville
City of Idaho Falls (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Marion Dof Walquist.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single.
6. DATE OF BIRTH: April (Month) 1 (Day) 1919 (Year)
7. AGE: 2 Yrs. 3 Mos. 4 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Child.
(b) General nature of industry, business or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Idaho.
10. NAME OF FATHER: E. W Walquist.
11. BIRTHPLACE OF FATHER (State or Country): Neb
12. MAIDEN NAME OF MOTHER: Hanna Bodin
13. BIRTHPLACE OF MOTHER (State or Country): Idaho.
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. W. Walquist.
(Address) 13 Fifth Idaho Falls
15. Filed 7/22 1921 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH

Dr Spencer

16. DATE OF DEATH: July (Month) 4 (Day) 21 (Year)
17. I HEREBY CERTIFY, That I attended deceased from June 30 1921, to July 4 1921, that I last saw h.im alive on July 3 1921, and that death occurred on the date stated above, at 10 P.M.
The CAUSE OF DEATH* was as follows:
Cholera Infantum
(Duration) ..... Yrs. ..... mos. 14 ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) H. B. Spencer M. D.
July 9 1921 (Address) H. B. Spencer

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rose Hill. DATE OF BURIAL: July 6 1921
20. UNDERTAKER: Cliff Hayes ADDRESS: Idaho Falls

Dr. Spencer.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

...em of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH ...ns, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

...MS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD of HEALTH
Bureau of Vital Statistics

File No. 35032

Registered No. 1

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BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH. Registration District No. 73

County of Bonneville Primary Registration District No. 2 1V-0

City of Ririe (If not in incorporated limits, give township) St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs Minnie Pugmire

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. (Month) Oct (Day) 29 (Year) 1883

7. AGE: 38 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Geo P Wards.

11. BIRTHPLACE OF FATHER (State or Country): England.

12. MAIDEN NAME OF MOTHER: Benicia Nielson

13. BIRTHPLACE OF MOTHER (State or Country): Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) A J Pugmire
(Address) Ririe.

15. Filed 7/12 1921 C Osmond Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (Month) March (Day) 30 (Year) 1921

17. I HEREBY CERTIFY, That I attended deceased from March 29 1921, to March 29 1921, that I last saw h[illegible] alive on March 29 1921, and that death occured on the date stated above, at 11 PM.

The CAUSE OF DEATH* was as follows:
Bronchio Pneumonia

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.

July 4 1921 (Address) Idaho Falls Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Aaron Cem — DATE OF BURIAL: Apr. 2, 1921

20. UNDERTAKER: Jeff Hagen — ADDRESS: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STNRS. 24853

Dr Peterson

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35033
Registered No. 14

1. PLACE OF DEATH.
Registration District No. 3
Primary Registration District No. 2007
County of Canyon
City of Caldwell St.
If death occurs away from usual residence, give facts called for under special information.

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AUG 27 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME John O'Malia

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. March 5 (Month) (Day) 1850 (Year)

7. AGE 71 Yrs. 4 Mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Engineer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Ireland

10. NAME OF FATHER J. O'Malia

11. BIRTHPLACE OF FATHER (State or Country) Ireland

12. MAIDEN NAME OF MOTHER Dorit Moran

13. BIRTHPLACE OF MOTHER (State or Country) Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) John C. Malia Jr.
(Address) Parma Ida.

15.
Filed 8-1 1921 Lulu Waldrop Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 31 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 31 to July 31 1921, that I last saw h..... alive on ..... 191..., and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Natural Causes - Prostate
Heart disease as final
given a Cystitis Chronic
(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) W. W. Mulen M. D.
Aug. 1 1921 (Address) Parma, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Boise. DATE OF BURIAL: 8-2 1921

20. UNDERTAKER: Beckham Furn Co. ADDRESS: Parma

BYMS - YORK CO., PTRS. & BORS. 24658

FORM V. S. No. 5-25 M. 1-16-13 (wadrop)

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35034

Registered No. 93

RECEIVED
AUG 27 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH.

Registration District No. 3

County of Canyon

Primary Registration District No. 1007

City of Parma (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Nancy O Simmons

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): widow

6. DATE OF BIRTH. Sept (Month) 16 (Day) 1851 (Year)

7. AGE: 69 Yrs. 9 Mos. 9 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New Hampshire

10. NAME OF FATHER: Clark

11. BIRTHPLACE OF FATHER (State or Country): Do not Know

12. MAIDEN NAME OF MOTHER: Do not Know

13. BIRTHPLACE OF MOTHER (State or Country): Do not Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Maggie Trembley
(Address) Parma

15. Filed 8-1 [redacted] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 28 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1, 1921, to July 28 1921, that I last saw h[illegible] alive on July 25 1921, and that death occured on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:
Chronic Bronchitis-disease

(Duration) — Yrs. 6 mos. — ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) W. E. Waldron M. D.
July 28 1921 (Address) Parma Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Parma, Ida. DATE OF BURIAL: July 29 1921

20. UNDERTAKER: Peckham Furn Co ADDRESS: Parma, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOOKS. 24658

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED
AUG 24 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 5

Primary Registration District No. 2007

File No. 35035

County of Canyon

City of Parma (St.)

Registered No. 12

If death occurs away from usual residence, give facts called for under special information:

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ida M. McCormick

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W

5. ~~SINGLE~~, MARRIED, ~~WIDOWED OR DIVORCED~~. (Write the word.)

6. DATE OF BIRTH. Aug. (Month) 20 (Day) 1852 (Year)

7. AGE: 68 Yrs. 11 Mos. 2 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Housewife

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Wisconsin

10. NAME OF FATHER Martin

11. BIRTHPLACE OF FATHER (State or Country) Do not Know

12. MAIDEN NAME OF MOTHER Ida " "

13. BIRTHPLACE OF MOTHER (State or Country) " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rae O. McCormick

(Address) Parma

15. Filed 8-1 1921 Lulu Waldrop Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 22 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 16 1921, to July 22 1921, that I last saw her alive on July 18 1921, and that death occured on the date stated above, at 7:15 P.M.

The CAUSE OF DEATH* was as follows:

Pyonephrosis

(Duration) Yrs. 6 mos. ds.

Contributory (Secondary)

(Duration yrs. mos. ds.

(Signed) Chas. B. Allen M. D.

7/25 1921 (Address) Parma, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL ~~OR REMOVAL~~ Roswell — DATE OF BURIAL June 24 1921

20. UNDERTAKER Peckham Fun Co — ADDRESS Parma

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SORS. 24658

FORM V. S. No. 5-25 M. 1-16-18

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
AUG 27 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH. Registration District No. 9
County of Canyon Primary Registration District No. 2007
City of Parma (If not in city give township) St.)
If death occurs away from usual residence, give facts called for under special information.

File No. 35036
Registered No. 711
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mrs C M Wasso

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE: Cygan

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. May (Month) 15 (Day) 1901 (Year)

7. AGE: 20 Yrs. 5 Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer)...

9. BIRTHPLACE (State or Country) St Louis Mo

10. NAME OF FATHER Joe Wasso

11. BIRTHPLACE OF FATHER (State or Country) Servia

12. MAIDEN NAME OF MOTHER Saka Jelenic

13. BIRTHPLACE OF MOTHER (State or Country) Servia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Milka Wasso
(Address)

15. Filed 7-19 1921 Buchanan Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 18 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I ~~attended deceased from~~ July 18 1921, to ~~1921~~, that I ~~last~~ saw him alive on ~~1921~~, and that death occured on the date stated above, at 5 or 6 P.M.

The CAUSE OF DEATH* was as follows:
apparently Typhoid
(Duration) ~~Yrs.~~ mos. ds.
Contributory (Secondary)
(Duration ~~yrs.~~ mos. ds.
(Signed) Don K. Mountsier M. D.
19 (Address) Parma, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Boise — DATE OF BURIAL: 191

20. UNDERTAKER: Buckham Furniture Co — ADDITRESS: Parma

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRNS - YORK CO., PTRS. & BKBS. 24858

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35037

Registered No. 5

RECEIVED
SEP 1 - 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH.

Registration District No. 82

Primary Registration District No. 2159

County of Caribou

City of ..... (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ralph Harrison

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH: Aug. (Month) 16, 1921 (Day) (Year)

7. AGE: 44 Yrs. ..... Mos. 9 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Rancher

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Thomas John Harrison

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Hannah M.Laws

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Hannah C.Swensen

(Address) Soda Springs, Idaho

15. Filed Aug.25,1921 191.... Ellis Kackley Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug. (Month) 25,1921 (Day) 191 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug.16,1921 191.... to Aug.25,1921 191...., that I last saw him alive on Aug.25,1921 191...., and that death occured on the date stated above, at 554 M.

The CAUSE OF DEATH* was as follows:

Fract.of 7,8,9th Vertebrae

.....(Duration) ..... Yrs. ..... mos. 9 ds.

Contributory (Secondary) None

.....(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Ellis Kackley Ellis Kackley M. D.

8/25/21 (Address) Soda Springs, Id

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Bancroft, Idaho — DATE OF BURIAL: 8/28/21 191....

20. UNDERTAKER: Linquist — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

STUB - YORK CO., PTRS. & STNRS. 24858

FORM V. S. No. 5-25 M. 1-19.

RECEIVED SEP 1 - 19 BUREAU OF STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Cubor
City of
(No. St.)
If death occurs away from usual residence, give facts called for under spec. information.

Registration District No. 82
Primary Registration District No. 2159
File No. 35038
Registered No. 6

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ross B. Pennell

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, ~~MARRIED, WIDOWED OR DIVORCED~~ (Write the word.)
M.	W.	

6. DATE OF BIRTH
Dont Know (Month) (Day) 1 (Year)

7. AGE
38 Yrs. — Mos. — ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Rancher
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Oregon?

10. NAME OF FATHER
James Pennell

11. BIRTHPLACE OF FATHER
(State or Country) Dont Know

12. MAIDEN NAME OF MOTHER
Dont Know

13. BIRTHPLACE OF MOTHER
(State or Country) Dont Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ellis Kaufley
(Address) Soda Springs Idaho

15.
Filed Aug 15, 1921 Ellis Kaufley
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Aug 11, (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 1, 1921, to Aug 11, 1921, that I last saw h[illegible] alive on Aug 11, 1921, and that death occurred on the date stated above, at 2 P.M.
The CAUSE OF DEATH* was as follows:

Hemorrhage of Bowels
(Duration) Yrs. mos. 14 ds.
Contributory (Secondary) Typhoid Fever
(Duration) yrs. mos. ds.
(Signed) Ellis Kaufley M. D.
Aug 15, 1921 (Address) Soda Springs Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Vilisca, Iowa
DATE OF BURIAL Aug 20 1921

20. UNDERTAKER Schumacher & Bell
ADDRESS Coalville

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
SEP 6 - 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 99
Primary Registration District No. 21 77
File No. 35039
Registered No.

1. PLACE OF DEATH

County of Fremont.
City of St Anthony Ida. (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Baby Smoot

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH: July (Month) 23 (Day) 1921 (Year)

7. AGE: ....Yrs....Mos....ds.
IF LESS than 1 day how many 1 hrs. or 30 min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Idaho.

10. NAME OF FATHER Horace A Smoot

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Edna L. Stubbs

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) .....
(Address) .....

15. Filed Aug 10 1921 W Durrant Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 23 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from — 19.... to — 19....
that I last saw h..... alive on ....19....,
and that death occurred on the date stated above, at ....M.
The CAUSE OF DEATH* was as follows:

Unknown
premature

(Duration) ....Yrs....mos....ds.

Contributory (Secondary) .....
(Duration) ....yrs....mos....ds.

(Signed) J Frank Watkins M. D.
July 1921 (Address) St Anthony Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL ....19....

20. UNDERTAKER | ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V.S. No. 625 M. 1-19.

SEP 6 - 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 99
Primary Registration District No. 2177
File No. 35040
Registered No.

1. PLACE OF DEATH
County of St. Anthony, Ida.
City of
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Baby Smoot
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH: July 23 -21.
(Month) (Day) 1 (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.? 1

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER: Horace A. Smoot

11. BIRTHPLACE OF FATHER: Utah
(State or Country)

12. MAIDEN NAME OF MOTHER: Edna L. Stubbs

13. BIRTHPLACE OF MOTHER: Utah.
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant)
(Address)

15. Filed Aug 10 19 21 — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July 23 -"I.
(Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Unknown Stillborn

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. Frank Watkins M. D.
July 24th 21 (Address) St. Anthony, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL ..... 19.....

20. UNDERTAKER | ADDRESS

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED
SEP 6 - 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 103
Primary Registration District No. 1001
File No. 35041
Registered No. 24

1. PLACE OF DEATH.
County of Idaho
City of Grangeville (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Frances Jane Smith

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow
6. DATE OF BIRTH. March 11th 1847 (Month) (Day) (Year)
7. AGE: Yrs. 74 Mos. 5 ds. 13 — IF LESS than 1 day how many ..... hrs. or ..... min.
8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry, business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Missouri
10. NAME OF FATHER: John J Maxey
11. BIRTHPLACE OF FATHER (State or Country):
12. MAIDEN NAME OF MOTHER: Laura Morris
13. BIRTHPLACE OF MOTHER (State or Country): —
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Leora Smith Martin
(Address) Salem, Oregon
15. Filed Sept 1 1921 — G S Stockton, Local Registrar

SYMS - YORK CO., PYRS. & SONS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August 24th 1921 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from June 1, 1921, to Aug 24 1921, that I last saw her alive on Aug 20 1921, and that death occured on the date stated above, at 7a, M.
The CAUSE OF DEATH* was as follows:
Senile decay
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Arteriosclerosis
(Duration) 2 yrs. ..... mos. ..... ds.
(Signed) G. S. Stockton M. D.
8/25 1921 (Address) Grangeville Ida

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Prairie View — DATE OF BURIAL: Aug 26th 1921
20. UNDERTAKER: E S Hancock — ADDRESS: Grangeville

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13 RECEIVED

SEP 6 - 1921

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35042

Registered No. 23

1. PLACE OF DEATH.

Registration District No. 103

Primary Registration District No. 1001

County of Idaho

City of Grangeville (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charles Muhlenberg King

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. May (Month) 23. (Day) 1868 (Year)

7. AGE: 53 Yrs. 2 Mos. 29 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: merchant

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE: Baltimore city (State or Country)

10. NAME OF FATHER: Theokeles King

11. BIRTHPLACE OF FATHER: Pennsylvania (State or Country)

12. MAIDEN NAME OF MOTHER: Mary Ellen Muehlenburg

13. BIRTHPLACE OF MOTHER: Virginia (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Grafton F. Johnson

(Address) Grangeville Idaho

15. Filed Sept 1 1921 G S Stockton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August (Month) 19 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 1 1921, to Aug 19 1921, that I last saw h~~im~~ alive on Aug 18 1921, and that death occured on the date stated above, at 4 p. M.

The CAUSE OF DEATH* was as follows:

Self enforced Starvation

(Duration) ..... Yrs. ..... mos. 4 3 ds.

Contributory (Secondary) Mental derangement

(Duration 2 mos.) ..... yrs. ..... mos. ..... ds.

(Signed) G S Stockton M. D.

8/20 1921 (Address) Grangeville Ida

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Prairie View — DATE OF BURIAL: 8—20 1921

20. UNDERTAKER: E. S. Hancock — ADDRESS: Grangeville

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

EVANS - YORK CO., PTRS. & STRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED SEP 6 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 103
County of Idaho. Primary Registration District No. 1001
City of Grangeville (No. ..... St.)
File No. 35043
Registered No. 22

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME James Eade

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Aug (Month) 2d (Day) 1921 (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many 1 hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer)...

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Joseph A Eade

11. BIRTHPLACE OF FATHER (State or Country) Illinois

12. MAIDEN NAME OF MOTHER Ethel Lemage

13. BIRTHPLACE OF MOTHER (State or Country) Hanover Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. A. Eade
(Address) Grangeville

15. Filed Sept 1 1921 G B Stockton Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 2 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 2 1921, to Aug 2 1921, that I last saw him alive on Aug 2 1921, and that death occured on the date stated above, at 3a, M.

The CAUSE OF DEATH* was as follows:
Non closure of foramen Ovale,

(Duration) ..... Yrs. ..... mos. 1 hour ds.

Contributory (Secondary) Don't Know

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G. B. Stockton M. D.

9/3 1921 (Address) Grangeville Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?...
Former or usual residence ...

19. PLACE OF BURIAL OR REMOVAL: Prairie view — DATE OF BURIAL: Sept 3 1921

20. UNDERTAKER: E S Hancock — ADDRESS: Kamiah

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35044
Registered No. 112

1. PLACE OF DEATH.
County of Idaho. Registration District No 106
City of near Stites (Reg. Registration District No 2184 St.)
If death occurs away from usual residence, give facts called for under special information.

RECEIVED AUG 16 1921 BUREAU OF VITAL STATISTICS

2. FULL NAME John Franklin Emmert

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write word): Married
6. DATE OF BIRTH. Aug (Month) 11th (Day) 1880 (Year)
7. AGE: 40 Yrs. 10 Mos. 26 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher
(b) General nature of industry, business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Iowa
10. NAME OF FATHER: John Franklin Emmert
11. BIRTHPLACE OF FATHER (State or Country):
12. MAIDEN NAME OF MOTHER: Mary Lytle
13. BIRTHPLACE OF MOTHER (State or Country):
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Arabelle Eliza Emmert
(Address) Stites Ida
15. Filed July 8 1921 H. W. Wentworth Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 7th (Day) 1921 (Year)
17. I HEREBY CERTIFY, That I attended deceased from June 25 1921, to July 6th 1921, that I last saw him alive on July 6th 1921, and that death occured on the date stated above, at 3:15 P. M.
The CAUSE OF DEATH* was as follows:
Uremia Exhaustion with heart failure — Prolonged uremia
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Prostate aneurism
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) H. W. Wentworth M. D.
July 7 1921 (Address) Stites Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Clearwater Ida — DATE OF BURIAL: July 8 1921
20. UNDERTAKER — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SVMS - YORK CO., PTRS. & STRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

RECEIVED
AUG 27 1921
BUREAU OF VITAL STATISTICS

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35015

Registered No. 96

1. PLACE OF DEATH.

Registration District No. 126

Primary Registration District No. 2204

County of Kootenai

City of Harrison (If not in incorporated territory give Township) St.)

If death occurs away from usual residence, give facts called for under special information.

2. USUAL NAME Bernard R Murray

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. (Month) Nov (Day) 25 1859 (Year)

7. AGE: 61 Yrs. 7 Mos. 19 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farm Labor

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mass

10. NAME OF FATHER: Murray

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Brennan

13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Hallie B Murray

(Address) Harrison Idaho

15. Filed Aug 1 1921 J M Timm Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 13 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 27 1921 to July 13 1921, that I last saw him alive on July 13 1921 and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Bursa on Chest

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) abscess of lung

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) J M Timm M. D.

7-31 1921 (Address) Harrison Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Harrison — DATE OF BURIAL: 7-14 1921

20. UNDERTAKER: Hutchinson — ADDRESS:

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35046
Registered No.

RECEIVED
SEP 6 - 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Latah
City of Bovill (If outside limits of city or village, give township.) Bovill Hospital St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 66
Primary Registration District No. 2176

2. FULL NAME Mick Chambers
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Not known (Month) (Day) (Year)

7. AGE: about 65 Yrs. Not known Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Lumber Camp Laborer
(b) General nature of industry, business or establishment in which employed (or employer): Winton Lumber Co

9. BIRTHPLACE (State or Country): Dont know

10. NAME OF FATHER: Dont know

11. BIRTHPLACE OF FATHER (State or Country): Dont know

12. MAIDEN NAME OF MOTHER: Dont know

13. BIRTHPLACE OF MOTHER (State or Country): Dont know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Pat Grady
(Address) Bovill Idaho.

15. Filed Aug. 17 1921 Wm. P. Gibson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) – 14 – (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 2 – 1921, to Aug 14 – 1921, that I last saw him alive on Aug 14 – 1921, and that death occurred on the date stated above, at 9 A. M.
The CAUSE OF DEATH* was as follows:

Prostatec Cancer and Cellulitis of perineum
(Duration) Yrs. mos. 3 ds.
Contributory (Secondary) Chronic Gonarrhoea and Stricture of urethra
(Duration) 10 yrs. mos. ds.

(Signed) F. C. Gibson M. D.
Aug 14-1921 (Address) Bovill Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. 3 days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence St. Maries, Idaho

19. PLACE OF BURIAL OR REMOVAL: Bovill Idaho — DATE OF BURIAL: 8/15 1921

20. UNDERTAKER: Glen Price — ADDRESS: Moscow Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 64
Primary Registration District No. 7142
File No. 35047
Registered No. 6

1. PLACE OF DEATH
County of Nez Perce
City of Genesee
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Hans C Larson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED — THIS IS EXACTLY WHERE CAUSE OF DEATH
WRITE PLAINLY, WITH UNFADING INK — THIS IS ... in back of certificate.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very im...

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	W	Married

6. DATE OF BIRTH: January (Month) 31 (Day) 1887 (Year)

7. AGE: 34 Yrs. 6 Mos. 17 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho (Genesee)

10. NAME OF FATHER: C Larson

11. BIRTHPLACE OF FATHER (State or Country): Norway

12. MAIDEN NAME OF MOTHER: Carrie Hanson

13. BIRTHPLACE OF MOTHER (State or Country): Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. E. Nordby
(Address) Genesee Idaho

15. Filed 8-19 1921 Lot Eblen
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 16 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1920 to 1921, to ..... 19..., that I last saw him alive on 11 day of Aug, 1921, and that death occurred on the date stated above, at 12 30 P. M.

The CAUSE OF DEATH* was as follows:
Tumor of the Brain or Encephalic Aneurysm
Long (Duration) 2 Yrs. ..... mos. 10 months ds.
Contributory (Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Marcus S Fitz M. D.
8-19 1921 (Address) Lewiston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Genesee | DATE OF BURIAL: 8-20 1921

20. UNDERTAKER: H. Lambert | ADDRESS: Genesee

FORM V. S. No. 5-25 M. 1-16-18

RECEIVED AUG 27 1921 BUREAU OF VITAL STATISTICS STATE OF IDAHO

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35048
Registered No. .....

1. PLACE OF DEATH.
County of Shoshone
City of Wallace (No. ....., ... St.)
Registration District No. 68
Primary Registration District No. .....
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Harold Eugene Smeeton
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Oct (Month) 19 (Day) 1920 (Year)

7. AGE: Yrs. 8 Mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: .....
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Spokane Wash

10. NAME OF FATHER: Not known, as

11. BIRTHPLACE OF FATHER (State or Country): Child was taken from Orphans Home

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Hawkins & Goodman
(Address) Wallace Ida

15. Filed 7-3 1921 — C. A. Popple, Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 1 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 30 1921 to July 1 1921 that I last saw h... alive on June 30 1921 and that death occured on the date stated above, at 9:30 A.M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) Yrs. — mos. 3 ds.

Contributory (Secondary) Measles

(Duration — yrs. mos. ds.

(Signed) C. A. Popple M. D.

7-2 1921 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Ivy Ridge Cem — DATE OF BURIAL: 7-3 1921

20. UNDERTAKER: A. A. Grauson — ADDRESS: Wallace Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

Form V. S. No. 5 20M.1-16-12

RECEIVED SEP 7 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35049
Registered No.

1. PLACE OF DEATH. Registration District No. 64
County of Latah Primary Registration District No. 2144
City of Troy (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ingrid Maria Anderson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Fem	white	widowed

6. DATE OF BIRTH: Jan (Month) 12 (Day) 1839 (Year)

7. AGE: 81 yrs. 7 mos. 14 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Sweden

10. NAME OF FATHER Magnus Anderson

11. BIRTHPLACE OF FATHER (State or Country) Sweden

12. MAIDEN NAME OF MOTHER Catherina Svenson

13. BIRTHPLACE OF MOTHER (State or Country) Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Frank Lindberg
(Address) Troy Ida

15.
Filed Aug 27 1921 Lucy M Packard Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Aug (Month) 26. (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 12 1921, to Aug 26 1921, that I last saw her alive on Aug 1 1921, and that death occurred on the date stated above, at 7 P M.

The CAUSE OF DEATH* was as follows:
apoplexy

(Duration) 2 yrs. 7 mos. ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) L B Hardedger M. D.
8/27 1921 (Address) Troy Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR ~~REMOVAL~~: Bear creek cemetary — DATE OF BURIAL: Aug 28 1921

20. UNDERTAKER: John J Pickerd — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SDRS. 19760

(Always write with black ink)

TRANSPORTATION OF CORPSE

1. PLACE OF DEATH.
County of Lotah
City of Genesee
If death occurs away from usual residence, give facts called for under special information.

CERTIFICATE OF DEATH.
Registration District No. 62
Primary Registration District No. 2142
(No. ....., ... St.)
2. FULL NAME Earl E. Hampton

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35050
Registered No. 7
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M | 4. COLOR OR RACE: W | 5. Single, Married, Widowed or Divorced. (Write the Word): Single

6. DATE OF BIRTH. Feb (Month) 22 (Day) 1886 (Year)

7. AGE: 35 Yrs 6 Mos 1 ds. IF LESS than 1 day how many ---- hrs. or ------min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Arkansas

10. NAME OF FATHER: James Hampton

11. BIRTHPLACE OF FATHER (State or Country): Mississippi

12. MAIDEN NAME OF MOTHER: Jane Norcott

13. BIRTHPLACE OF MOTHER (State or Country): Mississippi

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Arthur Hampton
(Address) Genesee Idaho

15. Filed 8-24-1921 W. H. Keen Local Registrar.

Place Where Remains are to be Sent. | Date of Shipment .....191...

SHIPPING UNDERTAKER J. E. Lambert
ADDRESS Genesee Firm Name

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH. 8 (Month) 23 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 8-18-21 .191..., to 8-23-21 .191..., that I last saw h--- alive on 8-23-21 .191..., and that death occured on the date stated above, at 2 P. M.

The CAUSE OF DEATH was as follows:
Pulmonary tuberculosis
(Duration) 4 Years ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... Years ..... mos ..... ds.
(Signed) H. H. Ponas M. D.
8-24-1921 (Address) Genesee, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transient or Recent Residents.)
At place of death....yrs....mos....days | In the State ....yrs...mos...days
Where was disease contracted if not at place of death: Lost River
Former or usual residence: Lolo Ky.

19. PLACE OF BURIAL ~~OR REMOVAL~~ Genesee | Date of Burial 8-24-1921

20. UNDERTAKER J. E. Lambert | Address Genesee

The information on this certificate is an exact COPY of the official certificate filed at place of death.

FORM V. S. No. 5-25 M. 1-16-

RECEIVED
SEP 6 - 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 60
County of Lewis Primary Registration District No. 2129.
City of Craigmont (No. St.)
File No. 35051
Registered No. 8
If death occurs away from usual residence, give facts called for under special information.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Sales. John Sales

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH. Sept. 5 (Month) (Day) 1844 (Year)

7. AGE: 76 Yrs. 11 Mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Canada

10. NAME OF FATHER: Robt. Sales

11. BIRTHPLACE OF FATHER (State or Country): English

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Loyle Sales
(Address) Craigmont Ida.

15. Filed 8/8 1921 P E Dunsdale Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug 7 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1 1921 to Aug 7 1921;
that I last saw h[illegible] alive on July 17 1921,
and that death occured on the date stated above, at 10.20 M.

The CAUSE OF DEATH* was as follows:
Nephritis
(Duration) Yrs. mos. 1½ ds.
Contributory (Secondary) Chronic Endocarditis Chronic nephritis
(Duration 2 yrs. mos. ds.

(Signed) P E Dunsdale M. D.
8/8 1921 (Address) Craigmont Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Foot Cemetery — DATE OF BURIAL: 8/8 1921

20. UNDERTAKER: Stan [illegible] — ADDRESS: Craigmont

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING
B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-18

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35052

Registered No. 64

1. PLACE OF DEATH.

County of Lewis

City of Nezperce, RFD.

(No. ....., ... St.)

Registration District No. 47

Primary Registration District No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lorna May Funkhauser

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH.: Aug (Month) 4 (Day) 1921 (Year)

7. AGE: ..... Yrs. ..... Mos. 13 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION

(a) Trade, profession or particular kind of work: .....

(b) General nature of industry, business, or establishment in which employed (or employer): infant

9. BIRTHPLACE (State or Country): Nezperce, RFD

10. NAME OF FATHER: George W. Funkhauser

11. BIRTHPLACE OF FATHER (State or Country): Nebraska.

12. MAIDEN NAME OF MOTHER: Etta Marie Buer

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George Funkhauser

(Address) c/o Rt 46 Dumas

15. Filed 8-21 1917

Albert Huff
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 17 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 4 1921, to Aug 17 1921, that I last saw her alive on Aug 16 1921, and that death occured on the date stated above, at 1 A. M.

The CAUSE OF DEATH* was as follows:

Prematurity of birth

(Developement that of 7 Mos 1,2 month foetus.

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) A. G. Dunsle M. D.

8, 17 1921 (Address) Orofino, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Nezperce Cemetery

DATE OF BURIAL: 8, 18 1921

20. UNDERTAKER: A. Huff Albert Huff

ADDRESS: Nezperce, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRNS - YORK CO., PTRS. & STNRS. 24658

FORM V. S. No. 5-25, M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Fremont — Registration District No. 92

City of Gifford (Ward) ..... St.) — Primary Registration District No. 2170

File No. 35053

Registered No. 29

If death occurs away from usual residence, give facts called for under special information.

RECEIVED SEP 6 1921 BUREAU OF VITAL STATISTICS

2. FULL NAME Lydia Moore

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: Indian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. April (Month) 3 (Day) 1916 (Year)

7. AGE: 5 Yrs. 4 Mos. 11 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: James Moore

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Edna Jones

13. BIRTHPLACE OF MOTHER (State or Country): Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) James Moore
(Address) Lenore Idaho

15.
Filed ..... 191 .....
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 8 (Month) 14 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 12 1921, to Aug 14 1921, that I last saw her alive on Aug 12 1921 and that death occured on the date stated above, at 2:30 P.M.

The CAUSE OF DEATH* was as follows:
Lobar pneumonia

(Duration) — Yrs. — mos. 7 ds.

Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) E. E. Watts M. D.
8-15 1921 (Address) Gifford Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Fridays Cemetery — DATE OF BURIAL: Aug 16 1921

20. UNDERTAKER: H. A. Toddard — ADDRESS: Gifford

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BKBS. 24658

FORM V. S. No. 5-25 M. 1-16-13

MARGIN RESERVED FOR BINDING

...NLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. ...rmation should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH.

RECEIVED
SEP 6 1921
BUREAU OF VITAL STATISTICS

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35054
Registered No. .....

1. PLACE OF DEATH.
Registration District No. .....
Primary Registration District No. .....
County of Nez Perce
City of Gifford (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Fred Edward Cozens

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. August 11 (Month) 15 (Day) 1915 (Year)

7. AGE: 6 Yrs. — Mos. 9 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Childwood
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Oregon

10. NAME OF FATHER Burl J Cozens

11. BIRTHPLACE OF FATHER (State or Country) Ino

12. MAIDEN NAME OF MOTHER Edna Ayers

13. BIRTHPLACE OF MOTHER (State or Country) Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Edna E Cozens
(Address) Lewiston Ida.

15. Filed 8-20- 1921 E.E. Watts Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 8 (Month) 20 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 8-19 1921, to 8-20 1921, that I last saw him alive on 8-20 1921, and that death occured on the date stated above, at 2:30 P M.

The CAUSE OF DEATH* was as follows:
Diptheria
.....
.....
.....
(Duration) ..... Yrs. ..... mos. 1 ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) E.E. Watts M. D.
8-20 1921 (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Gifford — DATE OF BURIAL: Aug 20 1921

20. UNDERTAKER: E E Stoddard — ADDRESS: Gifford

BYRD - YORK CO., PTRS. & BKBS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

RECEIVED SEP 6 - 1921 BUREAU OF VITAL STATISTICS

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35055

Registered No. 28

1. PLACE OF DEATH.
County of Fremont Registration District No. 92
City of Gifford Primary Registration District No. 2170
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Fred Lindemann

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH. August 24 1850
(Month) (Day) (Year)

7. AGE 70 Yrs. 11 Mos. 17 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Farmer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Germany

10. NAME OF FATHER Henry Lindemann

11. BIRTHPLACE OF FATHER (State or Country) Germany

12. MAIDEN NAME OF MOTHER Reka Lindemann

13. BIRTHPLACE OF MOTHER (State or Country) Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Wm Munstermann
(Address) Gifford Idaho

15. Filed 8 - 8 1921 E E Watts Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug 6 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 10 1921, to Aug 6 1921, that I last saw h[illegible] alive on Aug 1 1921 and that death occured on the date stated above, at 6:30 P M.

The CAUSE OF DEATH* was as follows:
Albuminuria

(Duration) Yrs. 9 mos. — ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) E E Watts M. D.
8-6 1921 (Address) Gifford

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Fremont County - Gifford	Aug 9 1921

20. UNDERTAKER	ADDRESS
J O Stoddard	Gifford

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & SORS. 24653

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35056

Registered No. 30

1. PLACE OF DEATH

County of Payette — Registration District No. 4

City of Payette — Registration District No. 1008

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Cora E Connerly

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Widowed

6. DATE OF BIRTH: Apr (Month) 6 (Day) 1875 (Year)

7. AGE: 46 Yrs. 3 Mos. 2 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mo

10. NAME OF FATHER: F C Howard

11. BIRTHPLACE OF FATHER (State or Country): Vermont

12. MAIDEN NAME OF MOTHER: Ella Story

13. BIRTHPLACE OF MOTHER (State or Country): Vermont

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Guy LeHoward

(Address) Payette Ida

15. Filed July 10 1921 J C Woodward Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 8 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 1921, to July 8 1921, that I last saw h[illegible] alive on July 8 1921, and that death occurred on the date stated above, at 8:30 P.M.

The CAUSE OF DEATH* was as follows:

Cancer of uterus

(Duration) 3 mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F. L. McDonald M. D.

7-9 1921 (Address) Payette Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Payette Ida — DATE OF BURIAL: 7-10 1921

20. UNDERTAKER: J A Cain — ADDRESS: Payette Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 4
Primary Registration District No. 1008
File No. 35057
Registered No. 29

RECEIVED
AUG 20 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Payette
City of Payette (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Cherlucile Fjelstrom.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Baby. (Write the word.)

6. DATE OF BIRTH: June (Month) 30 (Day) 1921 (Year)

7. AGE: 0 Yrs. 0 Mos. 6 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: 0
(b) General nature of industry, business or establishment in which employed (or employer): 0

9. BIRTHPLACE (State or Country): Payette County

10. NAME OF FATHER: Charles A. Fjelstrom

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Ruth E Snyder

13. BIRTHPLACE OF MOTHER (State or Country): Wisconsin.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. A. Fjelstrom
(Address) Payette Idaho.

15. Filed July 8 1921 J. C. Woodward Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 5 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 30 1921, to July 5 1921, that I last saw h[er] alive on July 4 1921, and that death occurred on the date stated above, at 12 30 M.
The CAUSE OF DEATH* was as follows:

(Malnutrition) caused by Toxic Albuminuria of Pregnancy.
(Duration) ..... Yrs. ..... mos. 6 ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) J. A. McWhirter M. D.
19..... (Address) Payette Ida

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Payette Idaho — DATE OF BURIAL: July 7 1921
20. UNDERTAKER: Glenn C Landon — ADDRESS: Payette Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35058
Registered No. 9

RECEIVED
AUG 27 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Shoshone
Registration District No. 123
City of Kellogg
Ward
Registration District No.
If death occurs away from usual residence, give facts called for under special information.
(No. ... St.)
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Kenneth Lien

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. April 17 1920 (Month) (Day) (Year)

7. AGE: 1 Yrs. 3 Mos. 10 ds.
IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: John Lien

11. BIRTHPLACE OF FATHER (State or Country): Norway

12. MAIDEN NAME OF MOTHER: Ingeborg Herren

13. BIRTHPLACE OF MOTHER (State or Country): Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John A. Lien
(Address) Kellogg, Idaho

15. Filed July 30 1921
E. E. Hardy
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July 22 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 17 1921 to July 22 1921
that I last saw h[illegible] alive on July 22 1921
and that death occurred on the date stated above, at 7A M.

The CAUSE OF DEATH* was as follows:
Meningitis
(Duration) Yrs. mos. 12 ds.
Contributory (Secondary)
(Duration) Yrs. mos. ds.
(Signed) W. L. Lindsay M. D.
7-22 1921 (Address) Kellogg Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Kootenai Cemetery — DATE OF BURIAL: July 24 1921

20. UNDERTAKER: C. Chamberlain — ADDRESS: Kellogg Idaho

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35059
Registered No. 10

1. PLACE OF DEATH
County of Shoshone — Registration District No. 122
City of Wardner — Primary Registration District No. .....
If death occurs away from usual residence, give facts called for under special information. ..... St.)

RECEIVED
AUG 27 1921
BUREAU OF VITAL STATISTICS

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Henry G Parry

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	W.	single

6. DATE OF BIRTH.
..... (Month) 1 (Day) ..... (Year)

7. AGE
41 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many .... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Miner
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE
(State or Country) Wales England

10. NAME OF FATHER [redacted] Griffith Parry

11. BIRTHPLACE OF FATHER
(State or Country) Wales England

12. MAIDEN NAME OF MOTHER Martha Thomas

13. BIRTHPLACE OF MOTHER
(State or Country) Wales England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wm G Parry
(Address) Kellogg Idaho

15.
Filed July 30 1921 E E Hardy
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
..... July (Month) 12 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191.... to ..... 191...
that I last saw h.....alive on ..... 191....
and that death occurred on the date stated above, at .....M.
The CAUSE OF DEATH* was as follows:

Coma on Mine

.....(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
.....(Duration) ..... Yrs. ..... mos. ..... ds.
(Signed) J. C. Bradley acting Coroner M. D.
.....19.... (Address) Kellogg Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Kellogg Ida — DATE OF BURIAL July 14 1921

20. UNDERTAKER C W Mackin — ADDRESS Kellogg Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35060
Registered No. 1

1. PLACE OF DEATH
County of Shoshone Registration District No. 123
City of Kellogg Primary Registration District No. .....
If death occurs away from usual residence, give facts called for under special information. (No. ..... St.)

RECEIVED AUG 27 1917 BUREAU OF VITAL STATISTICS

2. FULL NAME Robert S. Kelley

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. ..... (Month) 1 (Day) ..... (Year)

7. AGE: 64 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many .... hrs. or .....min.?'

8. OCCUPATION
(a) Trade, profession or particular kind of work [redacted]
(b) General nature of industry, business, or establishment in which employed (or employer) Mine

9. BIRTHPLACE (State or Country) No information

10. NAME OF FATHER " "

11. BIRTHPLACE OF FATHER (State or Country) " "

12. MAIDEN NAME OF MOTHER " "

13. BIRTHPLACE OF MOTHER (State or Country) " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) .....
(Address) .....

15. Filed July 30 1917 E. E. Hard Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH ..... July (Month) 11 (Day) 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191... to ..... 191...
that I last saw h...alive on ..... 191....
and that death occurred on the date stated above, at ....,....M.
The CAUSE OF DEATH* was as follows:
Accident — Explosion of dynamite
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... Yrs. ..... mos. ..... ds.
(Signed) J. C. Bodley M. D.
19.... (Address) Kellogg Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the ,State....yrs....mos....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL, OR REMOVAL Kellogg Idaho — DATE OF BURIAL July 19 1917

20. UNDERTAKER E. B. Chamberlain — ADDRESS Kellogg Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35061
Registered No. 12

1. PLACE OF DEATH

County of Shoshone — RECEIVED — Registration District No. 123

City of Kellogg — AUG 27 19.. — Primary Registration District No. .....

If death occurs away from usual residence, give facts called for under special information. — (No. ....., ... St.) — BUREAU OF VITAL STATISTICS

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME ..... John Lidmila

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH: ..... No information ..... 1 ..... (Month) (Day) (Year)

7. AGE: 60 ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many .... hrs. or ..... min.?'

8. OCCUPATION
(a) Trade, profession or particular kind of work: No informatuon
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Bohemia

10. NAME OF FATHER: No information

11. BIRTHPLACE OF FATHER (State or Country): Bohemia

12. MAIDEN NAME OF MOTHER: No information

13. BIRTHPLACE OF MOTHER (State or Country): Bohemia.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) ..... E. B. THornhill .....
(Address) ..... Kellogg, Idaho. ...

15. Filed July 30 ..... 1927. — E. E. Hand — Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: ..... July 8/21. ..... 191..... (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..... to ..... 191...
that I last saw h.....alive on ..... 191....
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

..... No physician in attendance .....

..... (Duration) ..... Yrs..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... Yrs..... mos. ..... ds.

(Signed) ..... M. D.
..... 19.... (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Greenwood Cemetery Kellogg, Idaho. — DATE OF BURIAL: July 9/21 191...

20. UNDERTAKER: E. B. Tornhill — ADDRESS: Kellogg, Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-12 M. 6-15-17.

1921
1831

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35062
Registered No. 18

RECEIVED
AUG 27 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Shoshone Registration District No. 123
City of Kellogg Primary Registration District No. .....
If death occurs away from usual residence, give facts called for under special information. (No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mrs. Nancy Emmaline Welch

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Dec (Month) 7 (Day) 1831 (Year)

7. AGE 89 Yrs. ..... Mos. ..... ds. IF LESS than 1 day how many .... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Tenn.

10. NAME OF FATHER James Anderson

11. BIRTHPLACE OF FATHER (State or Country) Tenn.

12. MAIDEN NAME OF MOTHER McMatheson

13. BIRTHPLACE OF MOTHER (State or Country) Tenn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. W. Sanders
(Address) Kellogg, Ida. Star Route

15. Filed July 30. 1921 E. E. Hardy Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH ..... July (Month) ..... 1 (Day) ..... 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 30 1921 to July 1st 1921
that I last saw her alive on June 30 1921
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Pneumonia & old age

..... (Duration) ..... Yrs. ..... mos. 7 ds.

Contributory (Secondary) .....

..... (Duration) ..... Yrs. ..... mos. 7 ds.

(Signed) W. L. Lindsay M. D.

7-6 1921 (Address) Kellogg Ida

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Kellogg Idaho — DATE OF BURIAL July 7 1921

20. UNDERTAKER E. B. Markham — ADDRESS Kellogg Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM [illegible] 6-13 M. 6-15-17.

Dr Mason

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35063
Registered No. 14

RECEIVED
AUG 27 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Shoshone
City of Wardner
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 123
Primary Registration District No. .....
St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. *FULL NAME Amos Forgethy White

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (or Widowed)

6. DATE OF BIRTH: June (Month) 26 (Day) 1849 (Year)

7. AGE: 71 Yrs. 10 Mos. 11 ds.
IF LESS than 1 day how many .... hrs. or .....min.?'

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE: Montrose (State or Country) Susquehanna Co. Penna

10. NAME OF FATHER: Edward White

11. BIRTHPLACE OF FATHER (State or Country): Massachusetts

12. MAIDEN NAME OF MOTHER: Wealthy Howard

13. BIRTHPLACE OF MOTHER (State or Country): Mass

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) L.A. Wilson
(Address) Kellogg Idaho

15. Filed July 3d. 1921. E.E. Hardy Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 26 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 23 1921 to June 26 1921
that I last saw h.....alive on .....191....
and that death occurred on the date stated above, at .....M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

.....(Duration) ..... Yrs..... mos. ..... ds.

Contributory (Secondary) .....

.....(Duration) ..... Yrs..... mos. ..... ds.

(Signed) J. R. Mason M. D.
.....19.... (Address) Kellogg Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Kellogg Idaho — DATE OF BURIAL: June 27 1921

20. UNDERTAKER: E.B. Reuben — ADDRESS: Kellogg Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-12 M. 6-15-17.

RECEIVED AUG 27 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35064
Registered No. 15

1. PLACE OF DEATH
County of Shoshone Registration District No. 123
City of Wardner Primary Registration District No. .....
If death occurs away from usual residence, give facts called for under special information. (.....St.)
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Clara Electa Peterson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: March (Month) 15 (Day) 1873 (Year)

7. AGE: 48 Yrs. 2 Mos. 20 ds. IF LESS than 1 day how many .... hrs. or .....min.?'

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Erie Nebraska

10. NAME OF FATHER: Edwin S. Judd

11. BIRTHPLACE OF FATHER (State or Country): Candor, New York

12. MAIDEN NAME OF MOTHER: Helen M. Giffin

13. BIRTHPLACE OF MOTHER (State or Country): Middlebury, Vermont

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Edwin D. Peterson
(Address) Wardner, Idaho

15. Filed July 30 1921 E. E. Stoard Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 4 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 1 1921 to June 4 1921
that I last saw her alive on June 4 1921
and that death occurred on the date stated above, at 11:30 P.M.

The CAUSE OF DEATH* was as follows:
Malignant goiter
Myxedema
.....
.....(Duration) 1 Yrs. ..... mos. ..... ds.
Contributory (Secondary) Acute Enteritis
.....(Duration) ..... Yrs. ..... mos. 21 ..... ds.

(Signed) E. E. Stoard M. D.
June 5 1921 (Address) Kellogg Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Spokane Wash. DATE OF BURIAL: 1921

20. UNDERTAKER: W. B. Shumlich & Son ADDRESS: Kellogg Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-12 M. 6-15-17.

RECEIVED
AUG 27 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35065
Registered No. 16
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Shoshone
Registration District No. 123
Primary Registration District No.
City of Kellogg Ida
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Logan Durbin

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. June 12 1856
(Month) (Day) (Year)

7. AGE 34 Yrs. 11 Mos. 23 ds.
IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Barber
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Rinehart Mo

10. NAME OF FATHER: Thomas L Durbin

11. BIRTHPLACE OF FATHER (State or Country): Larue Co Ky

12. MAIDEN NAME OF MOTHER: Liddie E Brown

13. BIRTHPLACE OF MOTHER (State or Country): Larue Co Ky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) O E Sheen
(Address) Kellogg Ida

15. Filed July 30 1921 E L Sandy Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 1 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191... to ..... 191...
that I last saw h... alive on ..... 191...
and that death occurred on the date stated above, at ...., ...M.
The CAUSE OF DEATH* was as follows:
Suicide - Pistol
(Duration) ... Yrs. ... mos. ... ds.
Contributory (Secondary)
(Duration) ... Yrs. ... mos. ... ds.
(Signed) John Bodle M. D.
19... (Address) Dept. Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 1 yrs. ... mos. ... days. In the State .... yrs. .... mos. 1 days 4
Where was disease contracted if not at place of death?
Former or usual residence Troy Idaho

19. PLACE OF BURIAL OR REMOVAL: Troy Ida. DATE OF BURIAL ..... 191...

20. UNDERTAKER: E B Shanklin ADDRESS Kellogg Ida.

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35066
Registered No. 17
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

RECEIVED
AUG 27 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
Registration District No. 127
Primary Registration District No.
County of Shoshone
City of Kellogg
If death occurs away from usual residence, give facts called for under special information.
No. ..... St.)

2. FULL NAME George N. Ebright

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH. July (Month) 9th (Day) 1835 (Year)

7. AGE: 86 Yrs. 3 Mos. 17 ds.
IF LESS than 1 day how many .... hrs. or .....min.?'

8. OCCUPATION
(a) Trade, profession or particular kind of work: Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: George Ebright

11. BIRTHPLACE OF FATHER (State or Country): Penn.

12. MAIDEN NAME OF MOTHER: Barbara Kuler

13. BIRTHPLACE OF MOTHER (State or Country): Penn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. U. J. Muzzy
(Address) Kellogg Ida.

15. Filed July 30 1921 E. L. Stand
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 26 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 1st 1921 to May 26 1921
that I last saw h.....alive on .....191....
and that death occurred on the date stated above, at .....,....M.

The CAUSE OF DEATH* was as follows:
Old age
.....(Duration) 1 Yrs..... mos. ..... ds.
Contributory (Secondary)
.....(Duration) Yrs..... mos. ..... ds.
(Signed) H. C. Lindsay M. D.
5/28 1921 (Address) Kellogg Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Coeur d'Alene City Idaho
DATE OF BURIAL: May 28 1921

20. UNDERTAKER: M C Hamblin
ADDRESS

Dr C Lindsay

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35067
Registered No. 15
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

RECEIVED
AUG 27 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Shoshone
Registration District No. 123
Primary Registration District No. .....
City of Kellogg
If death occurs away from usual residence, give facts called for under special information.
(No. ....., ... St.)

2. FULL NAME Baby Priest

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. May (Month) 22 (Day) 1921 (Year)

7. AGE .....Yrs.....Mos.....ds.
IF LESS than 1 day how many .... hrs. or .....min.?'

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho.

10. NAME OF FATHER Roy Priest

11. BIRTHPLACE OF FATHER (State or Country) Idaho

12. MAIDEN NAME OF MOTHER Leona Anderson

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Roy Priest
(Address) .....

15. Filed July 30 1921 E E Sandy
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH ..... May (Month) 24 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..... to .....191...
that I last saw h.....alive on .....191....
and that death occurred on the date stated above, at .....,....M.
The CAUSE OF DEATH* was as follows:
Prematurity.
.....
.....
.....(Duration) ..... Yrs..... mos. 2 ds.
Contributory (Secondary) .....
.....(Duration) ..... Yrs..... mos. ..... ds.
(Signed) ..... M. D.
7/28/1921 (Address) Kellogg Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL ..... 191...

20. UNDERTAKER

ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-12 M. 6-15-17.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.

RECEIVED
AUG 31 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35068
Registered No. 79

1. PLACE OF DEATH
County of Shoshone Registration District No. 12
City of Kellogg Primary Registration District No. .....
If death occurs away from usual residence, give facts called for under special information. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number. ..... St.)

2. FULL NAME Baby Folden

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. ..... (Month) 1 (Day) ..... (Year)

7. AGE ..... Yrs. ..... Mos. 21 ds.
IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: A. Folden

11. BIRTHPLACE OF FATHER (State or Country): Norway

12. MAIDEN NAME OF MOTHER: Elizabeth Hay

13. BIRTHPLACE OF MOTHER (State or Country): Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A. Folden
(Address) Kellogg, Idaho

15. Filed July 30 1921 E. E. Hardy Local Registrar.

MEDICAL CERTIFICATE OF DEATH Sunday

16. DATE OF DEATH ..... (Month) Aug. (Day) 26 (Year) 1921

17. I HEREBY CERTIFY, That I attended deceased from ..... 191... to ..... 191..
that I last saw h.....alive on ..... 191....
and that death occurred on the date stated above, at .....M.
The CAUSE OF DEATH* was as follows:
..... Prematurity .....
.....
.....
.....(Duration) ..... Yrs..... mos. ..... ds.
Contributory (Secondary) .....
.....(Duration) ..... Yrs. ..... mos. ..... ds.
(Signed) H. C. Landon M. D.
8/28 1921 (Address) Kellogg Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL ..... 191...

20. UNDERTAKER | ADDRESS

FORM V. S. No. 5-12 M. 6-15-17.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

RECEIVED
AUG 27 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35009
Registered No. 70

1. PLACE OF DEATH
County of Shoshone Registration District No. 123
City of Kingston Primary Registration District No. .....
If death occurs away from usual residence, give facts called for under special information. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Felix Brown

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed
6. DATE OF BIRTH. Oct. (Month) 6 (Day) 1842 (Year)
7. AGE: 78 Yrs. 6 Mos. 7 ds. IF LESS than 1 day how many .... hrs. or .... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Mining
(b) General nature of industry, business, or establishment in which employed (or employer) .....
9. BIRTHPLACE (State or Country): Tennessee
10. NAME OF FATHER: Hugh Brown
11. BIRTHPLACE OF FATHER (State or Country): No information
12. MAIDEN NAME OF MOTHER: Miss Browning
13. BIRTHPLACE OF MOTHER (State or Country): No information
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. O. Dufault
(Address) Kingston, Idaho.
15. Filed July 30 1921 E. E. Stand Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 25 1921 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from April 1st 1921 to April 15 1921
that I last saw h.....alive on .....191....
and that death occurred on the date stated above, at .....M.
The CAUSE OF DEATH* was as follows:
Bronchitis
Myocarditis
.....(Duration) ..... Yrs. 1 mos. ..... ds.
Contributory (Secondary) .....
.....(Duration) ..... Yrs. 2 mos. ..... ds.
(Signed) W. C. Buckley M. D.
5-24 1922 (Address) Kellogg Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Kingston, Idaho — DATE OF BURIAL: Apr. 27 1921
20. UNDERTAKER: M. C. Mauricet — ADDRESS: Kingston Ida

FORM V. S. No. 5-12 M. 6-15-17.

RECEIVED AUG 27 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35070
Registered No. 24

1. PLACE OF DEATH
County of Shoshone Registration District No. 1-3
City of Kellogg Precinct or Registration District No. .....
If death occurs away from usual residence, give facts called for under special information. (No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Stjepan V. Mitrovich

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH.
August (Month) 18 (Day) 1874 (Year)

7. AGE
46 Yrs. 8 Mos. 5 ds.
IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Dalmacia Jugoslavia

10. NAME OF FATHER: Vedo Mitrovich

11. BIRTHPLACE OF FATHER (State or Country): Dalmacia Jugoslavia

12. MAIDEN NAME OF MOTHER: Cristina Kulick

13. BIRTHPLACE OF MOTHER (State or Country): Dalmacia Jugoslavia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. S. Mitrovich
(Address) 106 Main St.

15. Filed Apr. 23 1921 Geo. D. Lesher Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Apr. (Month) 22 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 16 1921 to Apr. 22 1921
that I last saw him alive on Apr. 22 1921
and that death occurred on the date stated above, at 6:10 P. M.
The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) J. R. Mason M. D.
4/23 1921 (Address) Kellogg, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Spokane, Wash. DATE OF BURIAL: Apr. 25 1921

20. UNDERTAKER: M. C. Thornhill ADDRESS: Kellogg Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-12 M. 6-15-17.

Handy

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35071
Registered No. 2

1. PLACE OF DEATH

County of Shoshone

City of Kellogg

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 123

Primary Registration District No. .....

(No. .... St.)

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If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Chas. A. Evans

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	White	Widowed

6. DATE OF BIRTH. Sept. (Month) 9 (Day) 1851 (Year)

7. AGE 70 Yrs. 7 Mos. 5 ds. IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Ohio

10. NAME OF FATHER Chas. Evans

11. BIRTHPLACE OF FATHER (State or Country) Wales

12. MAIDEN NAME OF MOTHER No information

13. BIRTHPLACE OF MOTHER (State or Country) Wales

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. C. Truesdell
(Address) .....

15. Filed July 31 1927 E. E. Stand Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 14 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 7 1921 to April 14 1921 that I last saw him alive on April 14 1921 and that death occurred on the date stated above, at .... M.

The CAUSE OF DEATH* was as follows:

Influenza

.....

.....

.....(Duration) ..... Yrs. ..... mos. 5 ds.

Contributory (Secondary) Pneumonia

.....(Duration) ..... Yrs. ..... mos. 2 ds.

(Signed) E. E. Stand M. D.

April 14 1921 (Address) Kellogg Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs.....mos....days. In the ,State....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Farmington, Wash — DATE OF BURIAL .....191...

20. UNDERTAKER M. C. Thornhill — ADDRESS Kellogg, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35073
Registered No. 24

1. PLACE OF DEATH

County of Shoshone Registration District No. 123

City of Kellogg Primary Registration District No. .....

If death occurs away from usual residence, give facts called for under special nformation. .....

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BUREAU OF VITAL STATISTICS

2. FULL NAME Alexander Haggman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): Married

6. DATE OF BIRTH. Dec (Month) 24 (Day) 75 (Year)

7. AGE: 45 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many .... hrs. or .....min.?'

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Finland

10. NAME OF FATHER: Andrew Matfolk

11. BIRTHPLACE OF FATHER (State or Country): Finland

12. MAIDEN NAME OF MOTHER: Wooing.

13. BIRTHPLACE OF MOTHER (State or Country): Finland.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) Mrs. F. L. Cobb

15. Filed July 30 1921. Kellogg Ida. E. E. Stand ..... Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jy (Month) 8 (Day) 21 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 4th 1921, to April 8 1921, that I last saw h.....alive on .....191.... and that death occurred on the date stated above, at .....M.

The CAUSE OF DEATH* was as follows:

Peritonitis

.....(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Appendicitis

.....(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) H. C. Lindsay M. D.

5/28 1921, (Address) Kellogg Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Kingston Idaho — DATE OF BURIAL ..... 191...

20. UNDERTAKER ..... ADDRESS .....

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35074
Registered No. 25

1. PLACE OF DEATH
County of Shoshone Registration District No. 123
City of Enaville Primary Registration District No. .....
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

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BUREAU OF VITAL STATISTICS

2. FULL NAME John Louma

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Man
4. COLOR OR RACE: Light
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
6. DATE OF BIRTH: June 11 (Month) 1866 (Day) (Year)
7. AGE: .....Yrs. .....Mos. .....ds. IF LESS than 1 day how many .... hrs. or .....min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry, business, or establishment in which employed (or employer) .....
9. BIRTHPLACE (State or Country): Kankayoki Finland
10. NAME OF FATHER: — — —
11. BIRTHPLACE OF FATHER (State or Country): — — — —
12. MAIDEN NAME OF MOTHER: — — —
13. BIRTHPLACE OF MOTHER (State or Country): — — —
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Eliza Louma
(Address) Enaville Idaho
15. Filed July 30 1921 E. E. Stanley Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 24th 1921
17. I HEREBY CERTIFY, That I attended deceased from ..... 191..... to .....191...
that I last saw h.....alive on .....191....
and that death occurred on the date stated above, at .....M.
The CAUSE OF DEATH* was as follows:
Gun shot wound Head. Instantaneous
.....(Duration) ..... Yrs..... mos. ..... ds.
Contributory (Secondary) .....
.....(Duration) ..... Yrs..... mos. ..... ds.
(Signed) H. C. Lueders M. D.
7/1 1921 (Address) Kellogg Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Kellogg, Idaho. DATE OF BURIAL: Apr. 1/21 191...
20. UNDERTAKER ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

Leete

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35075

Registered No.

1. PLACE OF DEATH

Registration District No. 37

County of Twin Falls

Primary Registration District No. 1085

City of " " St.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
AUG 20 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME Homer Lee Alexander

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Male	White	Married (or Widowed)

6. DATE OF BIRTH: Mar (Month) 15 (Day) 1871 (Year)

7. AGE: 50 Yrs. 4 Mos. 12 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Mach.
(b) General nature of industry, business or establishment in which employed (or employer): Steam Eng.

9. BIRTHPLACE (State or Country): Ill

10. NAME OF FATHER: Joseph Alexander

11. BIRTHPLACE OF FATHER (State or Country): Don't Know

12. MAIDEN NAME OF MOTHER: Mrs. Wright

13. BIRTHPLACE OF MOTHER (State or Country): Don't Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. J. Pratt
(Address) Twin Falls Ida.

15. Filed July 29 1921 John M. Hopkins Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 27 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 15 1921, to July 27 1921, that I last saw h... alive on June 27 1921, and that death occurred on the date stated above, at 10:30 M.

The CAUSE OF DEATH* was as follows:

Nephritis

(Duration) Yrs. 5 mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) H M Leete M. D.

7/28 1921 (Address) Twin Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Ida DATE OF BURIAL: July 29 1921

20. UNDERTAKER: P J Brennan ADDRESS: Twin Falls Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

Warrant

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35076

Registered No.

1. PLACE OF DEATH

County of Twin Falls — Registration District No. 37

City of " " — Primary Registration District No. 1085 — St.)

RECEIVED
AUG 20 1921
BUREAU OF VITAL STATISTICS

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Costello

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Male	White	Married

6. DATE OF BIRTH: April (Month) 27 (Day) 1854 (Year)

7. AGE: 67 Yrs. 2 Mos. 19 ds. — IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer (retired)
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Thomas Costello

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Ellen Conway

13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Thos. H. Costello
(Address) Twin Falls Ida.

15. Filed July 29 1921 — John F. Coughlin Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 16 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 10 1921, to July 16 1921, that I last saw h.im alive on July 16 1921, and that death occurred on the date stated above, at 9 A. M.

The CAUSE OF DEATH* was as follows:

Apoplexy

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) T. S. Mason M. D.

7-25 1921 (Address) Twin Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls — DATE OF BURIAL: July 18 1921

20. UNDERTAKER: J. F. Corcoran — ADDRESS: Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 1-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35077
Registered No.

Registration District No. 37
Primary Registration District No. 1085

RECEIVED
AUG 20 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Twin Falls
City of " "
(No. St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ray P. Cole

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married

6. DATE OF BIRTH: Sept (Month) 18 (Day) 1878 (Year)

7. AGE: 42 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Electrician
(b) General nature of industry, business or establishment in which employed (or employer): Foreman

9. BIRTHPLACE (State or Country): Neb.

10. NAME OF FATHER: A. N. Cole

11. BIRTHPLACE OF FATHER (State or Country): Ohio.

12. MAIDEN NAME OF MOTHER: Nancy Dale.

13. BIRTHPLACE OF MOTHER (State or Country): Ky.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs R.C. Cole
(Address) 746 2nd N. Twin Falls

15.
Filed July 29 1921 John P. Coughlin Local Registrar
Twin Falls Ida.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 24 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 24 1921, to July 24 1921
that I last saw h.. alive on July 24 1921
and that death occurred on the date stated above, at 7:30 P.M.
The CAUSE OF DEATH* was as follows:
Electrocution—
accidental

(Duration) Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) H. N. Lee M. D.
7/26 1921 (Address) Twin Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Ida DATE OF BURIAL: July 27 1921
20. UNDERTAKER: J. D. Grosman ADDRESS: Twin Falls Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
AUG 20 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1085
File No. 35078
Registered No.

1. **PLACE OF DEATH**

County of Twin Falls
City of Twin Falls
(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. **FULL NAME** Howard Miller

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. **SEX** Mal

4. **COLOR OR RACE** White

5. **SINGLE, MARRIED, WIDOWED OR DIVORCED** (Write the word.)

6. **DATE OF BIRTH** Oct 31 (Month) (Day) 1920 (Year)

7. **AGE** 1 Yrs. 8 Mos. 23 ds.

IF LESS than 1 day how many hrs. or min.?

8. **OCCUPATION**

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. **BIRTHPLACE** (State or Country) Idaho

10. **NAME OF FATHER** Quincy Miller

11. **BIRTHPLACE OF FATHER** (State or Country) Kansas

12. **MAIDEN NAME OF MOTHER** Hearsey Collins

13. **BIRTHPLACE OF MOTHER** (State or Country) Utah

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**

(Informant) E. S. Miller

(Address) Filer Idaho

15. Filed July 23 1921 John H. Coughlin Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH** July 22 (Month) (Day) 1921 (Year)

17. **I HEREBY CERTIFY, That I attended deceased from** 7/10 1921 to 7/22 1921 **that I last saw him alive on** 7/22 1921 **and that death occurred on the date stated above, at** 8 P. M.

The CAUSE OF DEATH* was as follows:

Erysipelas

(Duration) Yrs. mos. 8 ds.

Contributory (Secondary) Broncho-pneumonia

(Duration) yrs. mos. 4 ds.

(Signed) C. D. Weaver M. D.

19 (Address) Twin Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. **PLACE OF BURIAL OR REMOVAL** Sunset — **DATE OF BURIAL** 7-24 1921

20. **UNDERTAKER** L. E. Ward — **ADDRESS** Twin Falls

Boilerm

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Twin Falls

City of ll

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
AUG 20 1921
BUREAU OF VITAL STATISTICS

Registration District No. 37

Primary Registration District No. 1085

(If ... St.)

File No. 3507

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ernest Allen France

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: June (Month) 27 (Day) 1921 (Year)

7. AGE: ... Yrs. ... Mos. 5 ds.

IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business or establishment in which employed (or employer) —

9. BIRTHPLACE (State or Country): Twin Falls

10. NAME OF FATHER: E. L. France

11. BIRTHPLACE OF FATHER (State or Country): Wash

12. MAIDEN NAME OF MOTHER: Alice Peterson

13. BIRTHPLACE OF MOTHER (State or Country): S. D.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E. L. France

(Address) Twin Falls Ida.

15. Filed July 9 1921

John F. Coughlin
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 2 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 27 1921, to July 2 1921, that I last saw h... alive on July 1 1921, and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Premature birth

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) H. W. Wilson M. D.

July 2 1921 (Address) Twin Falls, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls — DATE OF BURIAL: July 7 1921

20. UNDERTAKER: L. F. Grossman — ADDRESS: Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35080

Registration District No. 37
Primary Registration District No. 1085
(No. ... St.)
Registered No. ...

RECEIVED
AUG 20 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Twin Falls
City of ...
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Amelio Arrocoole

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Spanish
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Mar 8 (Month) ... (Day) 1 (Year)

7. AGE: 3 Yrs. ... Mos. ... ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Herder
(b) General nature of industry, business or establishment in which employed (or employer): ...

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Juan Amecabe

11. BIRTHPLACE OF FATHER (State or Country): Andarroa

12. MAIDEN NAME OF MOTHER: Antonia Arisabaren

13. BIRTHPLACE OF MOTHER (State or Country): Beriatua

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Juan Amecabe
(Address) Erega Hotel

15. Filed July 20 1921 — Jesse H. Coughlin, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 7 (Month) 19 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 7/11/1921, to 7/19/1921, that I last saw h[illegible] alive on 7/19/1921, and that death occurred on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:
Hypostatic pneumonia of Lues
...
(Duration) ... Yrs. Two Mos. ... ds.
Contributory (Secondary): Marasmus
(Duration) ... yrs. ... mos. 10 ds.

(Signed) W. F. Tobe, M. D.
7/20/1921 (Address) Twin Falls Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death? ...
Former or usual residence ...

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Ida — DATE OF BURIAL: 7-20 1921

20. UNDERTAKER: L E Wood — ADDRESS: Twin Falls

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1083
File No. 35081
Registered No.

1. PLACE OF DEATH

County of Twin Falls
City of
(No. RECEIVED AUG 20 1921 BUREAU OF VITAL STATISTICS St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Goodwell.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Wid.

6. DATE OF BIRTH: June (Month) 20 (Day) 1846 (Year)

7. AGE: 75 Yrs. Mos. Ds. | IF LESS than 1 day how many hrs. or min.? 18

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer): Retired

9. BIRTHPLACE (State or Country): Ind.

10. NAME OF FATHER: John H Goodwell

11. BIRTHPLACE OF FATHER (State or Country): Ohio.

12. MAIDEN NAME OF MOTHER: Don't Know.

13. BIRTHPLACE OF MOTHER (State or Country): Don't know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John F. Goodwell.
(Address) Hansen, Ida.

15. Filed July 14 1921 Joan M Coughlin Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 7 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..., to ..... 19...
that I last saw h... alive on ..... 19...,
and that death occurred on the date stated above, at 1.30 P.M.
The CAUSE OF DEATH* was as follows:
Valvular Heart Disease

(Duration) ... Yrs. ... mos. ... ds.
Contributory (Secondary)
(Duration) ... yrs. ... mos. ... ds.

(Signed) T. J. Iroquois Corner
7/7 1921 (Address) Twin Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Twin Falls	7/10 1921

20. UNDERTAKER: T. J. Iroquois
ADDRESS: Twin Falls Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35082

Registration District No. 37
Primary Registration District No. 1085
(No. ..... St.)
Registered No. .....

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If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Twin Falls
City of " "
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Freada M. Saris

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6. DATE OF BIRTH: April 18 (Month) (Day) 1898 (Year)

7. AGE: 23 Yrs. 3 Mos. 24 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Maid.
(b) General nature of industry, business or establishment in which employed (or employer): at home.

9. BIRTHPLACE (State or Country): Mont.

10. NAME OF FATHER: Jacob Brunner

11. BIRTHPLACE OF FATHER (State or Country): Switzerland

12. MAIDEN NAME OF MOTHER: Emma Wuthrich

13. BIRTHPLACE OF MOTHER (State or Country): France.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Earl S. Saris
(Address) .....

15. Filed July 16 1921 — Otha E. Coughlin, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 12 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 9th 1921, to July 1921, that I last saw her alive on July 12 1921, and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:
Streptococcus infection, general, following Cholecystitis
(Duration) ..... Yrs. ..... mos. 9 ds.
Contributory (Secondary) Operating for Cholecystitis July 5th 1921.
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Duncan L. Bloom M.D.
7/15 1921 (Address) Twin Falls Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls — DATE OF BURIAL: July 14 1921
20. UNDERTAKER: C. J. Franson — ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35083
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of Kimball
(No. ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 37
Primary Registration District No. 2085

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2. FULL NAME Ella L. Colbert
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widowed (Give the word.)
6. DATE OF BIRTH: Dec. (Month) 13 (Day) 1850 (Year)
7. AGE: 70 Yrs. 7 Mos. 1 ds.
IF LESS than 1 day how many ... hrs. or ... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: at home (retired)
(b) General nature of industry, business or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): New York
10. NAME OF FATHER: Thomas Jefford
11. BIRTHPLACE OF FATHER (State or Country): England
12. MAIDEN NAME OF MOTHER: Dont know
13. BIRTHPLACE OF MOTHER (State or Country): England
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. J. Colbert
(Address) Kimball
15. Filed July 16 1921 John N. Coughlin Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 14 (Day) 1921 (Year)
17. I HEREBY CERTIFY, That I attended deceased from June 1 1921, to July 14 1921, that I last saw h.e.r. alive on June 12 1921, and that death occurred on the date stated above, at 9:30 A.M.
The CAUSE OF DEATH* was as follows:
Valvular Heart disease
(Duration) 20 Yrs. ... mos. ... ds.
Contributory (Secondary)
(Duration) ... yrs. ... mos. ... ds.
(Signed) H. Wilson M. D.
July 14 1921, (Address) Twin Falls, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL ... 19...
20. UNDERTAKER: J. J. Grossman | ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
AUG 20 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Twin Falls
City of ..... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 37
Primary Registration District No. 1 x 5

File No. 35084
Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME R. Joseph Phillips

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
male	white	single

6. DATE OF BIRTH Don't Know (Month) (Day) 1 (Year)

7. AGE About 60 Yrs. Mos. ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry, business or establishment in which employed (or employer) Owner

9. BIRTHPLACE Indiana (State or Country)

10. NAME OF FATHER Don't Know

11. BIRTHPLACE OF FATHER (State or Country) " "

12. MAIDEN NAME OF MOTHER " "

13. BIRTHPLACE OF MOTHER (State or Country) " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) .....
(Address) Hollister Ida.

15. Filed Aug. 9 1921 John D Coughlin Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 29 1921
July (Month) 29 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 24 1921, to July 29 1921, that I last saw h.. alive on July 29 1921, and that death occurred on the date stated above, at 6 P.M.
The CAUSE OF DEATH* was as follows:

Acute Dilatation Heart.

(Duration) ..... Yrs. ..... mos. 1 ds.
Contributory (Secondary) Pneumonia Croupous
(Duration) 4 Yrs. ..... mos. ..... ds.

(Signed) Duncan, Ferguson & Ferguson M. D.
7/29 1921 (Address) Twin Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Twin Falls	8/2/21 19

20. UNDERTAKER	ADDRESS
P. J. Grossman	Twin Falls. Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35085

Registered No.

1. PLACE OF DEATH

County of Twin Falls

City of

(No. St.)

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 37

Primary Registration District No. 1085

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If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Muriel Brown

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: April 22 (Month) (Day) 1 (Year)

7. AGE: 90 Yrs. 3 Mos. 7 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Newfoundland

10. NAME OF FATHER: Robt Menge

11. BIRTHPLACE OF FATHER (State or Country): Newfoundland

12. MAIDEN NAME OF MOTHER: Elebeth Hill

13. BIRTHPLACE OF MOTHER (State or Country): Hampshire Worcester

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) D Shirley Brown

(Address)

15. Filed July 30 1921

John McCaughey
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July 29 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 24 1921, to July 29 1921 that I last saw her alive on July 29 1921, and that death occurred on the date stated above, at 6:30 P.M.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

(Duration) Yrs. mos. 4 ds.

Contributory (Secondary) Intestinal Intussusception

(Duration) yrs. mos. 6 ds.

(Signed) G. S. Murphy M. D.

7/29 1921 (Address) Twin Falls Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Homer Dell — DATE OF BURIAL 19

20. UNDERTAKER: J E Everett — ADDRESS Twin Falls Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Twin Falls Registration District No. 137

City of ..... Primary Registration District No. 1085 File No. 35086

(If outside limits, give township.) (St.) Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
AUG 20 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME Ina Morgan

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Feb 27 1911 (Month) (Day) (Year)

7. AGE: 10 Yrs. 5 Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: School Girl
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Wash

10. NAME OF FATHER: James Morgan

11. BIRTHPLACE OF FATHER (State or Country): Kansas

12. MAIDEN NAME OF MOTHER: Ellen Marson

13. BIRTHPLACE OF MOTHER (State or Country): Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. Morgan
(Address) Twin Falls Idaho

15. Filed Aug. 1 1921 John P. Coughlin
Local Registrar

SYMS-YORK CO. PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July 27 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 7/15 1921, to 7/27 1921 that I last saw her alive on 7/27 1921 and that death occurred on the date stated above, at 6:45 P.M.

The CAUSE OF DEATH* was as follows:

Traumatic meningitis

(Duration) ..... Yrs. ..... mos. 8 ds.

Contributory (Secondary) Fract from horse

(Duration) ..... yrs. ..... mos. 9 ds.

(Signed) W. O. Tate M. D.

7/29/1921 (Address) Twin Falls Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Idaho — DATE OF BURIAL: 7-28 1921

20. UNDERTAKER: J. E. Wood — ADDRESS: Twin Falls

MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

RECEIVED SEP 6 - 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Ada — Registration District No. 2

City of Boise — Primary Registration District No. 4

(No. U. S. P. H. S. Hospital St.)

File No. 35087

Registered No. 223

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Samuel Hugh Winstead

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Divorced

6. DATE OF BIRTH: July 28 (Month) (Day) 1874 (Year)

7. AGE: 47 Yrs. — Mos. 8 ds. IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Manufacturing Business.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Jacob P. Winstead

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Eliza Elizabeth A. McElroy

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Charles E. Winstead
(Address): 905 No 19th St, Boise, Idaho.

15. Filed Aug 6 1921 — A. N. Peat, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 5 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 13, 1921, to Aug 5 1921, that I last saw him alive on Aug 5 1921, and that death occurred on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:
Syphilitic Cerebral Hemorrhage

(Duration) 2 Yrs. 2 mos. 9 ds.

Contributory (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) H. H. Hoth P.A.U.S.P.H.S. M. D.
Aug 6 1921 (Address) U.S.P.H.S. Hospital 32 Boise Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs ... mos ... days. In the State ... yrs ... mos ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Circleville, Ohio — DATE OF ~~BURIAL~~ Shipment 8/7 1921

20. UNDERTAKER: Schreiber & Redemeyer — ADDRESS: Boise Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Original

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
OCT 5 1921
BUREAU OF VITAL STATISTICS

Registration District No. 2
Primary Registration District No. 1004
File No. 35088
Registered No. 3-41

1. PLACE OF DEATH
County of Ada
City of Boise, (No.) St Alphonsus Hospital
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Donald Bollman
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6. DATE OF BIRTH: May (Month) 3 (Day) 1910 (Year)

7. AGE: 11 Yrs. 3 Mos. 29 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: Chas Bollman

11. BIRTHPLACE OF FATHER (State or Country): Illinois.

12. MAIDEN NAME OF MOTHER: Laura Jackson

13. BIRTHPLACE OF MOTHER (State or Country): Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chas Bollman
(Address) .....

15. Filed: Sept 1 1921 — R H Pratt, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 1 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 25 1921, to Aug 31 1921; that I last saw him alive on Aug 31 1921 and that death occurred on the date stated above, at 5:45 M.

The CAUSE OF DEATH* was as follows:

Peritonitis from perforation of bowels

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo Collins M. D.

19..... (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cem — DATE OF BURIAL: Sept 2 1921

20. UNDERTAKER: Hummerston & Keb. — ADDRESS: Boise Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED OCT 5 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35089

Registered No. 276

1. PLACE OF DEATH

County of Ada

City of Boise

(No. Linck Boise St.)

Registration District No. 2

Primary Registration District No. 1004

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lou J. Coon.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
F	W.	Married (Write the word)

6. DATE OF BIRTH: June (Month) 7 (Day) 1 (Year)

7. AGE: 39 Yrs. Mos. ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Texas.

10. NAME OF FATHER: William W. Roman

11. BIRTHPLACE OF FATHER (State or Country): Georgia.

12. MAIDEN NAME OF MOTHER: Hannah Coon.

13. BIRTHPLACE OF MOTHER (State or Country): Georgia.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H. E. Coon
(Address) Boise Idaho

15. Filed 9/28/21 19 R. H. Pratt Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 27th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 23rd 1921, to Sept 27th 1921, that I last saw h[illegible] alive on Sept 27 1921 and that death occurred on the date stated above, at [illegible] M.

The CAUSE OF DEATH* was as follows:

Cerebro-Pneumonia

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Ray Burk M. D.

Sept 28 1921 (Address) Boise Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Pleasant Hill — DATE OF BURIAL: Sept 29 1921

20. UNDERTAKER: Summers & Jacobs — ADDRESS: Boise Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-12 M. 6-15-17.

RECEIVED OCT 5 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35090
Registered No. .....

1. PLACE OF DEATH
County of Bear Lake Registration District No. .....
City of Montpelier Primary Registration District No. 2136
If death occurs away from usual residence, give facts called for under special information. (No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Jesse Isaac Shane

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower
6. DATE OF BIRTH. ? (Month) ? (Day) 1882 (Year)
7. AGE: 40 about Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many .... hrs. or .... min.?'
8. OCCUPATION
(a) Trade, profession or particular kind of work: Railroad Conductor
(b) General nature of industry, business, or establishment in which employed (or employer): O.W.R.&N.
9. BIRTHPLACE (State or Country): West Virginia
10. NAME OF FATHER: Joseph S Shane
11. BIRTHPLACE OF FATHER (State or Country): Ohio
12. MAIDEN NAME OF MOTHER: Margaret Smith
13. BIRTHPLACE OF MOTHER (State or Country): Pennsylvania
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) L G Sloan
(Address) Montpelier Idaho
15. Filed 8-28-21 [signature] Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 27 (Day) 1921 (Year)
17. I HEREBY CERTIFY, That I attended deceased from 8-25-1921 to 8-27-1921
that I last saw h..... alive on 8-27-1921
and that death occurred on the date stated above, at 4 P.M.
The CAUSE OF DEATH* was as follows:
Uremia
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Nephritis
..... (Duration) ..... Yrs. ..... mos. ..... ds.
(Signed) [signature] M. D.
8-28-1921 (Address) Montpelier

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rochester Pennsylvania — DATE OF BURIAL: Aug 31 1921
20. UNDERTAKER: J M Williams — ADDRESS: Paris Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED OCT 5 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 8

County of Ada

Primary Registration District No. 2008

File No. 35091

City of Boise (No. House and Lincoln St.)

Registered No. 621

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Hampton

If death occurred in a hospital, institution or camp, give its NAME instead of street and number. South Side

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: (Month) (Day) 1854 (Year)

7. AGE: 67 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Miner and

(b) General nature of industry, business or establishment in which employed (or employer): Prospector

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: Not known

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Not known

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant): A Schneider

(Address): Boise

15. Filed Sept 20 1921 R. H. Pratt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 9 (Month) 18 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1, 1921, to 9-18 1921 that I last saw him alive on 9-15 1921 and that death occurred on the date stated above, at 1 P. M.

The CAUSE OF DEATH* was as follows:

Valvular Heart disease

(Duration) Yrs. mos. ds.

Contributory (Secondary) Arteriosclerosis of Heart

(Duration) yrs. mos. ds.

(Signed) F. W. Willenger M. D.

9/18 1921 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence Mountain Home Ida

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 9/20 1921

20. UNDERTAKER: Schneider Hillenger & Willenger — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED OCT 5 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 8
Primary Registration District No. 8008
File No. 35092
Registered No. 61

County of Ada
City of Boise (No. U.S.P.H.S. Hospital #52 St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Wyant, Martin Van Buren

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Male	White	Single (Write the word.)

6. DATE OF BIRTH: August (Month) 31 (Day) 1892 (Year)

7. AGE: 29 Yrs. X Mos. 13 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Bontiful, Utah.

10. NAME OF FATHER: J.A.Wyant

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Unknown Wm. McBratney
(Address) Boise Idaho

15. Filed Sept 17 1921 R.N. Pratt Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. (Month) 14, 1921 (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept.7,1921 19 to Sept.14,1921 19 that I last saw him alive on Sept.14,1921 19, and that death occurred on the date stated above, at 8:15 P.M.

The CAUSE OF DEATH* was as follows:

Valvular disease, chronic, cardiac

Unknown (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Tuberculosis, chr. pul.

Unknown (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W.P. Watt, Allen M. D.
Surgeon in Charge (A)
Sept.16 19 21 (Address) USPHS Hosp. #52, Boise, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients or Recent Residents.)

At place of death X yrs. X mos. 7 days. In the State Unknown yrs. mos. days

Where was disease contracted if not at place of death? Unknown

Former or usual residence Rigby, Idaho

19. PLACE OF BURIAL OR REMOVAL: Rigby, Idaho — DATE OF BURIAL 19

20. UNDERTAKER: Wm. McBratney, Boise, Idaho. — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35093
Registered No. 6 2

RECEIVED
OCT 5 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
Registration District No. 8
Primary Registration District No. 2 9 8
County of Ada
City of
(No. 4 Miles West of Boise)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William Schwan
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	White	Single

6. DATE OF BIRTH
(Month) (Day) 1877 (Year)

7. AGE 44 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Ohio

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (State or Country) Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Clyde E Dunmers
(Address) Boise Idaho

15. Filed Sept 3 1921 R. V. Gratt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH September 2 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I ~~attended~~ saw deceased from Sept 2 1921, to 19,
that I last saw h alive on 19,
and that death occurred on the date stated above, at 11 A M.

The CAUSE OF DEATH* was as follows:
Suicide, Gun Shot Wound,

(Duration) Yrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) Clyde E Dunmers Coroner M. D.
Sept 3 1921 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Cleveland Ohio DATE OF BURIAL Sept 7 1921

20. UNDERTAKER Dunmers & Krafs ADDRESS Boise Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35094
Registered No. 63

RECEIVED
OCT 5 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Ada Registration District No. 8

City of 3 mi West of Boise (If outside city limits, give township.) Primary Registration District No. 2008 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Russel R. Ragsdale

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write word.)

6. DATE OF BIRTH: Feb 12 (Month) (Day) 1897 (Year)

7. AGE: 24 Yrs. 7 Mos. 10 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kansas.

10. NAME OF FATHER: G. N. Ragsdale

11. BIRTHPLACE OF FATHER (State or Country): Iowa.

12. MAIDEN NAME OF MOTHER: Annie L. Armstrong.

13. BIRTHPLACE OF MOTHER (State or Country): Iowa.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) G. N. Ragsdale
(Address) Boise

15. Filed Sept 23 1921 R. H. Pratt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sep 22 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 4 1920, to Sept 22 1921, that I last saw h... alive on Sept 18 1921, and that death occurred on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows:
Pulmonary tuberculosis

(Duration) 3 Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) M. F. Coleman M. D.

9/23 1921 (Address) Boise

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Sept 25 1921

20. UNDERTAKER: Summers & Kirk — ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
OCT 5 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 8

County of Ada

Primary Registration District No. Town 8

City of Meridian (Name) Boise

(No. 2½ Mile N.W. of Eagle St.)

File No. 35095

Registered No. 64

If death occurs away from usual residence give facts called for under special information.

2. FULL NAME Jessie Clare Kuster

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): ~~Single~~

6. DATE OF BIRTH: Nov. (Month) 6 (Day) 1919 (Year)

7. AGE: 1 Yrs. 10 Mos. 15 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Boise

10. NAME OF FATHER: J. P. Kuster

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Nellie E. Cooper

13. BIRTHPLACE OF MOTHER (State or Country): Kas.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. P. Kuster

(Address) Eagle Ida

15.

Filed Sept 24 1921 R. K. Pratt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 21 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to Sept 21 1921

that I last saw h~~e~~ alive on ..... 19.....,

and that death occurred on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:

Strangulation in cow stanchion (accidental)

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) T. N. Bratton M. D.

Sept 24 1921 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 9/25 1921

20. UNDERTAKER: Schreiber & Siebenfeden — ADDRESS: Boise

Dr Bratton

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED OCT 5 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35096
Registered No. 65

1. PLACE OF DEATH
County of Ada
City of Boise
Registration District No. 8
Primary Registration District No. 3008
(No.) Riverside Station (St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Carlos D. Pulley
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	White	Widower

6. DATE OF BIRTH: March 5 1835 (Month) (Day) (Year)

7. AGE: 86 Yrs. 6 Mos. 19 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer): ********

9. BIRTHPLACE (State or Country): Kentucky

10. NAME OF FATHER: Lewis Pulley

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Clyde E. [illegible]
(Address) [illegible]

15. Filed Sept 27 1921 R. H. Pratt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept 24 1921. (Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar. 9" 1920 to Sept 10" 1921 that I last saw him alive on Aug. 29" 1921, and that death occurred on the date stated above, at 11:30 A.M.
The CAUSE OF DEATH* was as follows: General Debility

(Duration) 1 Yrs. 6 mos. 14 ds.
Contributory (Secondary) Degenerative Cerebritis
(Duration) ..... yrs. 1 mos. ..... ds.
(Signed) J. M. Henry M. D.
Sept 25" 1921 (Address) Caldwell Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery
DATE OF BURIAL: Sept 26 1921
20. UNDERTAKER: Summers & Krebs
ADDRESS: Boise, Idaho.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
OCT 5 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35097
Registered No. 265

1. PLACE OF DEATH
Registration District No. 2
County of Ada — Primary Registration District No. 1004
City of Boise (No. St. Alphonsus Hosp.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jane Elizabeth Ayres.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write word.)

6. DATE OF BIRTH: Sep 17 (Month) (Day) 1851 (Year)

7. AGE: ___ Yrs. ___ Mos. ___ ds.
IF LESS than 1 day how many 5 hrs. or ___ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer): ___

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Verne Ayres.

11. BIRTHPLACE OF FATHER (State or Country): Kansas.

12. MAIDEN NAME OF MOTHER: Libyl Hertz.

13. BIRTHPLACE OF MOTHER (State or Country): Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Verne A. Ayres.
(Address) 107 S 17th St Boise Idaho.

15. Filed Sept 20 1921 — R. H. Pratt, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 9 (Month) 17 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9/17 1921 to 9/17 1921 that I last saw h.er alive on 9/17 1921 and that death occurred on the date stated above, at 5 P. M.
The CAUSE OF DEATH* was as follows:
Congenital Malformation of Heart.
(Duration) ___ Yrs. ___ mos. ___ ds.
Contributory (Secondary) ___
(Duration) ___ yrs. ___ mos. ___ ds.
(Signed) Fred A. Tallentyre M. D.
9/17 1921 (Address) ___

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ___ yrs. ___ mos. ___ days. In the State ___ yrs. ___ mos. ___ days
Where was disease contracted if not at place of death? ___
Former or usual residence ___

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cem. DATE OF BURIAL: Sept 19 1921

20. UNDERTAKER: Summers & Keeler ADDRESS: Boise Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED OCT 5 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH — Registration District No. 2
County of Ada — Primary Registration District No. 1004.
City of Boise (If not in city give township) (No. 2429 Ellis Avenue St.)
File No. 35098
Registered No. 263
If death occurs away from usual residence, give facts called for under special information.
2. FULL NAME Katherine Elizabeth Duvornstedt
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single
6. DATE OF BIRTH: July (Month) 13 (Day) 1911 (Year)
7. AGE: 10 Yrs. 2 Mos. 7 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry, business or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Boise Idaho
10. NAME OF FATHER: Charles L. Duvornstedt
11. BIRTHPLACE OF FATHER (State or Country): Mo.
12. MAIDEN NAME OF MOTHER: Ina B Roe
13. BIRTHPLACE OF MOTHER (State or Country): Mo.
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Charles Duvornstedt
(Address) Boise, Idaho
15. Filed Sept 19 1921 — R. H. Pratt, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: September (Month) 17 (Day) 1921 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Sept 14 1921, to Sept 17 1921, that I last saw h[illegible] alive on Sept 17 1921, and that death occurred on the date stated above, at 3:30 A.M.
The CAUSE OF DEATH* was as follows:
(a) Poliomyelitis
(Poliomyelitis)
(Duration) ..... Yrs. ..... mos. 5 ds.
Contributory (Secondary) Bulbar Paralysis
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Jno. R. Nunnes M. D.
9/19/1921 (Address) Boise Idaho
*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.
18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence
19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Sept 20 1921
20. UNDERTAKER: Summers & Krebs — ADDRESS: Boise Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED OCT 5 1921 BUREAU OF VITAL STATISTICS

Stewart

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35099
Registered No. 261

1. PLACE OF DEATH
County of Ada
City of Boise Idaho (No. 116 E. Bannock St.)
Registration District No. 2
Primary Registration District No. 1004
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Effie E. Neher
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F	White	Married

6. DATE OF BIRTH: Nov. (Month) 11 (Day) 1877 (Year)

7. AGE: 43 Yrs. 10 Mos. 3 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Arkansas

10. NAME OF FATHER: James. T. Waltman

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Jamima Smith

13. BIRTHPLACE OF MOTHER (State or Country): Ohio.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. E. Neher
(Address) Weiser Idaho

15. Filed Sept 15 1921 R. L. Craft Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 14 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 10 1921, to Sept 14 1921, that I last saw h..... alive on Sept 14 1921, and that death occurred on the date stated above, at 10a M.

The CAUSE OF DEATH* was as follows:
Acute Peritonitis — Expiration
Post Operation for Abdominal adhesions
& Obstruction (Duration) ..... Yrs. ..... mos. 7 ds.

Contributory (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) James L Stewart M. D.
9/14 1921 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Nampa Idaho	Sept 16 1921
20. UNDERTAKER	ADDRESS
Summers & Trefz	Boise Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19. RECEIVED OCT 5 — 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35100
Registered No. 275

1. PLACE OF DEATH
County of Ada
City of Ada Boise
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2
Primary Registration District No. 1 and 4
(No. Soldiers Home St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Stephen A. Matthews

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widower
6. DATE OF BIRTH: June (Month) 27 (Day) 1839 (Year)
7. AGE: 82 Yrs. 2 Mos. 29 ds. IF LESS than 1 day how many ... hrs. or ... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Contractor
(b) General nature of industry, business or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): New York
10. NAME OF FATHER: Elias Matthews
11. BIRTHPLACE OF FATHER (State or Country): New York.
12. MAIDEN NAME OF MOTHER: Sarah Perry
13. BIRTHPLACE OF MOTHER (State or Country): New York,
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Jay Matthews
(Address): 702 Idaho Street
15. Filed Sept 28 1921 R. N. Pratt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 9 (Month) 26 (Day) 1921 (Year)
17. I HEREBY CERTIFY, That I attended deceased from 9/20 1921, to 9/26 1921
that I last saw him alive on 9/25 1921
and that death occurred on the date stated above, at ... M.
The CAUSE OF DEATH* was as follows:
Anemia. Progressive Pernicious
(Duration) ... Yrs. ... mos. ... ds.
Contributory (Secondary)
(Duration) ... yrs. ... mos. ... ds.
(Signed) Fred A. Jewett M. D.
9/27 1921 (Address) Boise Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Sept 27 1921
20. UNDERTAKER: Summers & Turk — ADDRESS: Boise, Ida

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

WRITING INK — THIS IS A PERMANENT RECORD
... be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH ... may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 5-19.

RECEIVED OCT 5 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35101

Registered No. 260

1. PLACE OF DEATH

Registration District No. [redacted]

County of Ada

Primary Registration District No. 1004

City of Boise (No. Room 15, 9th Floor St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Bertha Fueller

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F.	W.	Single

6. DATE OF BIRTH Sept 13 1921
(Month) (Day) (Year)

7. AGE — Yrs. — Mos. — ds.

IF LESS than 1 day how many 3 hrs. or — min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Boise Idaho.

10. NAME OF FATHER Jacob Albert Fueller

11. BIRTHPLACE OF FATHER (State or Country) Switzerland

12. MAIDEN NAME OF MOTHER Margaret Hegg

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. McBratney

(Address) Boise Idaho

15. Filed Sept 13 1921 R. H. Pratt Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 13 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 13 1921, to Sept 13 1921, that I last saw her alive on Sept 13 1921, and that death occurred on the date stated above, at 3.40 P.M.

The CAUSE OF DEATH* was as follows:

Septum defect of Heart

(Duration) Yrs. mos. 1 ds.

Contributory (Secondary) Asphyxiation

(Duration) yrs. mos. 3 hr ds.

(Signed) F. N. Braxton M. D.

9/13/21 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Morris Hill Cemetery — DATE OF BURIAL 9/17 1921

20. UNDERTAKER W. McBratney — ADDRESS Boise Ida

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
OCT 5 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 2

County of Ada

Primary Registration District No. 1004

File No. 35102

City of Boise (No. ..... St.)

Registered No. 259

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elsie Marie Moore

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: September 11th (Month) (Day) 1921 (Year)

7. AGE: ..... Yrs. ..... Mos. 1 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Bonnie Moore

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Pauline E. Ellsworth

13. BIRTHPLACE OF MOTHER (State or Country): Pennsylvania

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Margaret Cobb

(Address) Boise Idaho

15. Filed Sept 12 1921 R. H. Pratt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 9 (Month) 11 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9/11 1921 to 9 11 1921 that I last saw her alive on 10 PM 1921 and that death occurred on the date stated above, at 12 P.M.

The CAUSE OF DEATH* was as follows:

Blue baby. Non-closure Foramen ovale

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) S.A. Pittenger M. D.

9/11 1921 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery | DATE OF BURIAL: 9/13 1921

20. UNDERTAKER: Schrader & Eisenbeis | ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED OCT 5 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35103

Registered No. 2028

1. PLACE OF DEATH

Registration District No. 2

County of Ada — Primary Registration District No. 1004

City of Boise (No. 410 Hale St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Geo. Leon Hodge

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Aug (Month) 5 (Day) 1898 (Year)

7. AGE: 23 Yrs. 1 Mos. 5 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: G. H. Hodge

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Mary Teeples

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) George H. Hodge

(Address) Boise

15. Filed Sept 12 1921 — R. H. Pratt, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. (Month) 10 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from August 25 1921, to Sept. 10 1921, that I last saw him alive on Sept 10 1921, and that death occurred on the date stated above, at 4:30 P.M.

The CAUSE OF DEATH* was as follows:

Acute purulent meningitis. bacteriology undetermined

(Duration) ..... Yrs. ..... mos. 17 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. W. Baer M. D.

Sept 11 1921 (Address) 400 Idaho Bldg.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Firth Idaho — DATE OF BURIAL: 9/12 1921

20. UNDERTAKER: Schreiber & Hidenfeldt — ADDRESS: Boise Ida

Dr Baer

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35104
Registered No. 254

RECEIVED
OCT 5 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Ada Registration District No. 2

City of Boise (No. 213 South 7th St.) Primary Registration District No. 1004

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Go Hai

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Yellow

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1 (Year)

7. AGE: about 65 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Cook
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): China

10. NAME OF FATHER: Not obtainable

11. BIRTHPLACE OF FATHER (State or Country): China

12. MAIDEN NAME OF MOTHER: Not obtainable

13. BIRTHPLACE OF MOTHER (State or Country): China

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Harry W. Fong
(Address) Boise Ida

15. Filed Sept 10 1921 R. H. Pratt Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: September 8 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I ~~attended~~ saw deceased ~~from~~
Sept 8 1921 to ..... 19.....
that I last saw h..... alive on ..... 19.....
and that death occurred on the date stated above, at 6 P M.
The CAUSE OF DEATH* was as follows:
Suicide. Cut his throat with razor

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Clyde E. Summers Coroner of Ada County
9/10 1921 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Schreiber & Sidenfaden, Boise | DATE OF BURIAL: 9/10 1921

20. UNDERTAKER: Summers Funeral Co. | ADDRESS: Boise Ada Co Ida

Embalmer

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

RECEIVED OCT 5 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35105
Registered No. 753

1. PLACE OF DEATH
County of Ada Registration District No. 2
City of Boise (No. 410 State St.) Primary Registration District No. 1404

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs John Edwards

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Married

6. DATE OF BIRTH Feb. (Month) 2 (Day) 1862 (Year)

7. AGE 59 Yrs. 7 Mos. 7 ds. IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) England

10. NAME OF FATHER Francis Ellis

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER Grace Thomas

13. BIRTHPLACE OF MOTHER (State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) ...

(Address) Mrs Ada Brydon.

15. Filed Sept 9 1921 R. H. Pratt Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 9 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 25 1921, to Sept 9 1921, that I last saw h... alive on Sept 9 1921 and that death occurred on the date stated above, at 9a M.

The CAUSE OF DEATH* was as follows:

[redacted] — Cancer of uterus.

Operation for same

(Duration) — Yrs. 8 mos. ... ds.

Contributory (Secondary) ...

(Duration) ... yrs. ... mos. ... ds.

(Signed) James L Stewart M. D.

9/9 1921 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death? ...

Former or usual residence Bellevue Ida Permanent

19. PLACE OF BURIAL OR REMOVAL Bellevue Ida — DATE OF BURIAL 9/10 1921

20. UNDERTAKER Schreiber & Schuyladen — ADDRESS Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35106
Registered No. 251

RECEIVED
OCT 5 1921
BUREAU OF VITAL STATISTICS

Registration District No. 2
Primary Registration District No. 1004

1. PLACE OF DEATH
County of Ada
City of Boise (No. 1201 South Boise St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Gladys May Campbell
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Feb 19 (Month) (Day) 1 (Year)

7. AGE: 16 Yrs. 6 Mos. 17 ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: James Campbell

11. BIRTHPLACE OF FATHER (State or Country): Utah.

12. MAIDEN NAME OF MOTHER: Louise Branson.

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) James Campbell
(Address) Boise Idaho

15.
Filed Sept 8 1921 — R. N. Pratt, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept 6 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1, 1921 to Sept 6 1921
that I last saw h.. alive on Aug 1 1921
and that death occurred on the date stated above, at 9 P.M.
The CAUSE OF DEATH* was as follows:-
Acute nephritis
uremia.
(Duration) 10 Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) M. K. Tallman M. D.
9/7 1921 (Address) Boise.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Sept 7 1921
20. UNDERTAKER: Summers & Trefz — ADDRESS: Boise Idaho,

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
OCT 5 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Ada
City of Boise (If outside limits of city or village, write the name of township.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2
Primary Registration District No. 1004
No. 516 Lake (St.)

File No. 35107
Registered No. 249

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Winslo Parson Palmer

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word.): Single

6. DATE OF BIRTH: Oct. (Month) 26. (Day) 1909 (Year)

7. AGE: 11 Yrs. 10 Mos. 9 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: School Boy
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Meridian Id

10. NAME OF FATHER: Isaac Palmer

11. BIRTHPLACE OF FATHER (State or Country): Ill

12. MAIDEN NAME OF MOTHER: Hattie Pettit

13. BIRTHPLACE OF MOTHER (State or Country): Meridian Id.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Isaac Palmer
(Address): Nampa Idaho R.D. 3

15. Filed Sept 3 1921
R. N. Pratt
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. (Month) 1. (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 2 1921, to Sept 2 1921, that I last saw h... alive on Sept 1 19..., and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Concussion of Brain

(Duration) ..... Yrs. ..... mos. 1d Last

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. W. Mc ... M. D.

9-3-1921 (Address) Meridian Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State 3 hours ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Meridian Id. DATE OF BURIAL: Sept 4 1921

20. UNDERTAKER: W. D. Mahler ADDRESS: Meridian Id.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM U. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35108
Registered No. 264

RECEIVED
OCT 5 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Ada
Registration District No. 2
Primary Registration District No. 1 of 4
City of Boise (If outside city limits, give township) No. St Lukes Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Eldridge Harman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Feb 3 1901 (Month) (Day) (Year)

7. AGE: 20 Yrs. 7 Mos. 19 ds.
If LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer): At Home

9. BIRTHPLACE (State or Country): Nebraska

10. NAME OF FATHER: W. B. Harman

11. BIRTHPLACE OF FATHER (State or Country): Virginia

12. MAIDEN NAME OF MOTHER: Eva Hazen

13. BIRTHPLACE OF MOTHER (State or Country): Nebraska

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. McBratney
(Address) Boise, Idaho.

15. Filed Sept 19 1921 — R. W. Pratt, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. 19 1921 (Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 16 1921, to Sept. 18 1921, that I last saw her alive on Sept. 18 1921, and that death occurred on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:
abscessed tooth general septicemia

(Duration) ..... Yrs. ..... mos. 7 ds.

Contributory (Secondary) .....

(Duration) 11 hrs mos. ..... ds.

(Signed) W. L. Trayer M. D.
9/19/21 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 9/20/21

20. UNDERTAKER: W. McBratney — ADDRESS: Boise Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-25 M. 1-19.

RECEIVED OCT 5 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35109
Registered No. 278

1. PLACE OF DEATH

County of Ada Registration District No. 2
City of Mar Boise (No. Soldiers Home St.) Primary Registration District No. 1004

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Nelson Miller

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
M	White	Married

6. DATE OF BIRTH: September 26 1842 (Month) (Day) (Year)

7. AGE: 79 Yrs. 0 Mos. 2 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Veteran Civil War
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio.

10. NAME OF FATHER: Joseph Miller

11. BIRTHPLACE OF FATHER (State or Country): Penn

12. MAIDEN NAME OF MOTHER: Katherine Sherk

13. BIRTHPLACE OF MOTHER (State or Country): Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Clyde E Summers
(Address) Boise Idaho

15. Filed 9-30-1921 R. H. Roath Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July 9 (Month) 28 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1 1921, to Sept 28 1921, that I last saw him alive on Sept 27 1921, and that death occurred on the date stated above, at 24 M.

The CAUSE OF DEATH* was as follows:

Senile Dementia

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Fred A. Fulton M. D.

9/28 1921 (Address) Overland Bldg.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Sept 30 1921

20. UNDERTAKER: Summers & Krebs — ADDRESS: Boise Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED OCT 5 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 2

Primary Registration District No. 1004

File No. 35110

Registered No. 277 1/2

County of Ada

City of Near Boise (No. 2 Garden, Home St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John H Tyson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: (Month) (Day) 1846 (Year)

7. AGE: 75 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Veteran Civil War
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Unknown

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Clyde E. Dunnuss
(Address) Boise, Idaho

15. Filed 9-30-1921 R H. Grail Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 9 (Month) 28 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 15 1921, to Sept 28 1921, that I last saw him alive on Sept 27 1921, and that death occurred on the date stated above, at 19 M.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed) Fred A. Peters Jr. M. D.

9/28 1921 (Address) Overland Bldg

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery | DATE OF BURIAL: Sept 30 1921

20. UNDERTAKER: Dunnuss & Krebs | ADDRESS: Boise, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19

RECEIVED OCT 5 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Ada — Registration District No. 8

City of Boise — Primary Registration District No. 1004

(No. 1510 N. 17 st St.)

File No. 35111

Registered No. 247

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ruth Jacobs

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word.): Single

6. DATE OF BIRTH: Sept 7 1916 (Month) (Day) (Year)

7. AGE: 5 Yrs. Mos. 21 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): American Falls Ida

10. NAME OF FATHER: W. B Jacobs

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Rhoda A. Johnson

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. B. Jacobs

(Address) American Falls Ida

15. Filed 9-28- 1921 — R. H. Pratt, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 28 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 5 1921, to Sept 28 1921, that I last saw her alive on Sept. 28 1921 and that death occurred on the date stated above, at 2:30 P.M.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Dr. A. D. Morris M. D.

Sept 28 1921 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: American Falls Ida — DATE OF BURIAL: Sept 30 1921

20. UNDERTAKER: Summers & Tuft — ADDRESS: Boise Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19

RECEIVED OCT 5 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Ada — Registration District No. 2

City of Boise. — Primary Registration District No. 1004

(No. 234 Anderson St.)

File No. 35112

Registered No. 274

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jesse Coleman Green.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M.	W.	Single

6. DATE OF BIRTH Mch. 22 - 1921
(Month) (Day) (Year)

7. AGE — Yrs. 6 Mos. 3 ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Boise.

10. NAME OF FATHER: Coleman E. Green.

11. BIRTHPLACE OF FATHER (State or Country): Mo

12. MAIDEN NAME OF MOTHER: Ruth Emma Cole

13. BIRTHPLACE OF MOTHER (State or Country): Mich.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): W. M. Bradley
(Address): Boise. Idaho.

15. Filed Sept 26 1921 — R. H. Pratt, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 26 - 1921
(Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1 1921 to Sept 26 1921 that I last saw h... alive on Sept. 26 1921, and that death occurred on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) Yrs. 0 mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) W. R. Wheeler M. D.

9/26/1921 (Address) Boise Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Morris Hill	9/27 1921

20. UNDERTAKER	ADDRESS
W. M. Bradley	Boise Idaho

FORM V. S. No. 5-25. M. 1-19.

OCT 1927
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Ada — Registration District No. 9

City of Boise — Primary Registration District No. 1004

(No. 1712 Jefferson St.)

File No. 35114

Registered No. 232

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Caroline Alexander

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
F.	White.	Widow (write the word.)

6. DATE OF BIRTH: March 16 (Month) (Day) 1844 (Year)

7. AGE: 77 Yrs. 6 Mos. 17 ds. — IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: at Home
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country) Ohio.

10. NAME OF FATHER Alvin Alexander

11. BIRTHPLACE OF FATHER (State or Country) Unknown.

12. MAIDEN NAME OF MOTHER Coleman

13. BIRTHPLACE OF MOTHER (State or Country) Ohio.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W K Eagleson
(Address) Boise Idaho

15. Filed Sept 24 1921 — R. McPratt — Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sep 23 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1921, to Sep 23 1921, that I last saw h.r. alive on Sep 22 1921, and that death occurred on the date stated above, at 6 A M.

The CAUSE OF DEATH* was as follows:

Brights Disease

(Duration) 1 Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. H. Imes M. D.

19..... (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Morris Hill Cem.	Sep 24 1921
20. UNDERTAKER	ADDRESS
Summers & Keb.	Boise Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED OCT 5 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35115

Registered No. 279

1. PLACE OF DEATH

County of Ada

City of Boise Idaho (No. 5th Forbes St.)

Registration District No. 2

Primary Registration District No. 1004

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME. Jennie E Hatch

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Female	White	Married (or Widowed)

6. DATE OF BIRTH: May (Month) 5 (Day) 1867 (Year)

7. AGE: 54 Yrs. 5 Mos. 18 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housekeeper
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Omaha Neb

10. NAME OF FATHER: Hopkins

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. N. Hatch
(Address) Meridian Idaho

15. Filed Sept 23 1921 R. H. Smith Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 23 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 3 — 1921, to Sept. 23 — 1921, that I last saw h.. alive on Sept. 22 — 1921, and that death occurred on the date stated above, at 9 A M.

The CAUSE OF DEATH* was as follows:
Chronic nephritis.

..... (Duration) ..... Yrs. 10 mos. ..... ds.
Contributory (Secondary) General edema
..... (Duration) ..... yrs. 9 mos. ..... ds.

(Signed) W. L. Frazier M. D.
9/23/1921 (Address) 515 Overland Blk Boise Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Sept 25 1921

20. UNDERTAKER: W. S. Maker — ADDRESS: Meridian Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED OCT 5 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 3511f

Registered No. 270

1. PLACE OF DEATH

Registration District No. 2

County of Ada — Primary Registration District No. 1004

City of Boise (No. 410 State St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Infant J. Fletcher

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F	White	Single

6. DATE OF BIRTH: Sept (Month) 19 (Day) 1921 (Year)

7. AGE: ...Yrs. ...Mos. 3 ds. — IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Boise Idaho

10. NAME OF FATHER A. J. Fletcher

11. BIRTHPLACE OF FATHER (State or Country) Maine.

12. MAIDEN NAME OF MOTHER Ida M. Carleton

13. BIRTHPLACE OF MOTHER (State or Country) Maine

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A. J. Fletcher
(Address) Richfield Idaho

15. Filed Sept 22 1921 — R. H. Pratt, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 23 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 19 1921, to Sept 22 1921, that I last saw him alive on Sept 22 1921, and that death occurred on the date stated above, at 2P M.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
due to pneumonia bilat

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary) ...
(Duration) ... yrs. ... mos. ... ds.

(Signed) James L Clemens M. D.
9/23 1921 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was data contracted if not at place of death? ...
Former or usual residence ...

19. PLACE OF BURIAL OR REMOVAL: Richfield Idaho. DATE OF BURIAL: Sept 24 1921

20. UNDERTAKER: Summers & Hart ADDRESS: Boise Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED OCT 5 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Ada — Registration District No. 2

City of Boise — Primary Registration District No. 104 — Soldiers Home Hospital (St.)

File No. 35117

Registered No. 248

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William J. Rainey

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widower

6. DATE OF BIRTH: (Month) (Day) 1839 (Year)

7. AGE: 82 Yrs. — Mos. — ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Retired Soldier.

(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Unknown

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Harry Webb.

(Address) Boise Idaho.

15. Filed Sept 22, 1921 — R. H. Pratt, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept 21 (Month) 21 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9/20 1921, to 9/21 1921, that I last saw him alive on 9/20 1921 and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Senility

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary) Valvular Heart Disease

(Duration) ... yrs. ... mos. ... ds.

(Signed) Fred A. Paterson M. D.

9/22 1921 (Address) Boise Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cem — DATE OF BURIAL: Sept 22 1921

20. UNDERTAKER: Summers & Webb. — ADDRESS: Boise Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED OCT 5 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35118
Registered No. 267

1. PLACE OF DEATH
County of Ada
Registration District No. 2
Primary Registration District No. 1004
City of Boise (No. 110 E. Bannock St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Donnabelle Cory

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F	White	Single

6. DATE OF BIRTH: Sept (Month) 11 (Day) 1921 (Year)

7. AGE: ....Yrs. 7 Mos. ....ds. IF LESS than 1 day how many....hrs. or....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Boise Idaho.

10. NAME OF FATHER: J. A Cory

11. BIRTHPLACE OF FATHER (State or Country): South Dakota

12. MAIDEN NAME OF MOTHER: Laura A. Gage

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. J. A. Cory
(Address) 1702 N. 7th St.

15. Filed Sept 22 1921 P. H. Peate Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. (Month) 18th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 11th 1921, to Sept 18th 1921, that I last saw h.er alive on Sept 17th 1921, and that death occurred on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:
Malnutrition - not in normal condition at birth -
(Duration) ....Yrs. ....mos. ....ds.
Contributory (Secondary) Premature birth gestation estimated 34 weeks
(Duration) ....yrs. ....mos. ....ds.

(Signed) J. M Taylor - M. D.
9/22 1921 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery | DATE OF BURIAL: Sept 22 1921

20. UNDERTAKER: Summers & Keeler | ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35119
Registered No.

RECEIVED OCT 5 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No.

Primary Registration District No.

County of Ada

City or Town of Star (If outside limits, give township) (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James D. Karcher

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH: Sep (Month) ..... (Day) 1900 (Year)

7. AGE: 21 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day: how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Geo Karcher

11. BIRTHPLACE OF FATHER (State or Country): ~~N.Y~~ Penn

12. MAIDEN NAME OF MOTHER: Elizabeth McRobbie

13. BIRTHPLACE OF MOTHER (State or Country): N.Y.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Geo. J Karcher jr

(Address) N ampa Ida.

15. Filed Sept. 25 19 21 Owen Jackson Local Registrar

Eagle Idaho

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 21 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I ~~attended~~ saw deceased from Sept 22 1921, to ..... 19..., that I ~~last~~ saw him alive on ..... and died Sept 22 1921 and that death occurred on the date stated above, at 1 10 M.

The CAUSE OF DEATH* was as follows:

"Poison" from liquor that he drank, Chemical analysis being made of Stomach Contents by State Chemist

(Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Clyde E. Dunmers Coroner Ada Co

9/23 1921 (Address) Boise Ada County

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Nampa Ida. Kohlerlawn cem — DATE OF BURIAL: ..... 19.....

20. UNDERTAKER: Fred L. Robinson — ADDRESS: Nampa Ida.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED OCT 5 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35120
Registered No. 16

1. PLACE OF DEATH
County of Ada
City of Meridian (If outside limits of city or village, give township.) St.)
Registration District No.
Primary Registration District No. 11
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lewis Leroy Heikes
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH: Jan (Month) 29 (Day) 1903 (Year)

7. AGE: 18 Yrs. 7 Mos. 19 ds.
IF LESS than 1 day how many.....hrs. or.....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: High School Boy
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Miland Kansas

10. NAME OF FATHER: Wm Heikes

11. BIRTHPLACE OF FATHER (State or Country): Dillsburg Penn -

12. MAIDEN NAME OF MOTHER: Minnie D. Rule

13. BIRTHPLACE OF MOTHER (State or Country): Dalton Penn -

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. E. Heikes
(Address) Meridian Idaho

15. Filed Sept 30 1921 W. F. Rea Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 16 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I ~~attended~~ deceased ~~from~~ Sept 16 1921, to ..... 19.....
~~that I last saw him alive on ..... 19.....~~
~~and that death occurred on the date stated above, at~~ 7a.M.

The CAUSE OF DEATH* was as follows:
Accidental, Shot himself with 32 Caliber revolver

.....(Duration) .....Yrs.....mos.....ds.

Contributory (Secondary)
.....(Duration) .....yrs.....mos.....ds.

(Signed) Clyde E. Summers Coroner Ada County
Sept 16 1921 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Meridian Cemetery | DATE OF BURIAL: Sept 19 1921

20. UNDERTAKER: W. J. Mather Meridian | ADDRESS: Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED OCT 5 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35121
Registered No. 17

1. PLACE OF DEATH
County of Ada Registration District No.
City of Meridian Primary Registration District No.
(If outside limits, give township.) St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George N. Feldtman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	White	Married

6. DATE OF BIRTH
Feb (Month) 26 (Day) 1869 (Year)

7. AGE
52 Yrs. 9 Mos. 23 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Wisconsin

10. NAME OF FATHER Henry Feldtman

11. BIRTHPLACE OF FATHER (State or Country) Germany

12. MAIDEN NAME OF MOTHER Henrietta Kapfer

13. BIRTHPLACE OF MOTHER (State or Country) Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) G. N. Feldtman
(Address) Meridian Idaho

15. Filed Sept 20 1921 W. F. Ma... Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Sept (Month) 18 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 21 1921 to Sept. 18 1921 that I last saw h.im alive on Sept. 17 1921 and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 3 or 4 or longer Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. K. Numbers M. D.
9/19 1921 (Address) Meridian Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Sept Meridian Cem. | DATE OF BURIAL Sept 21 1921

20. UNDERTAKER W. S. Mather Meridian | ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 4-19.

RECEIVED OCT 1921 BUREAU OF VITAL STATS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Ada — Registration District No. ____

City of Meridian (St.) — Primary Registration District No. 11

If death occurs away from usual residence, give facts called for under special information.

File No. 35122

Registered No. 18

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Maria L Dorg

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Married

6. DATE OF BIRTH: July (Month) 24 (Day) 184* (Year)

7. AGE: 77 Yrs. 2 Mos. 4 ds. — IF LESS than 1 day how many ____ hrs. or ____ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housekeeper
(b) General nature of industry, business or establishment in which employed (or employer): ____

9. BIRTHPLACE (State or Country): Wisconsin

10. NAME OF FATHER: Isaac Fellows

11. BIRTHPLACE OF FATHER (State or Country): Penobscot Co Me

12. MAIDEN NAME OF MOTHER: Margrit Elmore

13. BIRTHPLACE OF MOTHER (State or Country): Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Leona M Veach
(Address) Meridian

15. Filed 9/29 1921 — H F Neal, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 28 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 5 1920 to Sept 23 1921 that I last saw her alive on Sept 23 1921 and that death occurred on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:
Senile Arteio-Sclerosis

(Duration) 1 Yrs. 2 mos. 23 ds.

Contributory (Secondary) Rheumatism

(Duration) 5 yrs. ____ mos. ____ ds.

(Signed) H. F. Neal M. D.

9/29 1921 (Address) Meridian Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days

Where was disease contracted if not at place of death? ____

Former or usual residence ____

19. PLACE OF BURIAL OR REMOVAL: Meridian — DATE OF BURIAL: Sept 24 1921

20. UNDERTAKER: W S Hales — ADDRESS: Meridian

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED
SEP 25 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35123
Registered No.

1. PLACE OF DEATH
County of Ada — Registration District No.
City of Meridian (No. St.) — Registration District No.
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Glen A. Potter

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH: June (Month) 10 (Day) 1921 (Year)

7. AGE: Yrs. 1 Mos. 8 ds. — IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Boise Idaho

10. NAME OF FATHER: R. H. Potter

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Bessie A. Morford.

13. BIRTHPLACE OF MOTHER (State or Country): Kansas.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ralph Potter
(Address) Boise R.D. 3.

15. Filed 7-18 1921 — H. F. Neal, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 18 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from January 10 1921 to January 18 1921
that I last saw him alive on January 18 1921,
and that death occurred on the date stated above, at 7.30 A.M.
The CAUSE OF DEATH* was as follows:
Auto toxemia
(Duration) ..... Yrs. ..... mos. 10 ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Herbert F. Neal M. D.
7-18 1921 (Address) Meridian Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Meridian Idaho — DATE OF BURIAL: July 19 1921

20. UNDERTAKER: W. S. Waters — ADDRESS: Meridian Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A--25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35124

RECEIVED
SEP 25 1921
BUREAU OF VITAL STATISTICS

Registration District No.
Primary Registration District No.

1. PLACE OF DEATH
County of Ada
City of Meridian (No. St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sargent M. Hutcheson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male.	White	Married

6. DATE OF BIRTH: January (Month) 6 (Day) 1864 (Year)

7. AGE: 57 Yrs. 6 Mos. 4 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Pendleton Indiana

10. NAME OF FATHER: Sargent M Hutcheson

11. BIRTHPLACE OF FATHER (State or Country): Tennessee

12. MAIDEN NAME OF MOTHER: Elisa L Johnson

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Herbert H. Hutchison
(Address) Meridian Ida

15. Filed 8-12 1921 — W. F. Neal, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug. (Month) 10 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 15 1921, to Aug. 10 1921, that I last saw him alive on Aug 10 1921, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Angina Pectoris

(Duration) ..... Yrs. 3 mos. — ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. F. Neal M. D.
8-12 1921 (Address) Meridian

*State the **Disease Causing Death**; or in deaths from **Violent Causes**, state (1) **Means of Injury**; and (2) whether **Accidental, Suicidal or Homicidal.**

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Meridian Cemetery	Aug 12 1921
20. UNDERTAKER	ADDRESS
W. D. Mokler	Meridian Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35125
Registered No.

1. PLACE OF DEATH

County of Ada

City of Meridian (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
SEP 25 1921
BUREAU OF VITAL STATISTICS

Registration District No.

Primary Registration District No.

2. FULL NAME Mary J. Edwards

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Widow

6. DATE OF BIRTH: August (Month) 1 (Day) 1847 (Year)

7. AGE: 74 Yrs. ..... Mos. 25 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House Keeper.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: John Noble

11. BIRTHPLACE OF FATHER (State or Country): England.

12. MAIDEN NAME OF MOTHER: Mary Moscop

13. BIRTHPLACE OF MOTHER (State or Country): England.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Nellie Edwards Merson
(Address) Meridian, Idaho

15. Filed 9-10 1921 — H. F. Mead, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug. (Month) 25 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19....., that I last saw h..... alive on Aug. 17 1921, and that death occurred on the date stated above, at .....M.

The CAUSE OF DEATH* was as follows:
Arteriosclerosis (Sen.)

(Duration) 5 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. F. Mead M. D.

19..... (Address) .....

*State the *Disease Causing Death*; or in deaths from *Violent Causes*, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Boise — DATE OF BURIAL: Aug 27 1921

20. UNDERTAKER: W. Bluhm Merchant St. — ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35126
Registered No.

RECEIVED
SEP 15 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 7
Primary Registration District No. 2056
County of Ada
City of Meridian (No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Thomas David Meikle

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: May 23, 1916 (Month) (Day) (Year)

7. AGE: 5 Yrs. 3 Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wash.

10. NAME OF FATHER: Thomas Meikle

11. BIRTHPLACE OF FATHER (State or Country): Wash.

12. MAIDEN NAME OF MOTHER: Margella K.Doll

13. BIRTHPLACE OF MOTHER (State or Country): Wash.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Thomas Meikle
(Address) Meredian Ida.

15. Filed Sept 10 1921 Pearle Dodds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug. 22, 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 21 1921, to Aug 22 1921, that I last saw him alive on Aug 22 1921, and that death occurred on the date stated above, at 5 P. M.
The CAUSE OF DEATH* was as follows:

Scarlet Fever

(Duration) Yrs. mos. 21 ds.
Contributory (Secondary) Complications Acute urinary suppression Retained uraic media
(Duration) yrs. mos. ds.

(Signed) Marion A. Fink M. D.
8/23/21 (Address) Nampa, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Kohlerlawn Cemetery Nampa, Ida.
DATE OF BURIAL: 8/23 1921

20. UNDERTAKER: Fred K. Robinson
ADDRESS: Nampa Ida

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
OCT 3 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 83
Primary Registration District No.
File No. 35127
Registered No.

1. PLACE OF DEATH

County of Bannock
City of Robin (No. Residence St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Amanda B Evans

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widow (Write the word.)

6. DATE OF BIRTH: April (Month) 14 (Day) 1840 (Year)

7. AGE: 80 Yrs. 9 Mos. 4 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Indiana

10. NAME OF FATHER: Emmitt Boone

11. BIRTHPLACE OF FATHER (State or Country): Indiana

12. MAIDEN NAME OF MOTHER: Elizabeth Purcell

13. BIRTHPLACE OF MOTHER (State or Country): Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. J. Evans
(Address) Robin

15. Filed Jan. 20, 1921 H. H. Hostetgrew Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: January (Month) 18 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 14 1921, to Jan 18 1921, that I last saw her alive on Jan 18 1921, and that death occurred on the date stated above, at 9:20 A.M.

The CAUSE OF DEATH* was as follows:
Angina Pectoris

(Duration) 4 Yrs. mos. ds.
Contributory (Secondary) Arteriosclerosis
(Duration) 4 yrs. mos. ds.

(Signed) Wilson H McNeill M. D.
Jan 19 21 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Woodbine Iowa
DATE OF BURIAL: 19

20. UNDERTAKER: Schumacher & Hall
ADDRESS: Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED OCT 3 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35128
Registered No. .....

Registration District No. .....
Primary Registration District No. .....

1. PLACE OF DEATH.
County of Bannock
City of Downey (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William H Coffin

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married
6. DATE OF BIRTH. Nov (Month) 10 (Day) 1867 (Year)
7. AGE: 53 Yrs. 4 Mos. 28 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work... Farmer
(b) General nature of industry, business, or establishment in which employed (or employer).....
9. BIRTHPLACE (State or Country) Idaho
10. NAME OF FATHER William Albert Coffin
11. BIRTHPLACE OF FATHER (State or Country) Iowa U.S.A.
12. MAIDEN NAME OF MOTHER Sophronia Hunt
13. BIRTHPLACE OF MOTHER (State or Country) Utah
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Cordelia Coffin
(Address) Downey
15. Filed April 10, 1921 — L J Sorteigsen — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 8 (Day) 1921 (Year).
17. I HEREBY CERTIFY, That I attended deceased from Feb. 25, 1921, to April 8, 1921, that I last saw him alive on April 8 1921, and that death occured on the date stated above, at 2:00 P.M.
The CAUSE OF DEATH* was as follows:
Nephritis
.....(Duration) 3 Yrs. ..... mos. ..... ds.
Contributory (Secondary) None
.....(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) L. J. Sorteigsen, M. D.
4-10 1921 (Address) Downey, Idaho

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Downey, Idaho — DATE OF BURIAL: April 10 1921
20. UNDERTAKER: C E Layton — ADDRESS: Downey

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24658

FORM V. S. No. 5-25 M. 1-19.

RECEIVED OCT 3 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35129
Registered No.

1. PLACE OF DEATH

County of Bannock Registration District No. 53

Primary Registration District No. 2160

City of Downey (If outside limits, give township.), St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Franklyn Johnson Robinson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Feb 2 1920 (Month) (Day) (Year)

7. AGE: 1 Yrs. 3 Mos. 5 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Downey, Idaho.

10. NAME OF FATHER: J. A. Robinson,

11. BIRTHPLACE OF FATHER (State or Country): Richmond, Utah

12. MAIDEN NAME OF MOTHER: Nettie L. Johnson.

13. BIRTHPLACE OF MOTHER (State or Country): Richmond, Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) F. A. Robinson

(Address)

15. Filed May 9 1921 J. J. Hastings Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 7 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ~~April~~ May 2 1921, to May 7 1921, that I last saw him alive on May 7 1921, and that death occurred on the date stated above, at 9.45 P.M.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(Duration) Yrs. mos. 21 ds.

Contributory (Secondary) measles

(Duration) yrs. mos. ds.

(Signed) H. J. Hastings, M. D.

5-9-1921 (Address) Downey Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Richmond Utah — DATE OF BURIAL: 5 10 1921

20. UNDERTAKER: J. A. Parker — ADDRESS: Pocatello Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

35130

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
SEP 15 1921
BUREAU OF VITAL STATISTICS

Registration District No. 28
Primary Registration District No. 2161
File No. 42
Registered No. 3631

1. PLACE OF DEATH
County of Va oc
City of Wocat o (No. ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs Agnes Nimich

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: July (Month) 29 (Day) 1894 (Year)

7. AGE: 27 Yrs. 2 Mos. ... ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wocatello

10. NAME OF FATHER: J. G. Carcovich

11. BIRTHPLACE OF FATHER (State or Country): Nelena Mont

12. MAIDEN NAME OF MOTHER: Rachel Arnida

13. BIRTHPLACE OF MOTHER (State or Country): Salt Lake City

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Jan Nemcich
(Address): Wocatello

15. Filed 9/1 19 21 J. H. Young. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 31 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 13 1921, to July 31 1921, that I last saw h[illegible] alive on July 31 1921, and that death occurred on the date stated above, at 6 P.M.

THE CAUSE OF DEATH* was as follows: Post Pneumonia (abscess) Left Side

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary) [illegible] (Duration) ... yrs. ... mos. ... ds.

(Signed) John L. Mooney M. D.
8/31 19 21 (Address) Preston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mt Auburn Cemetery
DATE OF BURIAL: 9/2 19 21

20. UNDERTAKER: J. T. Tracy
ADDRESS: Preston Idaho

SUNS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

35131

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
SEP 15 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Bannock Registration District No. 28
City of Pocatello Primary Registration District No. 2161
(No. 1527 Wilson Ave St.)
File No. 43
Registered No. 3640

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Frank Howard Lindell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: July (Month) 18 (Day) 1921 (Year)

7. AGE: Yrs. Mos. 27 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Pocatello

10. NAME OF FATHER: Frank Lindell

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Helma Peterson

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Frank Lindell
(Address) Pocatello Ida

15. Filed 9/15 1921 J. P. Young Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 14 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 10 1921, to Aug 13 1921, that I last saw h[illegible] alive on 8-12- 1921, and that death occurred on the date stated above, at 4:30 P.M.

The CAUSE OF DEATH* was as follows: Pulmonary Edema

(Duration) Yrs. mos. 3 ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) D. G. Ray M. D.
9/15 1921 (Address) Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Old Pio Cemetery — DATE OF BURIAL: 9/15 1921

20. UNDERTAKER: W. J. Walker — ADDRESS: Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

Each item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED SEP 18 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

35132

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 25
Primary Registration District No. 314
File No. 43
Registered No. 8243

1. PLACE OF DEATH

County of Bannock
City of Pocatello (No. General Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Edward Smith

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	white	Married

6. DATE OF BIRTH Dec (Month) 12 (Day) 1893 (Year)

7. AGE 48 Yrs. 8 Mos. 5 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Master Basket Maker
(b) General nature of industry, business or establishment in which employed (or employer): Foreman O. S. L. Basket Shops

9. BIRTHPLACE (State or Country) England

10. NAME OF FATHER Stephen Smith

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER Martha Land

13. BIRTHPLACE OF MOTHER (State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Cynthia Smith
(Address) Pocatello Idaho

15. Filed Aug 18 1921 J. W. Young Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August (Month) 17 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 8-11-1921 to 8-17-1921 that I last saw h[illegible] alive on 8-17 1921 and that death occurred on the date stated above, at 9:30 P. M.

The CAUSE OF DEATH* was as follows:

Paralytic ileus

(Duration) ..... Yrs. ..... mos. 3 ds.

Contributory (Secondary) Appendicitis Chronic

(Duration) ..... yrs ..... mos. 14 ds.

(Signed) [signature] M. D.

8/18/1921 (Address) Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State 14 yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence Pocatello Ida.

19. PLACE OF BURIAL OR REMOVAL Mt View Pocatello | **DATE OF BURIAL** Aug 20 1921

20. UNDERTAKER McFarland Undertaking Co. | **ADDRESS** Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19. RE...

SEP 15 ...

BUREAU ... STATIS...

CERTIFICATE OF DEATH

35133

25

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 25

Primary Registration District No. 2141

File No. 43

Registered No. 3644

1. PLACE OF DEATH

County of Bannock

City of Pocatello (No. County Farm St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Jonas Johnson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: May 19 1837 (Month) (Day) (Year)

7. AGE: 83 Yrs. 9 Mos. — ds. IF LESS than 1 day how many..... hrs. or.....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER: Jonas Johnson

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Johanna Jonkapson

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Anna Johnson
(Address) Pocatello, Idaho,

15. Filed Aug 20 1921 J. R. Young Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August (Month) 19 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 1917, to Aug 19 1921, that I last saw him alive on Aug 17 1921, and that death occurred on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

Apoplexy,

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary) ...

(Duration) ... yrs. ... mos. ... ds.

(Signed) [illegible] M. D.

Aug 20 1921 (Address) Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 5 yrs. ... mos. ... days. In the State 21 yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence Pocatello, Idaho,

19. PLACE OF BURIAL OR REMOVAL: Mt View — DATE OF BURIAL: Aug 21 1921

20. UNDERTAKER: McHan Undertaking — ADDRESS: Pocatello Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED SERIAL BUREAU STATISTICS

CERTIFICATE OF DEATH

35134

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 28
Primary Registration District No. 2161
File No. 43
Registered No. 3648

1. PLACE OF DEATH
County of Bannock
City of Pocatello (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Phillip T. Taylor
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): married

6. DATE OF BIRTH: June (Month) 24 (Day) 1884 (Year)

7. AGE: 37 Yrs. 2 Mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Garrison Ida.

10. NAME OF FATHER: Joe C. Taylor.

11. BIRTHPLACE OF FATHER (State or Country): N C

12. MAIDEN NAME OF MOTHER: Sarah Jane Folland

13. BIRTHPLACE OF MOTHER (State or Country): Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. Cranshaw
(Address) McCammon

15. Filed 8/29 1921 J. Manning Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August (Month) 27 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 10 1921, to Aug 27 1921
that I last saw h[illegible] alive on Aug 26 1921
and that death occurred on the date stated above, at 7 a.m.
The CAUSE OF DEATH* was as follows:
Lobar Pneumonia
(Duration) ..... Yrs. ..... mos. 6 ds.
Contributory (Secondary) Emphysema
(Duration) ..... yrs. 1 mos. 17 ds.
(Signed) W. J. Howard M. D.
8/29 1921 (Address) Pocatello, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: McCammon. DATE OF BURIAL: Aug 29 1921

20. UNDERTAKER: F. L. McHan. ADDRESS: 215 So Main Pocatello Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
SEP 15 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

35135

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 42

Registered No. 3630

1. PLACE OF DEATH

County of Bannock — Registration District No. 28

City or (STREET) 654 E. Shoshone St. — Primary Registration District No. 2161

Ward

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Clara H. Scott

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): married

6. DATE OF BIRTH: Apr 16th 1855 (Month) (Day) (Year)

7. AGE: 66 Yrs. 3 Mos. 15 Ds.

IF LESS than 1 day: how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: A. M. Johnston

11. BIRTHPLACE OF FATHER (State or Country): Indiana

12. MAIDEN NAME OF MOTHER: unknown

13. BIRTHPLACE OF MOTHER (State or Country): unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) James E. Scott
(Address) 1251 E. Sherman

15.
Filed 9/1 1921 — Local Registrar

SUNS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July 31st 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....
and that death occurred on the date stated above at 9:15 A. M.
The CAUSE OF DEATH* was as follows:
Paralytic Stroke

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D. A. Ferguson Corner M. D.
7-31-1921 (Address) Pocatello Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain View — DATE OF BURIAL: Aug 2 1921

20. UNDERTAKER: Schumacher Hall — ADDRESS: Pocatello Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

35136

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 42

Registered No. 3632

RECEIVED
SEP 15 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Bannock

City of Pocatello

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 28

Primary Registration District No. 2161

Ward No. [illegible] Street No. [illegible]

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Margaret Osborne

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: Indian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: May (Month) 12 (Day) 1920 (Year)

7. AGE: 1 Yrs. 2 Mos. 19 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Fort Hall

10. NAME OF FATHER: Thos Osborne.

11. BIRTHPLACE OF FATHER (State or Country): Nevada

12. MAIDEN NAME OF MOTHER: Louisa Ory.

13. BIRTHPLACE OF MOTHER (State or Country): Yukon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Margaret Osborne

(Address) Fort Hall

15. Filed 9/1 1921

J. H. Young. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 1st (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 30 1921, to July 31 1921, that I last saw h[illegible] alive on July 31 1921, and that death occurred on the date stated above, at 5-30 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... Yrs. ..... mos. 12 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. V. Lyman M. D.

July 31 1921 (Address) Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. 2 days

Where was disease contracted if not at place of death? Sterling Idaho.

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Fort Hall Cemetery

DATE OF BURIAL: 9/1 1921

20. UNDERTAKER: [illegible] Parker

ADDRESS: Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

35137

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED SEP 14 1921 BUREAU OF VITAL STATISTICS

Registration District No. 20
Primary Registration District No. 2141
File No. 42
Registered No. 3433

1. PLACE OF DEATH
County of Bannock
City of Pocatello (No. 210 So. 4th ave St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lucian R. Riley
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word)

6. DATE OF BIRTH: October 26 1898 (Month) (Day) (Year)

7. AGE: 22 Yrs. 9 Mos. 9 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Mail Clerk U. S.
(b) General nature of industry, business or establishment in which employed (or employer): Postoffice Pocatello

9. BIRTHPLACE (State or Country): Nebraska

10. NAME OF FATHER: William Riley

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Lala Berry

13. BIRTHPLACE OF MOTHER (State or Country): Arkansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Lala Riley
(Address) 210 So. 4th ave

15.
Filed aug 6. 1921
J. R. Young. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August 5 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1st 1920 to aug 5th 1921 that I last saw him alive on aug 5th 1921 and that death occurred on the date stated above, at 5:30 M. The CAUSE OF DEATH* was as follows:

Tuberculosis of the lungs.

(Duration) 3 Yrs. ..... mos. ..... ds.

Contributory (Secondary) nephritis

(Duration) ..... yrs. 6 mos. ..... ds.

(Signed) Owen Lynn M. D.
aug 6th 1921 (Address) Pocatello

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 13 yrs. ..... mos. ..... days. In the State 13 yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence Blackfoot, Idaho.

19. PLACE OF BURIAL OR REMOVAL: Mt View Cem. DATE OF BURIAL: aug 7 1921

20. UNDERTAKER: H. L. McHan ADDRESS: Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED SEP 15 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

35138

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 28
Primary Registration District No. 2161
File No. 42
Registered No. 3634

1. PLACE OF DEATH
County of BANNOCK
City of POCATELLO (No. LYNN BROS HOSPITAL St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME JAMES C MC NICHOLS

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M.	W.	

6. DATE OF BIRTH: Febr (Month) 13 (Day) 1862 (Year)

7. AGE: 59 Yrs. 5 Mos. 25 ds. IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Merchant
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Fond Du Lac Mich

10. NAME OF FATHER: John J.Mc Nichols

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Mary Lucid

13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) M.C. Mc Nichols
(Address) Pocatello

15. Filed 8/8 1921

Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: AUG 7th 1921 (Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 19 21 to Aug 7th 1921 19, that I last saw h IM alive on AUG 7th 1921, and that death occurred on the date stated above, at 8.10 A.M.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) ~~Yrs.~~ mos. 18 hrs ds.

Contributory (Secondary) Old age

(Duration) yrs. mos. ds.

(Signed) J. H. Simpson M. D.

8/7/21 (Address) POCATELLO Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days In the State 20 yrs. ... mos. ... days

Where was disease contracted if not at place of death? ~~Apoplexy~~

Former or usual residence Pocatello Ida.

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
MT VIEW CEMETERY	8/9/21 19
20. UNDERTAKER	**ADDRESS**
WILL T.WALKER	POCATELLO

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED SEP 15 1921 BUREAU OF STATISTICS

CERTIFICATE OF DEATH

35139 State of Idaho BOARD OF HEALTH Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 28

Primary Registration District No. 2161

File No. 42

Registered No. 3635

County of Bannock

City of Pocatello (If not in hospital, give street address or location.) Lynn Bros Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Chas Henry Chapman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH: Aug (Month) 8 (Day) 1921 (Year)

7. AGE: Yrs. Mos. 1 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Pocatello Ida

10. NAME OF FATHER C. H. Chapman

11. BIRTHPLACE OF FATHER (State or Country) Liverpool Ohio

12. MAIDEN NAME OF MOTHER Myrtle Beatrice Stewart

13. BIRTHPLACE OF MOTHER (State or Country) America N. York Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. H. Chapman
(Address) Tyhee

15. Filed 8/10 1921 J. W. Young Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 9 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 8, 1921, to Aug 9 1921, that I last saw h. was alive on Aug 9 1921, and that death occurred on the date stated above, at 6:15 P. M.

The CAUSE OF DEATH* was as follows:

Bowel Bad

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. V. Thomas M. D.

Aug 10 1921 (Address) Pocatello Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Tyhee Idaho	8/10 1921

20. UNDERTAKER	ADDRESS
W. T. Walker	Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

SEP 15 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

35140

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 28
Primary Registration District No. 7161
File No. 42
Registered No. 3434

1. PLACE OF DEATH
County of Bannock
City or (Name) Pocatello St. Dr Anthony Hospital
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Genevieve Burns
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Jan (Month) 28th (Day) 1896 (Year)

7. AGE: 25 Yrs. 6 Mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Nurse
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: James J. Burns

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Genevieve Sullivan

13. BIRTHPLACE OF MOTHER (State or Country): Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) James J. Burns
(Address) Pocatello Idaho

15. Filed 8/12 1921
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 11th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 6th 1921, to Aug. 11th 1921, that I last saw her alive on Aug. 11th 1921, and that death occurred on the date stated above, at 9:45 A.M.

The CAUSE OF DEATH* was as follows:

Mercurial poisoning

(Duration) ..... Yrs. ..... mos. 6 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

8/12 1921 (Signed) W. A. Wright M. D.
(Address) Pocatello, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain View — DATE OF BURIAL: 8/12 1921

20. UNDERTAKER: Schumacher & Hall — ADDRESS: Pocatello Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
SEP 15 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

28 35141

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2141
Primary Registration District No.
File No. 42
Registered No. 3687

1. PLACE OF DEATH
County of Bannock
City of Pocatello
(No. 1234 S. 5th St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ethel M. Goodson
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Jan 22nd 1921
(Month) (Day) (Year)

7. AGE: Yrs. 0 Mos. 7 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Marvin Goodson

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Margaret Diamond

13. BIRTHPLACE OF MOTHER (State or Country): Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Marvin Goodson
(Address) 1234 S. 5th

15. Filed 8/12 1921
J. P. Young Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug 11 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 8/11 1921, to 8/11 1921
that I last saw her alive on 8/11 1921,
and that death occurred on the date stated above, at 10 P. M.
The CAUSE OF DEATH* was as follows:
Acute Enteritis
(Duration) Yrs. 1 mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) J. P. Young M. D.
8/12 1921 (Address) Pocatello

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain View — DATE OF BURIAL: Aug 13 1921

20. UNDERTAKER: Schumacher & May — ADDRESS: City

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED SEP 15 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

35142

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bannock — Registration District No. 28

City of POCATELLO — Primary Registration District No. 2141 — File No. 42

(No.) St Anthonys Hospital — Registered No. 3658

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Thomas Stephen Williams

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Widower

6. DATE OF BIRTH: Nov (Month) 13 (Day) 1867 (Year)

7. AGE: 64 Yrs. 8 Mos. 29 ds. — IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Deputy Sheriff
(b) General nature of industry, business or establishment in which employed (or employer): Bannock County

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Thomas S. Williams

11. BIRTHPLACE OF FATHER (State or Country): N. Y. State

12. MAIDEN NAME OF MOTHER: Alvesia M. Merrill

13. BIRTHPLACE OF MOTHER (State or Country): N. Y. State

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mamie Williams
(Address) 218 So. Garfield Pocatello

15. Filed aug 13 1921 — Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August (Month) 11 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 9 1921, to Aug 11 1921, that I last saw him alive on Aug 11 1921, and that death occurred on the date stated above, at 11-30 a. M.

The CAUSE OF DEATH* was as follows:

Uremia

(Duration) ..... Yrs. ..... mos. 10 ds.

Contributory (Secondary): Chronic interstitial nephritis

(Duration) 5 yrs. ..... mos. ..... ds.

(Signed) A M. Newton M. D.

Aug 13 1921 (Address) POCATELLO, IDAHO

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 15 yrs. — mos. — days. In the State 21 yrs. — mos. — days
Where was disease contracted if not at place of death?
Former or usual residence Soda Springs Ida.

19. PLACE OF BURIAL OR REMOVAL: Soda Springs Ida — DATE OF BURIAL: aug 19 1921

20. UNDERTAKER: H. L. McHAN — ADDRESS: POCATELLO, IDAHO

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

28 35143

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
SEP 15 1921
BUREAU OF VITAL STATISTICS

Registration District No. 2161
Primary Registration District No.
File No. 43
Registered No. 3641

1. PLACE OF DEATH
County of Bannock
City of Pocatello (If outside limits, give township) St. Anthony Hospital (If not in hospital, give street and number)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sabbatino Evangelista

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Italian
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widowed
6. DATE OF BIRTH: Exact date unknown (Month) 1 (Day) 1852 (Year)
7. AGE: 69 Yrs. Mos. ds. — Near as known. IF LESS than 1 day how many hrs. or min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business or establishment in which employed (or employer)
9. BIRTHPLACE (State or Country): Italy
10. NAME OF FATHER: Dominico Evangelista
11. BIRTHPLACE OF FATHER (State or Country): Italy
12. MAIDEN NAME OF MOTHER: unknown
13. BIRTHPLACE OF MOTHER (State or Country): unknown
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Thomas Zanga
(Address) St. Anthony Hospital
15.
Filed 9/14 1921
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 15 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 13 1921, to Aug 15 1921, that I last saw h alive on Aug 14 1921, and that death occurred on the date stated above, at 1:30 P.M.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(Duration) Yrs. mos. 3 ds.

Contributory (Secondary) Chronic nephritis

(Duration) few yrs. mos. ds.

(Signed) A.M. Newton M. D.

Aug 14 1921 (Address) Pocatello Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain View — DATE OF BURIAL: Aug 17 1921

20. UNDERTAKER: Schumacher Hall — ADDRESS: Pocatello Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED SEP 1 BUREAU OF VITAL STATISTICS STATE OF IDAHO

35144

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 28
Primary Registration District No. 2161
File No. 43
Registered No. 3442

1. PLACE OF DEATH

County of Bannock
City of Pocatello (No. 835 N. 11th and, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Emily Ruth Shambaw

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	white	single

6. DATE OF BIRTH April 27 1921 (Month) (Day) (Year)

7. AGE — Yrs. 3 Mos. 20 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Pocatello, Ida.

10. NAME OF FATHER John Shambaw

11. BIRTHPLACE OF FATHER (State or Country) Nebraska

12. MAIDEN NAME OF MOTHER Amelia Rawson

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Shambaw
(Address) 835 N. 11th Pocatello

15. Filed Aug 17 1921 Local Registrar

SUNS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 16 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 15 1921 to Aug 16 1921 that I last saw her alive on Aug 15 1921 and that death occurred on the date stated above, at 1230 P.M.

The CAUSE OF DEATH* was as follows:
Entero-colitis acute.

(Duration) ..... Yrs. ..... mos. 5 ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. W. Brothers M. D.
Aug 17 1921 (Address) Pocatello

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days. of Pocatello
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Mt View Cem. **DATE OF BURIAL** Aug 17 1921

20. UNDERTAKER [redacted] **ADDRESS** Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED SEP 15 1921 STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

35145

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 28
Primary Registration District No. 241
File No. 43
Registered No. 3645

1. PLACE OF DEATH

County of Bannock
City of Pocatello (No. 342 N. 4th ave St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME ~~Ernest~~ Amedee Oscar Dufresne

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	white	Married

6. DATE OF BIRTH

October 10 1862
(Month) (Day) (Year)

7. AGE

58 Yrs. 10 Mos. 11 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: R.R. fireman
(b) General nature of industry, business or establishment in which employed (or employer): O.S.L. Shops

9. BIRTHPLACE (State or Country): Canada

10. NAME OF FATHER: Peter Dufresne

11. BIRTHPLACE OF FATHER (State or Country): Canada

12. MAIDEN NAME OF MOTHER: Elise Dufraine ~~Dufresne~~

13. BIRTHPLACE OF MOTHER (State or Country): Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Celina Dufresne
(Address) 342 N. 4th Pocatello

15.

Filed Aug 22 1921

J. P. Young
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

August 21 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 15 1921, to Aug 21 1921
that I last saw h. alive on Aug 21 1921
and that death occurred on the date stated above, at 11:45 M.

The CAUSE OF DEATH* was as follows:

Carcinoma of stomach
(Inoperable)

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. P. Young M. D.
8/22 1921 (Address) Pocatello

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 20 yrs. ..... mos. ..... days. In the State 20 yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence: Canada

19. PLACE OF BURIAL OR REMOVAL: Mt View Cem — DATE OF BURIAL: Aug 23 1921

20. UNDERTAKER: McHan Undertaking Co — ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED SEP 13 1921 BUREAU OF VITAL STATISTICS STATE OF IDAHO

CERTIFICATE OF DEATH

35146

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 28
Primary Registration District No. 2161
File No. 43
Registered No. 3646

1. PLACE OF DEATH

County of Bannock
City of POCATELLO. IDAHO (No. 1324, Taft ave St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charles Junius Newkirk

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6. DATE OF BIRTH: October 2 (Month) (Day) 1917 (Year)

7. AGE: 3 Yrs. 10 Mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Missouria

10. NAME OF FATHER: Charles Newkirk

11. BIRTHPLACE OF FATHER (State or Country): Missouria

12. MAIDEN NAME OF MOTHER: Gladys Kimmett

13. BIRTHPLACE OF MOTHER (State or Country): Missouria

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Josephine Kimmett
(Address) POCATELLO. IDAHO

15. Filed Aug 24 1921 J. M. Sprague Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August 23 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 23 1921 to Aug. 23 1921 that I last saw h[illegible] alive on Aug 23 1921 and that death occurred on the date stated above, at 1:30 P. M.

The CAUSE OF DEATH* was as follows:

Infectious Diarrhoea
Enteritis
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Pneumonia
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Sprague M. D.
Aug 24 1921 (Address) POCATELLO. IDAHO

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. 5 mos. ..... days. In the State ..... yrs. 5 mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence California

19. PLACE OF BURIAL OR REMOVAL: Mexico Missouria
DATE OF BURIAL: Aug 25 1921

20. UNDERTAKER: H. L. McNAIN
ADDRESS: POCATELLO. IDAHO

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

35147

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 28
Primary Registration District No. 2161
File No. 43
Registered No. 3647

1. PLACE OF DEATH
County of Bannock
City of POCATELLO IDAHO (If outside limits, give township) 217 So Johnson St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Dickinson
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widowed

6. DATE OF BIRTH: July (Month) 11 (Day) 1869 (Year)

7. AGE: 52 Yrs. 1 Mos. 12 ds.
IF LESS than 1 day how many..... hrs. or.....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: Henry Fisher

11. BIRTHPLACE OF FATHER (State or Country): Not Known

12. MAIDEN NAME OF MOTHER: Minnie Stoner

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Edward D. Dickenson
(Address) 217 So Johnson St

15.
Filed Aug 24 1921
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August (Month) 23 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 1st 1921, to Aug. 23rd 1921, that I last saw her alive on July 20th 1921, and that death occurred on the date stated above, at 6:30 P. M.

The CAUSE OF DEATH* was as follows:

Uterine Carcinoma

(Duration) Unknown yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) W. D. Griffith M. D.

8/24/1921 (Address) POCATELLO, IDAHO

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 4 yrs. mos. days. In the State 45 yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mt View Cemetery
DATE OF BURIAL: Aug 25 1921

20. UNDERTAKER
ADDRESS: POCATELLO, IDAHO

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

35148

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

RECD SEP 19 BUREAU STATS

Registration District No. 28

Primary Registration District No. 7161

County of Bannock

City of Pocatello (No. 321 - No Elemt St.)

File No. 95

Registered No. 5648

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Alvin Joseph McNally

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Infant

6. DATE OF BIRTH: June (Month) 11 (Day) 1921 (Year)

7. AGE: — Yrs. 2 Mos. 14 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Pocatello Ida.

10. NAME OF FATHER: Francis McNally

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Lena McVigh

13. BIRTHPLACE OF MOTHER (State or Country): Nebraska

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Francis McNally
(Address) Pocatello Ida.

15. Filed 8/24 1921

J. Mowry
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 25 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 21 1921, to Aug 24 1921, that I last saw h. alive on Aug 20 1921, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Convulsions caused by auto gastro-enteritis

(Duration) ..... Yrs. ..... mos. 15 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A M Newton M. D.

Aug 26 1921. (Address) Pocatello Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mountain View Cem. — DATE OF BURIAL: Aug 26 1921

20. UNDERTAKER: Schumacher & Hall — ADDRESS: Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statem of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

City of Downey BUREAU OF VITAL STATISTICS ..... St.) Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sarah Bybee

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: (Write the word.)

6. DATE OF BIRTH. May (Month) 13 (Day) 1852 (Year)

7. AGE: 79 Yrs. 3 Mos. 9 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Home Wife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) England

10. NAME OF FATHER William Lloyd

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER Mary Rowley

13. BIRTHPLACE OF MOTHER (State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. F. Bybee
(Address) Downey

15. Filed Aug 21 1921 — J. F. Harrington — Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24053

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Aug (Month) 19 (Day) 1921 (Year)
I did not attend her.

17. I HEREBY CERTIFY, That I attended deceased from ....., 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at 5.05 A. M.
The CAUSE OF DEATH* was as follows:
Epithelioma of face.

(Duration) 3 Yrs. ..... mos. ..... ds.
Contributory (Secondary) Old age
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) J. F. Harrington M. D.
8-21-1921 (Address) Downey Ida.

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Downey, Idaho. DATE OF BURIAL: Aug. 24, 1921

20. UNDERTAKER: L. E. Layton ADDRESS: Downey

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35151

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No. 83

County of Bannock

Primary Registration District No. 2160

City of Virginia

No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
OCT 3 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME Sarah Evelyn Brown

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Nov (Month) 15 (Day) 1902 (Year)

7. AGE: 18 Yrs. 9 Mos. 15 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... School Girl
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Utah

10. NAME OF FATHER Edmund James Brown

11. BIRTHPLACE OF FATHER (State or Country) Utah Salt Lake Co

12. MAIDEN NAME OF MOTHER Olive Jane Butterfield

13. BIRTHPLACE OF MOTHER (State or Country) Utah Salt Lake Co

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Ellen S. Brown.
(Address) Downey RFD No 2

15. Filed Sept. 1, 1921 — H. H. Hartigan. Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
August (Month) 30 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 4, 1921, to June 22, 1921, that I last saw h.. alive on June 22, 1921, and that death occured on the date stated above, at 11:00 A.M.

The CAUSE OF DEATH* was as follows:
Complications following
Operation for Appendicitis

(Duration) Yrs. 3 mos. 26 ds.

Contributory (Secondary) Sepsis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. H. Hartigan M. D.

9/1/1921 (Address) Downey Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Downey	Sept 1 1921
20. UNDERTAKER C E Layton	ADDRESS Downey

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED
OCT 3 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35153

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No. 83

Primary Registration District No. 2160

County of Bannock

City of Downey (If outside limits of city or village, write RURAL.) St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Isavilla Whitaker

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Aug (Month) 14 (Day) 1921 (Year)

7. AGE: .....Yrs. .....Mos. 2 ds.

IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): Downey Bannock Co

10. NAME OF FATHER: Claude Whitaker

11. BIRTHPLACE OF FATHER (State or Country): Bannock Co Idaho

12. MAIDEN NAME OF MOTHER: Cecil Porter

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Claude Whitaker

(Address) Downey Idaho

15. Filed 8-18- 1921

H. J. Hoertgesen
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 17 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from .....191....., to .....191.....,

that I last saw h.....alive on .....191.....,

and that death occured on the date stated above, at .....M.

The CAUSE OF DEATH* was as follows:

Congenital Atelectasis

.....(Duration) .....Yrs. .....mos. 2 ds.

Contributory (Secondary) asphyxia Neonatorum

.....(Duration .....yrs. .....mos. ½ hour ds.

(Signed) H. J. Hoertgesen M. D.

8-18-1921 (Address) Downey, Ida.

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Downey, Idaho — DATE OF BURIAL: 8-18-1921

20. UNDERTAKER: C E Layton — ADDRESS: Downey

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SVIBS - YORK CO., PTRS. & BKBS. 24858

Copy

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
OCT 5 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 83

Primary Registration District No. 3160

File No. 35154

County of Bannock

City of Hawney (St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Hyrum A. Byington

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: married (Write the word.)

6. DATE OF BIRTH: September 26 1893
June 7 1921
(Month) (Day) (Year)

7. AGE: 27 Yrs. 8 Mos. 12 ds.

IF LESS than 1 day how many..... hrs. or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer.

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Hawney, Idaho

10. NAME OF FATHER: L. E. Byington

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Jane E. Larson

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Hyrum A Byington

(Address) Hawney, Idaho

15.

Filed June 9 1921

H. H. Hartogsen
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 7 1921.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, ~~That I attended deceased from~~ I did not attend
19..... to ~~19~~.....
that I last saw h..... alive on ~~19~~.....
and that death occurred on the date stated above, at 1:15 P.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia
(This I consider the cause from description of illness given)

(Duration) Yrs. mos. 3 ds.

Contributory (Secondary): None

(Duration) yrs. mos. ds.

(Signed) H. H. Hartogsen, M. D.

6-11-1921 (Address) Hawney, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Byington Cemetery near Hawney	6-9-1921
20. UNDERTAKER	ADDRESS
J. H. Morgan	Hawney

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED OCT 3 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35155

Registered No. .....

1. PLACE OF DEATH.

Registration District No. .....

County of Bannock

Primary Registration District No. .....

City of ..... (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Harriet Alice Bloxham

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: X

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Nov (Month) 14 (Day) 1859 (Year)

7. AGE: 61 Yrs. 6 Mos. 5 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: House Wife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: Thomas Coryall

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Ann Taylor

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) .....

15. Filed May 21, 1921. H. H. Huntington Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 19 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 16, 1921, to May 19, 1921, that I last saw her alive on May 19, 1921, and that death occured on the date stated above, at 2:00 P.M.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) ..... Yrs. ..... mos. 3 ds.

Contributory (Secondary) Chronic Nephritis

(Duration) ? yrs. ..... mos. ..... ds.

(Signed) H. H. Huntington M. D.

5-21-1921 (Address) Downey, Ida

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Downey — DATE OF BURIAL: 5-24-1921

20. UNDERTAKER: C E Layton — ADDRESS: Downey

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24653

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

3515 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
SEP 15 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Bear Lake Registration District No. 53
City of Paris Primary Registration District No. File No. 12
(If outside limits, give township.) St.) Registered No.
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Annie B. Baker.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widowed

6. DATE OF BIRTH: July (Month) 12 (Day) 1831 (Year)

7. AGE: 90 Yrs. 1 Mos. 7 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Home Wife.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): England.

10. NAME OF FATHER: William Bryceson.

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Mary Tate.

13. BIRTHPLACE OF MOTHER (State or Country): England.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) F. B. Baker
(Address) Eureka - Utah.

15. Filed 8/31 1921 Mrs. J. S. Skinner, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug. (Month) 19 (Day) 1921. (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 20 1920, to Aug 19 1921, that I last saw her alive on Aug 18 1921, and that death occurred on the date stated above, at 3 A M.

The CAUSE OF DEATH* was as follows:
Cerous of Fever.

(Duration) 1 Yrs. 5 mos. ds.
Contributory (Secondary) Hemeplegia
(Duration) yrs. 17 mos. ds.

(Signed) C. C. Dutton M. D.
8/21 1921 (Address) Paris Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: St Charles Ida. DATE OF BURIAL: 8/22/21.

20. UNDERTAKER: F. M. Williams ADDRESS: Montpelier Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH.

RECEIVED SEP 15 1921 BUREAU OF VITAL STATISTICS

Registration District No. .....

Primary Registration District No. 53

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35157

Registered No. .....

1. PLACE OF DEATH.

County of Bear Lake

City of St Charles (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Kirsten Larsen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH. Nov (Month) 23 (Day) 1841 (Year)

7. AGE: 79 Yrs. 8 Mos. 23 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: House Wife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Denmark

10. NAME OF FATHER: Jens Andersen

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: Une

13. BIRTHPLACE OF MOTHER (State or Country): Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Alma Larsen

(Address) St Charles Ida

15. Filed Aug 25 1921 John Matson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 13 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Uremia Tumor
No Dr in attendance

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: St Charles Ida — DATE OF BURIAL: Aug 16 1921

20. UNDERTAKER — ADDRESS

SYMS - YORK CO. PTRS. & BOBS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

RECEIVED SEP 15 19 BUREAU OF STATISTICS

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35158

Registered No. .....

1. PLACE OF DEATH.
County of Bear Lake
City of St Charles (No. ..... St.)
Registration District No. .....
Primary Registration District No. 57
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Nels Oluf Bergreen

male

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: ~~Female~~ Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married (Write the word.)

6. DATE OF BIRTH. Jan (Month) 21 (Day) 1841 (Year)

7. AGE 80 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Shoemaker
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Benesta Sweden

10. NAME OF FATHER Ola Person

11. BIRTHPLACE OF FATHER (State or Country) dont know

12. MAIDEN NAME OF MOTHER Sarah Trantrum

13. BIRTHPLACE OF MOTHER (State or Country) dont not know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Clara Bergreen
(Address) St Charles Ida.

15. Filed aug 19 1921 John Mattson Local Registrar

BYMS - YORK CO., PTRS. & BORS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH aug (Month) 16 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Old age
no Dr in attendance
.....(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
.....(Duration ..... yrs. ..... mos. ..... ds.
(Signed) ..... M. D.
..... 19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: St Charles Id. DATE OF BURIAL: aug 18 1921

20. UNDERTAKER ..... ADDRESS .....

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35159

Registered No. 35

RECEIVED
SEP 15 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 52

Primary Registration District No. 2[illegible]19

County of Benewah

City of Emida (No. [illegible] St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Stephen L. Carman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH: March (Month) 9 (Day) 1849 (Year)

7. AGE: 72 Yrs. 5 Mos. 2 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Penn-

10. NAME OF FATHER: Jose Carman

11. BIRTHPLACE OF FATHER (State or Country): Penn.

12. MAIDEN NAME OF MOTHER: Mary Ann Wright

13. BIRTHPLACE OF MOTHER (State or Country): Penn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Hattie I. Carman
(Address) Emida, Ida.

15. Filed Aug. 12 1921 H E Hunt Local Registrar

SYMS-YORK CO. PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August (Month) 11 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 15 1921, to Aug 9 1921
that I last saw him alive on July 9 1921,
and that death occurred on the date stated above, at 9 P.M.
The CAUSE OF DEATH* was as follows:

Gangrene lower Extremities

(Duration) Yrs. 2 mos. ds.

Contributory (Secondary) Cardiac Insufficiency

(Duration) 2 yrs. mos. ds.

(Signed) Geo. D. Platt M. D.
Aug 11 1921 (Address) St Maries Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Emida	8/12 1921
20. UNDERTAKER H E Hunt	ADDRESS St Maries

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35161

Registered No. 326

RECEIVED SEP 15 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 32

Primary Registration District No. 2049

County of Bonneville

City of St Maries (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George Nelson Richards

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: widowed (Write the word.)

6. DATE OF BIRTH: October (Month) 2 (Day) 1836 (Year)

7. AGE: 84 Yrs. 10 Mos. 14 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country): France

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country): France

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. C. E. Barnhart

(Address) Deer Park, Wash.

15. Filed Aug 17 1921

H E Hunt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug. (Month) 16 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1 1921, to Aug 16 1921, that I last saw h-em alive on Aug 1 1921, and that death occurred on the date stated above, at 9:45 A.M.

The CAUSE OF DEATH* was as follows:

Nasal Hemmorage

One Year

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Gen Senility

(Duration) 3 yrs. ..... mos. ..... ds.

(Signed) Owen R Hall M. D.

Aug 16 1921 (Address) St. Maries, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Wauseca Wis. DATE OF BURIAL: on Arrival

20. UNDERTAKER: H E Hunt Co ADDRESS: St Maries

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35162

Registered No. 34

RECEIVED SEP 13 1921 BUREAU OF VITAL STATISTICS

Registration District No. 32

Primary Registration District No. 2049

1. PLACE OF DEATH

County of Benewah

City of St Maries (No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Maude L White

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F M	White	Married

6. DATE OF BIRTH: February 12 1884 (Month) (Day) (Year)

7. AGE: 37 Yrs. 5 Mos. 23 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Michigan

10. NAME OF FATHER: J. Edward Smith

11. BIRTHPLACE OF FATHER (State or Country): Canada

12. MAIDEN NAME OF MOTHER: Mary J. Rowes

13. BIRTHPLACE OF MOTHER (State or Country): Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Thomas C White
(Address) St Maries Idaho

15. Filed Aug 5 1921 H E Hunt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug. (Month) 4 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 15 1921, to Aug 4 1921, that I last saw her alive on Aug 4 1921, and that death occurred on the date stated above, at 12:30 P.M.

The CAUSE OF DEATH* was as follows:

Peritonitis

(Duration) ..... yrs. ..... mos. 4 ds.

Contributory (Secondary): abortion 4 days

(Duration) ..... yrs. ..... mos. 15 ds.

(Signed) Owen D. Hall M. D.

Aug 4 1921 (Address) St Maries Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Woodlawns	8/7 1921
20. UNDERTAKER	ADDRESS
H E Hunt Co	St Maries

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED SEP 10 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 121

Primary Registration District No. 2194

File No. 35163

County of Bingham

City of Blackfoot (If not in incorporated limits, give township.) No. State Hospital St.)

Registered No. 119

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jim Daly

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH

1889
(Month) (Day) (Year)

7. AGE

32 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) New York

10. NAME OF FATHER unknown

11. BIRTHPLACE OF FATHER (State or Country) unknown

12. MAIDEN NAME OF MOTHER unknown

13. BIRTHPLACE OF MOTHER (State or Country) unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Hospital Records R. F. Earle

(Address) Blackfoot Idaho

15. Filed Aug 27 1921 W. S. Fuller Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug (Month) 26 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 29 1908, to Aug 26 1921, that I last saw him alive on Aug 26 1921, and that death occurred on the date stated above, at 12.30 P.M.

The CAUSE OF DEATH* was as follows:

Pericarditis, Chronic

2

(Duration) Yrs. 2 mos. ds.

Contributory (Secondary) Dementia Praecox

(Duration) 13 yrs. mos. ds.

(Signed) C. N. Moore M. D.

Aug 26 1921 (Address) Blackfoot Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 13 yrs. 0 mos. 29 days. In the State 13 yrs. + mos. + days

Where was disease contracted if not at place of death?

Former or usual residence Idaho Penitentiary

19. PLACE OF BURIAL OR REMOVAL Asylum Cemetery

DATE OF BURIAL 8-27 1921

20. UNDERTAKER Chas J. Wright

ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED SEP 15 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35164
Registered No.

1. PLACE OF DEATH
Registration District No. 121
Primary Registration District No. 2194
County of Bingham
City of Blackfoot (No. State Hospital St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Samuel C Smith

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH ? (Month) ? (Day) 1853 (Year)

7. AGE 68 Yrs. ? Mos. ? ds. IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Michigan

10. NAME OF FATHER unknown

11. BIRTHPLACE OF FATHER (State or Country) New York

12. MAIDEN NAME OF MOTHER unknown

13. BIRTHPLACE OF MOTHER (State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Hospital Records (R. J. Eaton M.D.)
(Address) Blackfoot Idaho

15. Filed Aug 20 1921 Mrs Helen E. Patrick Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 20 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 18 1921, to Aug 20 1921, that I last saw him alive on Aug 19 1921, and that death occurred on the date stated above, at 2:45 P.M.

The CAUSE OF DEATH* was as follows:
Cerebral arterio sclerosis

(Duration) 1 Yrs. 1 mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) C. A. Hoover M. D.
Aug 21 1921 (Address) Blackfoot Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. 1 mos. 2 days. In the State 20 yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence Boise, Idaho

19. PLACE OF BURIAL OR REMOVAL Blackfoot, Hosp. Cem. DATE OF BURIAL Aug 22 1921

20. UNDERTAKER Rock King, Sup. ADDRESS Blackfoot Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

RECEIVED SEP 15 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35165
Registered No. 112

1. PLACE OF DEATH
County of Bingham Registration District No. 121
City of Blackfoot Registration District No. 2194
(No. State Hospital St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Elizabeth Edwards
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: married (Write the word.)

6. DATE OF BIRTH: April (Month) 10 (Day) 1868 (Year)

7. AGE: 53 Yrs. 3 Mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: house wife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Oregon

10. NAME OF FATHER: unascertained

11. BIRTHPLACE OF FATHER: unascertained (State or Country)

12. MAIDEN NAME OF MOTHER: unascertained

13. BIRTHPLACE OF MOTHER: unascertained (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Hospital Records, R. G. Eaton M.D.
(Address) Blackfoot Idaho

15. Filed Aug 7 1921 Mrs Violet E. Palmer Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August (Month) 5 (Day), 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 29 1918, to Aug 5 1921, that I last saw h[er] alive on Aug 4 1921, and that death occurred on the date stated above, at 8 A.M.
The CAUSE OF DEATH* was as follows:
Cerebral Thrombus
Sudden
(Duration) ... Yrs. ... mos. ... ds.
Contributory (Secondary) Paralytic Condition
(Duration) 3 yrs. ... mos. ... ds.
(Signed) R. G. Eaton M. D.
Aug 5 1921 (Address) Blackfoot Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 2 yrs. 11 mos. 7 days. In the State 3 yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence Hamer, Idaho

19. PLACE OF BURIAL OR REMOVAL: Falland Aryan — DATE OF BURIAL: 8-7 1921

20. UNDERTAKER: E Funk — ADDRESS: Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED SEP 15 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 121

Primary Registration District No. 2194

File No. 3516

Registered No. 128

County of Bingham

City of Shelley (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Edna Gettings

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Infant

6. DATE OF BIRTH: Aug (Month) 1 (Day) 1921 (Year)

7. AGE: ....Yrs. ....Mos. 3 ds. IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Shelley Ida.

10. NAME OF FATHER: Jesse Gettings

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Belle Teeple

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jesse Gettings
(Address) Shelley Idaho R.F.D. No 1

15. Filed Aug 4 1921 Mrs Hales C. Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug. (Month) 4 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 1 1921, to Aug 4 1921, that I last saw her alive on Aug 4 1921, and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:
Icterus of New Born

(Duration) ....Yrs. ....mos. 3 ds.

Contributory (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) C. P. Egbert M. D.

19.... (Address) Shelley Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs. ....mos. ....days. In the State ....yrs. ....mos. ....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Shelley Idaho	....19....
20. UNDERTAKER	ADDRESS

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35167
Registered No. 111

RECEIVED SEP 15 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 21

Primary Registration District No. 21 14

County of Bingham

City of Blackfoot (If outside limits) State Hospital St.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lottie Harris

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: married (Write the word.)

6. DATE OF BIRTH: (Month) (Day) 1886 (Year)

7. AGE: 35 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: housework
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah.

10. NAME OF FATHER: unknown

11. BIRTHPLACE OF FATHER (State or Country): unknown

12. MAIDEN NAME OF MOTHER: unknown

13. BIRTHPLACE OF MOTHER (State or Country): unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Hospital Record B G Carol
(Address) Blackfoot Idaho

15. Filed Aug 19 21 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 5 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 27 1921 to Aug 5 1921 that I last saw h[illegible] alive on Aug 5 1921 and that death occurred on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:
Cerebral embolus

(Duration) Sudden Yrs. mos. ds.

Contributory (Secondary) Pneumonia f acute mania

(Duration) 1 yrs. mos. 0 ds.

(Signed) C. N. Brown M. D.

Aug 5 1921 (Address) Blackfoot Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. 10 days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence Rupert Idaho

19. PLACE OF BURIAL OR REMOVAL: Harville Cem DATE OF BURIAL: Aug 19 21

20. UNDERTAKER: Ed L Eglin ADDRESS: Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 2194
File No. 35169
Registered No. 114

RECEIVED SEP 15 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Bingham
City of Blackfoot
(If outside limits, give ward, township, or village.) (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Earl Ferdinand Anderson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M.	White	Single

6. DATE OF BIRTH: October (Month) 8 (Day) 1920 (Year)

7. AGE: — Yrs. 10 Mos. 9 ds. IF LESS than 1 day how many — hrs. or — min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Blackfoot Idaho

10. NAME OF FATHER Carl G. Anderson

11. BIRTHPLACE OF FATHER (State or Country) Sweden

12. MAIDEN NAME OF MOTHER Amanda Grahn

13. BIRTHPLACE OF MOTHER (State or Country) Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Carl G. Anderson
(Address) Blackfoot Idaho

15. Filed Aug 19 1921 Mrs Hattie E. Futrell Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 17 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 14 1921, to Aug 17 1921, that I last saw him alive on Aug 17 1921, and that death occurred on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis

(Duration) — Yrs. — mos. 1/2 ds.

Contributory (Secondary) Acute Cerimal Adentis

(Duration) yrs. mos. 4 ds.

(Signed) Joseph B Davis M. D.
8/18 1921 (Address) Blackfoot Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Grove City Cemetery	Aug 19 1921

20. UNDERTAKER	ADDRESS
Ed L Egli	Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED SEP 13 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 1, 21

Primary Registration District No. 2194

File No. 35170

Registered No. 175

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Bingham
City of Blackfoot (If not in incorporated limits, give township.)
Hospital St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Louisa Howell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): widow

6. DATE OF BIRTH: — — 84/7
(Month) (Day) (Year)

7. AGE: 74 Yrs. ... Mos. ... ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: unknown

11. BIRTHPLACE OF FATHER (State or Country): unknown

12. MAIDEN NAME OF MOTHER: unknown

13. BIRTHPLACE OF MOTHER (State or Country): unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Hospital Records R. J. Eaton
(Address) Blackfoot Idaho

15. Filed Aug 12 1921 Mrs Nellie E. Tate Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August 11 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 8 1917 to Aug. 11 1921 that I last saw h.Er. alive on Aug. 10 1921 and that death occurred on the date stated above, at 6 10 P.M.

The CAUSE OF DEATH* was as follows:
Exhaustion + Heart Failure
due to Senility
Senility
(Duration) 4 Yrs. 2 mos. 5 ds.
Contributory (Secondary) Senile Dementia
(Duration) 4 yrs. 2 mos. 3 ds.

(Signed) C. V. Howell M. D.
Aug 12 1921 (Address) Blackfoot Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 4 yrs. 2 mos. 5 days. In the State 54 yrs. ... mos. ... days
Where was disease contracted if not at place of death? —
Former or usual residence Caldwell Idaho

19. PLACE OF BURIAL OR REMOVAL: Blackfoot — DATE OF BURIAL: Aug 14 1921

20. UNDERTAKER: [illegible] — ADDRESS: Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED SEP 15 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 121

Primary Registration District No. 1194

File No. 35172

County of Bingham

City of Shelley (Ward, Village or Precinct) St.)

Registered No. 118

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Earl Herman Fackrell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	White	Single

6. DATE OF BIRTH: Feb (Month) 14 (Day) 1921 (Year)

7. AGE: Yrs. 6 Mos. 11 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Prudahl H. Fackrell

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Nellie Hoyt

13. BIRTHPLACE OF MOTHER (State or Country) Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) R. P. Fackrell

(Address) Shelley Idaho

15. Filed Aug 26 1921 Mrs Nadine E. Peterson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 25 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 25 1921, to Aug 25 1921, that I last saw h. alive on Aug 25 1921, and that death occurred on the date stated above, at 11:30 P.M.

The CAUSE OF DEATH* was as follows:

Septicemia - Infection

(Duration) ..... Yrs. 1 mos. ..... ds.

Contributory (Secondary) —

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. J. Summers M. D.

Aug 26 1921 (Address) Blackfoot Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Thomas Rexburg | DATE OF BURIAL: 8/21 1921

20. UNDERTAKER: Eggertsen | ADDRESS: Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED SEP 10 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 121

County of Bingham Primary Registration District No. 1007

City of Blackfoot No. No Shelling St.)

File No. 35173

Registered No. 9178

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Edith Hayle Simmons

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	white	widowed

6. DATE OF BIRTH.

Sept (Month) 10 (Day) 1855 (Year)

7. AGE

65 Yrs. 11 Mos. 16 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... housewife

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country) Penn

10. NAME OF FATHER Silas Hayle

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER Edith Hayle

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lewis D. Simmons

(Address) Blackfoot Idaho

15.

Filed Aug 27 1921 Mrs Helen E. Pate Local Registrar

SYMS - YORK CO., PTRS. & STRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

August (Month) 26 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 19 1921, to Aug 26 1921, that I last saw her alive on Aug 26 1921, and that death occured on the date stated above, at 2:15 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) Yrs. mos. 6 ds.

Contributory (Secondary) —

(Duration — yrs. — mos. — ds.

(Signed) H. W. Mudgett M. D.

8/26 1921 (Address) Blackfoot, Idaho

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL

Gem City Cemetery 8-28 1921

20. UNDERTAKER | ADDRESS

E J Peck Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 1007
File No. 35174
Registered No. 121

RECEIVED SEP 13 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Bingham
City of Blackfoot (If outside limits of city or village, write the name of township.) 17 North Emmett St.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Martha Allen Tawey

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	white	married

6. DATE OF BIRTH: March (Month) 28 (Day) 1855 (Year)

7. AGE: 65 Yrs. 10 Mos. 28 ds.
IF LESS than 1 day: how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: James Allen

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Unt Known

13. BIRTHPLACE OF MOTHER (State or Country): Unt Kinn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Henry C. Tawey
(Address) Blackfoot, Idaho.

15. Filed Aug 27 1921 Mrs Hulen E. Potter Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: aug (Month) 26 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from april 1920 to aug 26 1921
that I last saw her alive on aug 26 1921
and that death occurred on the date stated above, at 6 P.M.
The CAUSE OF DEATH* was as follows:
Cancer uteris

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. H. Simmons M. D.
8/27 1921 (Address) Blackfoot Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Ogden Utah	19

20. UNDERTAKER: E J Peck ADDRESS: Blackfoot Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

RECEIVED AUG 27 1921 BUREAU OF VITAL STATISTICS

RECEIVED SEP 15 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 2174

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35175
Registered No. 59

1. PLACE OF DEATH

County of Bingham

City of Shelley

If death occurs away from usual residence, give facts called for under special information.

(No. 2 Miles East Shelly Ida St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Robert K Parker

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: March 12 (Month) (Day) 1887 (Year)

7. AGE: 34 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Rancher

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: William Parker

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Dickinson

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Louisa Parker

(Address) Shelley Idaho

15. Filed 7/29 1921 Mrs Thalia E. Patrick Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 20 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ____ 19__, to ____ 19__ that I last saw h__ alive on ____ 19__ and that death occurred on the date stated above, at ____M.

The CAUSE OF DEATH* was as follows:

Struck by Lightning

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Ed L. Egli Coroner M. D.

7/21/1921 (Address) Blackfoot Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Springville Utah

DATE OF BURIAL 19__

20. UNDERTAKER: Cliff C Hayes

ADDRESS: Idaho Fall

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-

RECEIVED
OCT 5 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 57
County of Blaine Primary Registration District No. 2075
City of Carey (No. ....., ... St.)
File No. 35176
Registered No. 29

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Frank L. Biehl.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. May (Month) 27 (Day) 1890 (Year)

7. AGE: 31 Yrs. 2 Mos. 25 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): General farming.

9. BIRTHPLACE (State or Country): Germany.

10. NAME OF FATHER: Vincent P. Biehl

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Mary Swoboda

13. BIRTHPLACE OF MOTHER (State or Country): Germany.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) V. P. Biehl
(Address) R. F. D. Rupert, Box 57

15. Filed 8-30 1921 R. H. Wright
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August 21 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h[illegible] alive on ..... 191...,
and that death occured on the date stated above, at about 6:02 M.

The CAUSE OF DEATH* was as follows: Rounding curve Auto turned over into a ditch.

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) Houston C. Snyder M. D.
19..... (Address) Carey Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Hailey, Ida — DATE OF BURIAL: 8-23 1921

20. UNDERTAKER: R. D. Harris — ADDRESS: Hailey

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

RECEIVED OCT 5 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Blaine Registration District No. 57

City of Near Gannett Primary Registration District No. 2022 (No. ..... St.)

File No. 35167

Registered No. 26

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Wm W. Nisson.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Mar. (Month) 1st. (Day) 1899. (Year)

7. AGE: 22 Yrs. 5 Mos. 1 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer.

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: S. A. Nisson.

11. BIRTHPLACE OF FATHER (State or Country): Denmark.

12. MAIDEN NAME OF MOTHER: Maria Christinsen.

13. BIRTHPLACE OF MOTHER (State or Country): Denmark.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C A Nisson

(Address) Boise

15. Filed 8-30 1921 R. H. Wright Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug. (Month) 2 (Day) 1921. (Year)

17. I HEREBY CERTIFY, That I attended deceased from — 19..., to — 19..., that I last saw h— alive on — 19..., and that death occurred on the date stated above, at ...M.

The CAUSE OF DEATH* was as follows:

Electricuted.

(Duration) — Yrs. — mos. — ds.

Contributory (Secondary) —

(Duration) — yrs. — mos. ... ds.

(Signed) Houston C Snyder M. D. (Coroner)

19... (Address) Carey Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ...yrs. ...mos. ...days. In the State ...yrs. ...mos. ...days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Hailey Ida. DATE OF BURIAL: 8-4 1921

20. UNDERTAKER: C. D. Harris ADDRESS: Hailey

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
OCT 5 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Blaine Registration District No. 57
City of Hailey Primary Registration District No. 2022 St.)
If death occurs away from usual residence, give facts called for under special information.

File No. 35178
Registered No. 75
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William Boyd.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Divorced.
6. DATE OF BIRTH: May (Month) 2. (Day) 1861 (Year)
7. AGE: 60 Yrs. 2 Mos. 20 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry, business or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Canada.
10. NAME OF FATHER: —
11. BIRTHPLACE OF FATHER (State or Country): —
12. MAIDEN NAME OF MOTHER: —
13. BIRTHPLACE OF MOTHER (State or Country): —
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) X John Boyd.
(Address) Hailey, Ida.
15. Filed 8-30 1921 R. H. Wright
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dutton
July (Month) 22. (Day) 1921. (Year)
17. I HEREBY CERTIFY, That I attended deceased from July 12 1921, to July 22 1921
that I last saw him alive on July 22 1921,
and that death occurred on the date stated above, at 4 P. M.
The CAUSE OF DEATH* was as follows:
Endocarditis
(Duration) Yrs. mos. 14 ds.
Contributory (Secondary) Cirrhosis
(Duration) yrs. mos. 14 ds.
(Signed) H. H. Dutton M. D.
July 22 1921 (Address) Hailey Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Hailey — DATE OF BURIAL: July 25 1921
20. UNDERTAKER: T. B. Hamo. — ADDRESS: Hailey

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. Seeinstructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

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SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED OCT 5 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 57

County of Blaine

Primary Registration District No. 2077

File No. 35179

City of Hailey (No. ..... St.)

Registered No. 78

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Cederberg.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White.	Single

6. DATE OF BIRTH

..... (Month) ..... (Day) ..... 1 ..... (Year)

7. AGE About 55 Years

..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Miner.

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Germ

10. NAME OF FATHER —

11. BIRTHPLACE OF FATHER (State or Country) —

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER (State or Country) —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15. Filed 9-6 1921

R. H. Wright
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. 4, 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....

that I last saw h..... alive on ..... 19.....,

and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Houston E. Snyder M. D.

19..... (Address) Carey (Corey) Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Hailey Ida.	Sept 7 1921
20. UNDERTAKER	ADDRESS
J. D. Harris	Hailey

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

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SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

D. W. DAVIS, GOVERNOR

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BOISE, IDAHO

PUBLIC HEALTH SERVICE
FOOD AND DRUG INSPECTION
BACTERIOLOGICAL LABORATORY
CHEMICAL LABORATORY
BUREAU OF CHILD HYGIENE
VITAL STATISTICS
MEDICAL ADVISOR

RECEIVED
NOV 10 1921
BUREAU OF VITAL STATISTICS

October 8, 1921.

Dr. Houston E. Snyder,
Coronor,
Carey, Idaho.

Dear Doctor: Re: 35179.

We are in receipt of Certificate of death of John Cederberg which you sign as Coronor. He died September 4th, 1921 of Cerebral Hemorrhage. No age was given on the certificate. Could you kindly give us the approximate age of this young man in order that we may complete the certificate?

We enclose herewith self-addressed stamped envelope for your convenience in making reply.

Thanking you for your early attention to this matter, we are,

Respectfully yours,

F. W. Almond

F. W. Almond, M. D.
Medical Advisor.

About 55 years.
R
Please write Aaron Clements Hailey Ida.

Houston E Snyder M/S
Coroner Blaine Co Idaho

FORM V. S. No. 5-25 M. 1-19.

RECEIVED OCT 5 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35180

Registered No. 29

1. PLACE OF DEATH

County of Blaine, Registration District No. 57

City of Hailey, Primary Registration District No. 2075

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Merlin Francis McLin.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: May. (Month) 11 (Day) 1901 (Year)

7. AGE: 20 Yrs. 5 Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None.

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Minn.

10. NAME OF FATHER: Frank J. McLin.

11. BIRTHPLACE OF FATHER (State or Country): Minn.

12. MAIDEN NAME OF MOTHER: Laura C. McLin.

13. BIRTHPLACE OF MOTHER (State or Country): Minn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Frank J McLin.

(Address) .....

15. Filed 9-6 1921 R. H. Wright Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. (Month) 8. (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 8 1921, to Sept 8 1921, that I last saw him alive on Sept 8 1921, and that death occurred on the date stated above, at 10 45 A.M.

The CAUSE OF DEATH* was as follows: Streptococcemia Sore Throat

(Duration) ..... Yrs. ..... mos. 14 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E. S. Fry M. D.

9/8 1921 (Address) Hailey, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. 14 days. In the State 11 yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? Hailey, Ida.

Former or usual residence Torrington, Wyo.

19. PLACE OF BURIAL OR REMOVAL: Boise Ida. DATE OF BURIAL ..... 19.....

20. UNDERTAKER: C D Harris ADDRESS Hailey

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

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FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35182
Registered No. 31

RECEIVED OCT 5 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
Registration District No. 57
Primary Registration District No. 2022
County of Blaine
City of Hailey (St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Maria M. Pearson
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: May 22 1891 (Month) (Day) (Year)

7. AGE: 6 Yrs. 3 Mos. 24 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: L
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Bellevue, Idaho

10. NAME OF FATHER: John Pearson

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Myrtle Roark

13. BIRTHPLACE OF MOTHER (State or Country): N. C.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. P. Van Ouer
(Address) Bellevue, Idaho

15. Filed 9-6 1921 R. H. Wright
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 9 (Month) 16 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9/16 1921, to 9/16 1921 that I last saw h.er alive on 9/16 1921 and that death occurred on the date stated above, at 8 P.M.

The CAUSE OF DEATH* was as follows:
Acute Appendicitis
(Duration) ..... Yrs. ..... mos. 5 ds.
Contributory (Secondary) Peritonitis
(Duration) ..... yrs. ..... mos. 1 ds.

(Signed) E. S. Foy M. D.
9/16 1921 (Address) Hailey, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. 1 days. In the State 6 yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence Bellevue, Idaho

19. PLACE OF BURIAL OR REMOVAL: Bellevue, Idaho
DATE OF BURIAL ..... 19.....

20. UNDERTAKER: Ralph Harris
ADDRESS: Hailey, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED OCT 5 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
Registration District No. 57
County of Blaine
Primary Registration District No. 2022
File No. 35183
City of Hailey, (No. ....., ... St.)
Registered No. 32

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James H. Bonning.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male.	White	Married.

6. DATE OF BIRTH
Dec. (Month) 8 (Day) 1856. (Year)

7. AGE
64 Yrs. 9 Mos. 16 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Farmer.
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) New York.

10. NAME OF FATHER ✓

11. BIRTHPLACE OF FATHER (State or Country) ✓

12. MAIDEN NAME OF MOTHER ✓

13. BIRTHPLACE OF MOTHER (State or Country) ✓

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. T. Bonning
(Address) .....

15. Filed 9-6 1921 R. H. Wright Local Registrar

MEDICAL CERTIFICATE OF DEATH

Plumer.

16. DATE OF DEATH
Sept. (Month) 24. (Day) 1921. (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 16 1921, to Sept 23 1921, that I last saw h[illegible] alive on Sept 23 1921, and that death occurred on the date stated above, at 3 P M.

The CAUSE OF DEATH* was as follows:
Diabetes

(Duration) — Yrs. — mos. 30 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. J. Plumer M. D.
9 27 1921 (Address) Hailey Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Hetchum Ida.	Sept 26 1921

20. UNDERTAKER	ADDRESS
P Harris	Haley,

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

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FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35184

Registered No.

RECEIVED JUN 9 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 12

Primary Registration District No. 12

County of Boise

City of Idaho (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Gidion B Pettus

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1 (Year)

7. AGE: 65 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Laborer.

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Bloomington Ind.

10. NAME OF FATHER: .....

11. BIRTHPLACE OF FATHER (State or Country): unknown

12. MAIDEN NAME OF MOTHER: .....

13. BIRTHPLACE OF MOTHER (State or Country): unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15. Filed May 19 21

Mrs E S Robison
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 18 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19....., that I last saw h..... alive on ..... 19....., and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Found dead in bed.

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

..... 19..... (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BERIAL OR REMOVAL: Idaho City

DATE OF BURIAL ..... 19.....

20. UNDERTAKER: Morfe

ADDRESS

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 12
Primary Registration District No. 12
File No. 35185
Registered No.

1. PLACE OF DEATH

County of Boise
City of Garden Valley (St.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED JUN 9 1921 BUREAU OF VITAL STATISTICS

2. FULL NAME Mary Smith Moore

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE:

SINGLE, MARRIED, WIDOWED OR DIVORCED: Widowed (Write the word.)

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1 (Year)

7. AGE: 82 yrs. ... Yrs. ... Mos. ... ds.

IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farming

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: unknown

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Castle

(Address)

15. Filed June 1 1921 Mrs E S Robison Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 9 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ... 19..., to ... 19...,
that I last saw h... alive on ... 19...,
and that death occurred on the date stated above, at ... M.
The CAUSE OF DEATH* was as follows:

Found dead.

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) ... M. D.

... 19... (Address) ...

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Garden Valley — DATE OF BURIAL: June 1921

20. UNDERTAKER: None — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

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FORM V. S. No. 5-25 M. 1-19.

RECEIVED
SEP 24 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Boise — Registration District No. 12

City of Horse Shoe bend — Primary Registration District No. 12

(No. ..... St.)

File No. 35186

Registered No. 9

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Clara Gunderson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
female	White	Single

6. DATE OF BIRTH: Jan (Month) 17 (Day) 1911 (Year)

7. AGE: 10 Yrs. 7 Mos. ds. — IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: School girl
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Horse Shoe bend

10. NAME OF FATHER: Chris Gunderson

11. BIRTHPLACE OF FATHER (State or Country): Norway

12. MAIDEN NAME OF MOTHER: Maggie Zimmer

13. BIRTHPLACE OF MOTHER (State or Country): Horse Shoe bend

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Ida
(Address) Quartz Engr.

15. Filed ..... 192 .....
Mrs E S Kuhn
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 27 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19....., to ..... 19.....,
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows: Shot-Gun wound accidental instant death

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G. E. Tefft M. D.

19..... (Address) Quartz Engr.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Horse Shoe	Sept 29 1921
20. UNDERTAKER Wm	ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

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FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35187

Registered No. ____

1. PLACE OF DEATH

County of Boise

City of Idaho

(No. ____ St.)

Registration District No. 12

Primary Registration District No. 12

RECEIVED SEP 24 19 BUREAU OF VITAL STATISTICS

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William White

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widowed

6. DATE OF BIRTH: dont know (Month) (Day) 1 (Year)

7. AGE: 65 Yrs. ____ Mos. ____ ds.

IF LESS than 1 day how many ____ hrs. or ____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business or establishment in which employed (or employer): ____

9. BIRTHPLACE (State or Country): Tennessee

10. NAME OF FATHER: dont know

11. BIRTHPLACE OF FATHER (State or Country): dont know

12. MAIDEN NAME OF MOTHER: not known

13. BIRTHPLACE OF MOTHER (State or Country): ____

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) ____

(Address) ____

15. Filed ____ 19____ Mrs El Rohrs Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 15 (Day) 192 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ____ 19____, to ____ 19____, that I last saw h____ alive on ____ 19____, and that death occurred on the date stated above, at ____ M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(no doctor)

(Duration) ____ Yrs. ____ mos. ____ ds.

Contributory (Secondary) ____

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) ____ M. D.

____ 19____ (Address) ____

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days

Where was disease contracted if not at place of death? ____

Former or usual residence ____

19. PLACE OF BURIAL OR REMOVAL: Idaho City

DATE OF BURIAL: Sept 16 1924

20. UNDERTAKER

ADDRESS

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Boise — Registration District No. 12

City of Princeton — Primary Registration District No. 12

(No. ..... St.)

File No. 35188

Registered No. 11

If death occurs away from usual residence, give facts called for under special information.

BUREAU OF VITAL STATISTICS

2. FULL NAME William Farrimble

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: not known (Month) (Day) 1 (Year)

7. AGE: 52 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: farming

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Garden Valley

10. NAME OF FATHER: George Farrimble

11. BIRTHPLACE OF FATHER (State or Country): not known

12. MAIDEN NAME OF MOTHER: not known

13. BIRTHPLACE OF MOTHER (State or Country): not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15. Filed ..... 19..... Mrs E S Robson Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 6 (Day) 1924 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 3 1924, to Sept 5 1924, that I last saw h sis alive on Sept 5 1924, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G E Pitz M. D.

19..... (Address) Emmett Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Garden Valley — DATE OF BURIAL: Sept 8 1924

20. UNDERTAKER: none. — ADDRESS

FORM V. S. No. 5-25 M. 1-19.

RECEIVED OCT 6 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH — Registration District No. 85

County of Bonner — County Registration District No. 2185

File No. 35189

City of Priest River (Ward, ... St.)

Registered No. 46

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Joseph Bossio.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH: May (Month) 30 (Day) 1876 (Year)

7. AGE: 45 Yrs. 3 Mos. 21 ds. — IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Italy

10. NAME OF FATHER: Frank Bossio

11. BIRTHPLACE OF FATHER (State or Country): Italy

12. MAIDEN NAME OF MOTHER: Sera Bifano

13. BIRTHPLACE OF MOTHER (State or Country): Italy

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Pete Bossio
(Address) Priest River, Idaho.

15. Filed Oct 1 1921 19.....

C. F. Gettloff
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 21 (Day) 21 (Year) 19.....

17. I HEREBY CERTIFY, That I attended deceased from ..... 19....., to ..... 19.....,
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at 5.55 P.M.
The CAUSE OF DEATH* was as follows:

Fracture of left temporal bone of skull. (Accidental by a bank caveing in.)

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. F. Gettloff M. D.

Sept 23 1921 (Address) Priest River, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Burial Priest River	Sept 24 19 21
20. UNDERTAKER: Wm Davis	ADDRESS: Newport

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED OCT 6 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 25

Primary Registration District No. 2185

File No. 32190

County of Bonner

City of Near Newport (No. ....., ... St.)

Registered No. 47

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ray G. Butler

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH: Feb (Month) I8 (Day) I898 (Year)

7. AGE: 23 Yrs. 6 Mos. 28 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wash

10. NAME OF FATHER: Jacob C. Butler

11. BIRTHPLACE OF FATHER (State or Country): Ill

12. MAIDEN NAME OF MOTHER: Grace Williams

13. BIRTHPLACE OF MOTHER (State or Country): Ill

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E. M. Butler

(Address) Newport Wash

15. Filed Oct 1 1921 C. P. Gentry Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sep (Month) I7 (Day) I92I9 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....

that I last saw h..... alive on ..... 19.....,

and that death occurred on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Accidental - Skull crushed by blow from sweep on stump pulling machine

(Duration) ..... Yrs. Instant ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Dr W S Bardwell M. D.

9/7-1921 (Address) Newport, Wash.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Newport Wash

DATE OF BURIAL: Sep 20 1921

20. UNDERTAKER: William Davis

ADDRESS: Newport Wash

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51083

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bonner

City of Near Newport

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No. , St.)

File No. 1

Registered No. 48

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ray G. Butler

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Feb (Month) 18 (Day) 1898 (Year)

7. AGE: 23 Yrs. 6 Mos. 28 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wash

10. NAME OF FATHER: Jacob C. Butler

11. BIRTHPLACE OF FATHER (State or Country): Ill

12. MAIDEN NAME OF MOTHER: Grace Williams

13. BIRTHPLACE OF MOTHER (State or Country): Call

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E M. Butler

(Address) Newport Wash

15. Filed Oct 1 1921

Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sep (Month) 17 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....

that I last saw h..... alive on ..... 19.....,

and that death occurred on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Accidental - Skull Crushed by blow from sweep on Stump pulling Machine

(Duration) ..... Yrs. Instant ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Dr. W. S. Bardwell M. D.

9-17-1921 (Address) Newport Mich.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injary; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Newport Wash

DATE OF BURIAL: Sep 20 1921

20. UNDERTAKER: William Davis

ADDRESS: Newport Wash

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35192
Registered No.

1. PLACE OF DEATH

County of Bonner Registration District No. 78

City of Sand Point (If outside limits of city or village, give name of township.) Primary Registration District No. 2155

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Peter Erickson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

RECEIVED SEP 5 1921 BUREAU OF VITAL STATISTICS

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single
6. DATE OF BIRTH: (Month) (Day) 1856 (Year)
7. AGE: 65 Yrs. Mos. ds. IF LESS than 1 day how many hrs. or min.?
8. OCCUPATION
   (a) Trade, profession or particular kind of work: Rancher
   (b) General nature of industry, business or establishment in which employed (or employer): Retired
9. BIRTHPLACE (State or Country): Sweden
10. NAME OF FATHER: Erickson
11. BIRTHPLACE OF FATHER (State or Country): Sweden
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (State or Country): Sweden
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
    (Informant) Frank Ringstrom
    (Address) Cavanaugh Bay, Ida.
15. Filed Sept 8 1921
    Boyd C. Meade Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug. (Month) 4 (Day) 1921 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Aug 4 1921, to — 19..., that I last saw him alive on Aug 4 1921, and that death occurred on the date stated above, at 9 P. M.
    The CAUSE OF DEATH* was as follows:
    Carcinoma of stomach
    (Duration) 2 Yrs. mos. ds.
    Contributory (Secondary)
    (Duration) yrs. mos. ds.
    (Signed) W. R. Wallace M. D.
    Aug 13 1921 (Address) Sand Point, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
    At place of death yrs. mos. days. In the State yrs. mos. days
    Where was disease contracted if not at place of death?
    Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Sand Point, Ida. DATE OF BURIAL: Aug. 13, 1921
20. UNDERTAKER: B. K. Engle ADDRESS: Sand Point, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35193
Registered No. ●

RECEIVED SEP 15 1921 BUREAU OF VITAL STATISTICS

Registration District No. 78
Primary Registration District No. 2155

1. PLACE OF DEATH
County of Bonner
City of Sand Point (If outside limits of city or village, write the name of township.) No. City Hospital (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME C. L. Longworth

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	White	Married

6. DATE OF BIRTH
Feb 11 (Month) (Day) 1 (Year)

7. AGE
24 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Shingle maker
(b) General nature of industry, business or establishment in which employed (or employer) Employed

9. BIRTHPLACE (State or Country) Mich

10. NAME OF FATHER Mary Longworth

11. BIRTHPLACE OF FATHER (State or Country) Canada

12. MAIDEN NAME OF MOTHER Mary Thompson

13. BIRTHPLACE OF MOTHER (State or Country) Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A. A. Compton
(Address) Bonners Ferry, Ida.

15. Filed Sept 8 1921 Floyd Wendt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
July 27 Aug 12 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 27 1921 to Aug 12 1921
that I last saw him alive on Aug 12 1921
and that death occurred on the date stated above, at 3:15 P.M.

The CAUSE OF DEATH* was as follows:
Acute obstruction
(Intestines) (Lemma)

(Duration) Yrs. mos. ds.
Contributory (Secondary) Shock from Secondary operation
(Duration) yrs. mos. 16 ds.

(Signed) C. W. Page M. D.
1921 (Address) Sand Point Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Sand Point | DATE OF BURIAL Aug 15 1921

20. UNDERTAKER C. W. Engle | ADDRESS Sand Point

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED SEP 15 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 75
Primary Registration District No. 2155
File No. 35194
Registered No.

1. PLACE OF DEATH

County of Bonner
City of Sand Point (No. 35 Hillcrest St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Oliver Troy Nolan

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	White	Widower

6. DATE OF BIRTH Sept. 18, 1852 (Month) (Day) (Year)

7. AGE 69 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry, business or establishment in which employed (or employer) Retired

9. BIRTHPLACE (State or Country) Ohio

10. NAME OF FATHER — Nolan

11. BIRTHPLACE OF FATHER (State or Country) Unknown

12. MAIDEN NAME OF MOTHER "

13. BIRTHPLACE OF MOTHER (State or Country) "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Elsie McInnis
(Address) Sand Point, Ida

15. Filed Sept 8 1921 Floyd Wade Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug. 28 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 26 1921, to 8-28- 1921, that I last saw h- alive on 8-28 1921, and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Uremia -

(Duration) Yrs. mos. ds.

Contributory (Secondary) Gall stones - Senility.

(Duration) yrs. mos. ds.

(Signed) C. P. Blackmore M. D.

Aug. 1921. (Address) Sand Point, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Sand Point, Ida — DATE OF BURIAL Aug. 30 1921.

20. UNDERTAKER C. K. Tough — ADDRESS Sand Point, Ida

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 75
Primary Registration District No. 2155
File No. 35195
Registered No.

1. PLACE OF DEATH

County of Boundary
City of Sand Point (No. Talache Mine St.) Sand Point, Ida.

If death occurs away from usual residence, give facts called for under special information.

SEP 1921 BUREAU

2. FULL NAME M. J. Skirda

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH Nov 14 (Month) (Day) 1865 (Year)

7. AGE 36 Yrs. Mos. ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Miner
(b) General nature of industry, business or establishment in which employed (or employer) Employed

9. BIRTHPLACE (State or Country) Colo.

10. NAME OF FATHER — Skirda

11. BIRTHPLACE OF FATHER (State or Country) Unknown

12. MAIDEN NAME OF MOTHER "

13. BIRTHPLACE OF MOTHER " (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. J. Ryan
(Address) Sand Point, Ida.

15. Filed Sept 8 1921 Floyd Wendle Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug 29 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....19...., to ....19....,
that I last saw h.... alive on ....19....,
and that death occurred on the date stated above, at 2 P.M.
The CAUSE OF DEATH* was as follows:
Accident - Mine.
Skull Crushed - left arm & right leg fractured
(Duration) Yrs. 1 mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) C. F. Stacehouse M. D.
Aug 1921 (Address) Sand Point, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Eagle, Ida. DATE OF BURIAL [redacted] 1, 1921

20. UNDERTAKER E. E. Engh ADDRESS Sand Point, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

Permit issued to: L.C. Moon
Moon Funeral Home
Sandpoint, Idaho

10-5-55
Date

Sent 10-18-55
Department of Public Health
Boise, Idaho

I hereby give authorization for the disinterment of: _____

NAME OF DECEASED Michael J. Skirda

DATE OF DEATH August, 1921

CAUSE OF DEATH Industrial Accident Mine

ATTENDING PHYSICIAN E.T. Anderson - Dr. Page

BURIED IN Craig Cemetery (Farm at Sagle) CEMETERY

TO BE REMOVED TO Pinecrest Cemetery Sandpoint CEMETERY

RELATIONSHIP TO PERSON REQUESTING PERMIT wife

NAME OF LICENSED EMBALMER ?, Brower

REASON FOR DISINTERMENT Selling Craig Farm want Permanent Location in Dedicated Cemetery

Very truly yours,

Theodosia Lehman
Signature of relative or person requesting permit.

Bayview Idaho
Address

- * * * * * * * * * * * * * * -

State of Idaho)
County of Bonner) ss

On this 12th day of October, 195 , before me Clyde E Rutherford a Notary Public in and for the within county and state personally appeared Theodosia Lehmon known to me (or proved by the oath of L.C. Moon Jr to be the person whose name is subscribed to the foregoing instrument, and acknowledged to me that he executed the same.

In Witness whereof I have hereunto set my hand and affixed my official seal this the day and year first above written.

Clyde E Rutherford
Notary Public, residing at Sandpoint, Idaho
My commission expires July 26, 1959

(Seal)

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35196
Registered No.

1. PLACE OF DEATH

County of Bonner — Registration District No. 78

City of Sand Point — Ward No. 6 — (St.) — Registration District No. 2155

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Alice Corbett

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

SEP 13 1921 BUREAU OF VITAL STATISTICS

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6. DATE OF BIRTH: Mar 15 (Month) / 1863 (Day) (Year)

7. AGE: 58 Yrs. Mos. ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer): At Home

9. BIRTHPLACE (State or Country): Wis

10. NAME OF FATHER: Clinton Craig

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Sarah Collins

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chas E Corbett
(Address) Sand Point, Ida

15. Filed Sept 8 1921 — Hoyt Wendell — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug / 13 (Month) / (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 5 1921, to Aug 13 1921, that I last saw her alive on Aug 13 1921, and that death occurred on the date stated above, at 8 P.M.

The CAUSE OF DEATH* was as follows:
Carcinoma - Intestines

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) C. P. Isaacs M. D.

1921 (Address) Sand Point, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Sand Point, Ida. DATE OF BURIAL: Aug 15 1921

20. UNDERTAKER: C. M. Sutton ADDRESS: Sand Point, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
SEP 22 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 21 V 0
File No. 35197
Registered No. 71

1. PLACE OF DEATH
County of Bannock
City of Idaho Falls (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Henry Thornock
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH: March 6 (Month) (Day) 1865 (Year)

7. AGE: 56 Yrs. 4 Mos. 27 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farming
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: John B Thornock

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Emma Ward

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Thornock
(Address) Idaho Falls

15. Filed Aug 3 1921 [signature] Local Registrar
D Hatch

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 7 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 28 1921, to Aug 2 1921
that I last saw h[illegible] alive on Aug 2 1921
and that death occurred on the date stated above, at 10:30 P.M.

The CAUSE OF DEATH* was as follows:
Following Operation for
Perforating Ulcer of
Duodenum.
(Duration) ..... Yrs. ..... mos. 2 ds.
Contributory (Secondary) Chronic Duodenal Ulcer
(Duration) 6 yrs. 5 mos. ..... ds.

(Signed) I V Ray Hatch M. D.
19..... (Address) Idaho Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence Idaho.

19. PLACE OF BURIAL OR REMOVAL: Paris, Ida. DATE OF BURIAL: 8/4 1921

20. UNDERTAKER: C C Dunwoody ADDRESS: Ida Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
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FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35198
Registered No. 90

RECEIVED
SEP 22 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
Registration District No. 13
Primary Registration District No. 2170
County of Bannock
City of Ida Falls (If outside limits, give township.) St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Logan Igan

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): married

6. DATE OF BIRTH: Dec (Month) 29 (Day) 1865 (Year)

7. AGE: 55 Yrs. 7 Mos. 28 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Hotel Clerk
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ill

10. NAME OF FATHER: John L Igan

11. BIRTHPLACE OF FATHER (State or Country): Pa

12. MAIDEN NAME OF MOTHER: ?

13. BIRTHPLACE OF MOTHER (State or Country): ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. L. Igan
(Address) Soldman, Idaho

15. Filed Aug 26 1921 (Illegible) Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 26 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..., to ..... 19...,
that I last saw h..... alive on ..... 19...,
and that death occurred on the date stated above, at 10 P M.
The CAUSE OF DEATH* was as follows:
Accidental. Fell from roof of building breaking his neck, jaw, arms & ribs.
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) C E Dunwoody M.D.
8/29 1921 (Address) Ida Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence Ship

19. PLACE OF BURIAL OR REMOVAL: Soldman, Ida. DATE OF BURIAL: 8/28 1921

20. UNDERTAKER: C E Dunwoody ADDRESS: Ida Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
SEP 22 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 73

Primary Registration District No. 1215-0

File No. 35199

Registered No. 29

County of Bonneville

City of Ida Falls (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John V. Messervey

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Widowed

6. DATE OF BIRTH: Dec (Month) 26 (Day) 1838 (Year)

7. AGE: 82 Yrs. 7 Mos. 27 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farming
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Jersey Island

10. NAME OF FATHER: Joshua Messervey

11. BIRTHPLACE OF FATHER (State or Country): Jersey Island

12. MAIDEN NAME OF MOTHER: Jane Roberts

13. BIRTHPLACE OF MOTHER (State or Country): Jersey Island

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Jas Everett
(Address) Ida Falls, Ida

15. Filed Aug 22 1921 ..... Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 23 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at 8 A. M.
The CAUSE OF DEATH* was as follows:
Shock from accidental fall down basement steps

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) General debelidy
(Duration) ..... yrs. ..... mos. 0 ds.

(Signed) C E Dunwoodey M. D.
8/25 1921 (Address) Ida Falls, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Ida Falls	8/26 1921

20. UNDERTAKER	ADDRESS
C E Dunwoodey	Ida Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

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FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35200
Registered No.

RECEIVED
SEP 22 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
Registration District No. 7
Primary Registration District No. 2170
County of Bannock
City of Taylor Precinct (No. St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Harry Spencer Lauder

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Dec (Month) 11 (Day) 1889 (Year)

7. AGE: 31 Yrs. 9 Mos. 0 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farming
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Henry B Lauder

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Annie Jensen

13. BIRTHPLACE OF MOTHER (State or Country): Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Annie Jensen
(Address) Ida Falls

15. Filed Sep 20 1921 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug. (Month) 11 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....
and that death occurred on the date stated above, at 4 P M.
The CAUSE OF DEATH* was as follows: Instantly killed. Struck by lightning.
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) C E Dunwoody M.D.
8/13 1921 (Address) Ida Falls, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Taylor Ida	8/14 1921
20. UNDERTAKER	ADDRESS
C E Dunwoody	Ida Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

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5-25 M. 1-19.

RECEIVED SEP 22 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEAL
Bureau of Vital Statist

PLACE OF DEATH

County of Bannock Registration District No. 13 Primary Registration District No. 1 V 2 File No. 35201

City of Mcan (Ward, ... St.) Registered No. 57

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Erma Curtis

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Infant

6. DATE OF BIRTH: May (Month) 9 (Day) 1920 (Year)

7. AGE: 1 Yrs. 2 Mos. 15 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Mcan, Ida

10. NAME OF FATHER: Wm C Curtis

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Eley A Ellsworth

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wm C Curtis
(Address) Mcan, Ida

15.
Filed Sep 20 1921 (Mrs. ...) Local Registrar
D. Strat

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 24 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 18 1921 to July 24 1921 that I last saw h.w alive on July 22 1921, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Acute Myocarditis

(Duration) ..... Yrs. ..... mos. 3 ds.

Contributory (Secondary) Broncl Pneumonia

(Duration) — yrs. — mos. 10 ds.

(Signed) Jabez W Strat M. D.

7/26 1921 (Address) Idaho Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mcan, Ida — DATE OF BURIAL: 7-26 1921

20. UNDERTAKER: C C Dunwoody — ADDRESS: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

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MARGIN RESERVED FOR BINDING

M V. S. No. 5-25 M. 1-19.

RECEIVED
SEP 22 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of IDAHO
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
Registration District No. 73
Primary Registration District No. 2 1 V 0
File No. 35202
Registered No. 46

County of Bonneville
City of Iona
(No. " " St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Baby Walker

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Child

6. DATE OF BIRTH: August (Month) 5 (Day) 1921 (Year)

7. AGE: 0 Yrs. 0 Mos. 3 ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: James H. Walker

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Laura L. Kalmer

13. BIRTHPLACE OF MOTHER (State or Country): Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) James H. Walker
(Address) Idaho Falls, R. D. #1

15. Filed Aug 30 1921
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 31088

Dr. Hester Pendleton

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August (Month) 8 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 5th 1921, to Aug 5 1921, that I last saw him alive on Aug 5 1921, and that death occurred on the date stated above, at — M.

The CAUSE OF DEATH* was as follows:
Failure of a certain heart Valve to close at the time of birth
(Duration) — Yrs. — mos. — ds.
Contributory (Secondary) Breach presentation at time of birth.
(Duration) — yrs. — mos. — ds.

(Signed) H. H. Pendleton M. D.
8/9 1921 (Address) Idaho Falls, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Iona, Idaho — DATE OF BURIAL: 8-9 1921

20. UNDERTAKER: C. C. Sherwood — ADDRESS: Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
SEP 22 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bannock — Registration District No. 73

City of Ida Falls — Primary Registration District No. 21 V-0

(No. ..... St.)

File No. 35203

Registered No. 49

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Christina Mary Oswald

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Married

6. DATE OF BIRTH: January (Month) 6 (Day) 1875 (Year)

7. AGE: 46 Yrs. 7 Mos. 10 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: Fred Klingsen

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Bauer

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E. F. Oswald

(Address) Ida Falls

15. Filed Aug 30 1921 — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 17 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 17 1921, to Aug 17 1921, that I last saw h.. alive on Aug 17 1921, and that death occurred on the date stated above, at 6 9 M.

The CAUSE OF DEATH* was as follows: Interuterine Hemorrhage, Premature separation of Placenta.

(Duration) ..... Yrs. ..... mos. 8 hrs.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A Ray Hatch M. D.

8/30 1921 (Address) Idaho Falls.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Coltman Ida — DATE OF BURIAL: 8-31-21

20. UNDERTAKER: C. E. Linnwood — ADDRESS: Ida Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

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SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

Dr Ernest

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
SEP 22 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 21 v -0
File No. 35204
Registered No. 44

1. PLACE OF DEATH
County of Bonneville
City of Idaho Falls (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lucius Nelson Scovil
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH October (Month) 5 (Day) 1858 (Year)

7. AGE 63 Yrs. 10 Mos. — ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Janitor
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Utah

10. NAME OF FATHER Lucius Nelson Scoville

11. BIRTHPLACE OF FATHER (State or Country) Connecticut

12. MAIDEN NAME OF MOTHER Alice Hurst

13. BIRTHPLACE OF MOTHER (State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) L. A. Scovil
(Address) L. A. Scovil Ashdale

15. Filed Aug 30 1921 W. Kennard Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 4 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 19 1921, to Aug 4 1921, that I last saw him alive on Aug 4 1921, and that death occurred on the date stated above, at 12:20 AM.

The CAUSE OF DEATH* was as follows:
Pulmonary Embolism ?
.....
.....
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) fracture femur
(Duration) ..... yrs. mos. 14 ds.

(Signed) J. F. Ramp Hatch M. D.
8/8 1921 (Address) Idaho Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Idaho Falls	8/8 1921

20. UNDERTAKER	ADDRESS
C. E. Linwood	Idaho Falls

Dr. Hatch

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
SEP 22 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35205
Registered No. 53

1. PLACE OF DEATH

County of Bonneville — Registration District No. 73
City of Ucon — Primary Registration District No. 21 V 0
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George W Foglesong

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.)
Male	White	Widowed

6. DATE OF BIRTH: March (Month) 15 (Day) 1872 (Year)

7. AGE: 48 Yrs. 4 Mos. 8 ds. — IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farming
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ill

10. NAME OF FATHER: Henry Foglesong

11. BIRTHPLACE OF FATHER (State or Country): Ind.

12. MAIDEN NAME OF MOTHER: ~~Unknown~~ Harriet Imel

13. BIRTHPLACE OF MOTHER (State or Country): Ill

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. W. Foglesong
(Address) Idaho Falls

15. Filed Aug 30 1921 — C. Freeman — Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 23 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Cancer of Stomach
(Carcinoma)
..... (Duration) 2 Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) H Ray Hatch M. D.
7/26 1921 (Address) H Ray Idaho Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Ucon, Ida — DATE OF BURIAL: 7-26-1921

20. UNDERTAKER: C E Linwood — ADDRESS: Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED SEP 22 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 73

Primary Registration District No. 2170

File No. 35206

County of Bonneville

City of Idaho Falls (No. ..... St.)

Registered No. 52

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME S. L. Middaugh

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH ? (Month) (Day) 1 (Year)

7. AGE about 60 yrs ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Farming
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) ?

10. NAME OF FATHER ?

11. BIRTHPLACE OF FATHER (State or Country) ?

12. MAIDEN NAME OF MOTHER ?

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. C. Dunwoody
(Address) Idaho Falls, Ida.

15. Filed Aug 30 1921 W. Fuhrman Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 22 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 20, 1921 to July 22, 1921 that I last saw h.... alive on July 20, 1921 and that death occurred on the date stated above, at 8 00 M.

The CAUSE OF DEATH* was as follows:

Chronic endocarditis

Indefinite
(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Chronic interstitial nephritis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Jno. O. Mellar M. D.

7/22 1921 (Address) Idaho Falls, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Idaho Falls Ida.	7/26 1921
20. UNDERTAKER	ADDRESS
C. C. Dunwoody	Idaho Falls

Dr Mellar

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
SEP 22 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 13

Primary Registration District No. 2170

File No. 35207

County of Bannock

City of Ida Falls (No. ..... St.)

Registered No. 70

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James F Barry

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: May (Month) 19 (Day) 1868 (Year)

7. AGE: 53 Yrs. 1 Mos. 27 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farming

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): B. C.

10. NAME OF FATHER: James F Barry

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Jane Lyon

13. BIRTHPLACE OF MOTHER (State or Country): New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A. J. Barry

(Address) Spencer, Ida

15. Filed Aug 3 1921 [signature] Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 15 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 13 1921, to July 15 1921, that I last saw h[illegible] alive on July 15 1921, and that death occurred on the date stated above, at 3 P M.

The CAUSE OF DEATH* was as follows:

Acc. tox.

(Duration) ? Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo Clews M. D.

7/19 1921 (Address) Ida. Falls, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Firth, Ida — DATE OF BURIAL: July 19 21

20. UNDERTAKER: [illegible] — ADDRESS: Ida Falls

Dr Cline.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
SEP 22 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 21V-0
File No. 35208
Registered No. 79

1. PLACE OF DEATH
County of Bannock
City of Ida Falls (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elmer E Dary
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widower (Write the word.)

6. DATE OF BIRTH: May 23 1870 (Month) (Day) (Year)

7. AGE: 51 Yrs. 2 Mos. 5 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Prop. feed Stable
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mo

10. NAME OF FATHER: F A Dary

11. BIRTHPLACE OF FATHER (State or Country): France

12. MAIDEN NAME OF MOTHER: Susan A Burns

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ralph E. Dary
(Address) Ontario Oregon

15. Filed Aug 3 1921 [signature] Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July 28 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....
and that death occurred on the date stated above, at 6 P M.

The CAUSE OF DEATH* was as follows:
Gun Shot wound.
Homicide.

..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C E Dunwoody M. D.
7-30 1921 (Address) Idaho Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Ida Falls Ida — DATE OF BURIAL: 7-31 1921

20. UNDERTAKER: C E Dunwoody — ADDRESS: Ida Falls

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
SEP 22 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 2110
File No. 35209
Registered No. 74

1. PLACE OF DEATH
County of Bannock
City of Ida Falls (If outside city limits, give township) St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Martha Hale

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widow

6. DATE OF BIRTH: Oct (Month) 13 (Day) 1843 (Year)

7. AGE: 77 Yrs. 9 Mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: at Home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Moses Marion Arnold

11. BIRTHPLACE OF FATHER (State or Country): U. S.

12. MAIDEN NAME OF MOTHER: Jannie Barnes

13. BIRTHPLACE OF MOTHER (State or Country): Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Howard Hale
(Address) Ida Falls

15. Filed Sep 3 1921 — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 16 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at 11 A.M.
The CAUSE OF DEATH* was as follows:
Nephritis
No physician on the case.
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) ..... M. D.
9/17 1921 (Address) Ida Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Idaho Falls — DATE OF BURIAL: 9-19-1921

20. UNDERTAKER: C E Dunwoody — ADDRESS: Ida Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
SEP 22 1921
BUREAU OF VITAL STATISTICS

Registration District No. 73
Primary Registration District No. 2170
File No. 35210
Registered No. 77

1. PLACE OF DEATH
County of Bannock
City of Ida Falls (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Henry L Hughes

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: April (Month) 17 (Day) 1906 (Year)

7. AGE: 15 Yrs. 2 Mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): St Louis, Mo

10. NAME OF FATHER: Henry L Hughes

11. BIRTHPLACE OF FATHER (State or Country): Mo

12. MAIDEN NAME OF MOTHER: Allie Yeamans

13. BIRTHPLACE OF MOTHER (State or Country): Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) M Beyeaman
(Address) City

15. Filed Aug 3 1921 W Kinnaird
Local Registrar
Dr Nelson

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 7 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 14 1921, to July 7 1921, that I last saw h... alive on July 7 1921, and that death occurred on the date stated above, at 10 P M.
The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ..... Yrs. ..... mos. 4 ds.
Contributory (Secondary) Hemorrhagic Purpura,
(Duration) ..... yrs. ..... mos. 23 ds.
(Signed) Harry L. Wilson M. D.
7/7 1921 (Address) Idaho Falls, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Ida Falls Ida. | DATE OF BURIAL: 7-9 1921

20. UNDERTAKER: C E Linwood | ADDRESS: Ida Falls

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
SEP 29 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 21V-0
(Subdistrict, St.)

File No. 35211
Registered No. 76

1. PLACE OF DEATH
County of Bannock
City of Shelton
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Samuel D. Glitton

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Sep 8 1887 (Month) (Day) (Year)

7. AGE: 38 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farming
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Layton, Utah

10. NAME OF FATHER: Albert Glitton

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Mara Jane Hales

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. E. Dunwoody (M.D.)
(Address) Rigby R. D. 5 Idaho

15. Filed Aug 3 1921 [illegible]
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug 7 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at 11 a M.

The CAUSE OF DEATH* was as follows:
Killed by being struck with lightning while in the harvest fields.
(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. E. Dunwoody M.D. Coroner
8/3 1921 (Address) Ida Falls, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Shelton Ida.	8/6 1921
20. UNDERTAKER	ADDRESS
C. E. Dunwoody	Ida Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
SEP 22 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 2170
File No. 35212
Registered No. 7

1. PLACE OF DEATH

County of Bonneville
City of Idaho Falls
(No. 373 S Water ave. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Edgar Bartlett

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
male	White	Single.

6. DATE OF BIRTH: Nov. (Month) 8 (Day) 1906 (Year)

7. AGE: 15 Yrs. Mos. ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: School boy,
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Oklahoma,

10. NAME OF FATHER: Jno. Bartlett

11. BIRTHPLACE OF FATHER (State or Country): Virginia

12. MAIDEN NAME OF MOTHER: Lota Belmear.

13. BIRTHPLACE OF MOTHER (State or Country): Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jno. Bartlett
(Address) Idaho Falls

15. Filed Sept. 14 1921 C. Kennard Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 2 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 27 1921, to Sept. 2 1921, that I last saw him alive on Sept 2 1921, and that death occurred on the date stated above, at 3:30 P.M.

The CAUSE OF DEATH* was as follows:
Mitral Insufficiency

(Duration) Yrs. 3 mos. 9 ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) Dr. Geo. A. Lupperle M. D.
Sept 6 1921 (Address) Idaho Falls, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rose Hill Cemetery — DATE OF BURIAL: Sept Aug 4 1921

20. UNDERTAKER: Cliff Hayes — ADDRESS: Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35213
Registered No.

RECEIVED
SEP 25 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 71
Primary Registration District No. 215-6.

County of Boundary
City of Kalka (or Village of, or Township of) St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Frank Fuzzi

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: Italian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Dec. (Month) 31 (Day) 1870 (Year)

7. AGE: About 50 Yrs. 7 Mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Section-Man
(b) General nature of industry, business or establishment in which employed (or employer): G. N. Ry.

9. BIRTHPLACE (State or Country): Italy

10. NAME OF FATHER: Luigi Fuzzi

11. BIRTHPLACE OF FATHER (State or Country): Italy

12. MAIDEN NAME OF MOTHER: Felomena Bergono

13. BIRTHPLACE OF MOTHER (State or Country): Italy

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Rocco Filipponi
(Address) Spokane

15. Filed Aug. 15-th 1921
E E Fry
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 14 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Drowning "accidental"

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E E Saunders M. D.
19..... (Address) Bonners Ferry, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Bonners Ferry Ida
DATE OF BURIAL: Aug 20 1921

20. UNDERTAKER: C R Stookey
ADDRESS: Bonners Ferry

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
SEP 1 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 79

Registration District No. 1186.

File No. 35214

County of Boundary

City of Bonners Ferry (No. ..... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Per Anderson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
M	W.	Single (Write the word.)

6. DATE OF BIRTH ..... (Month) ..... (Day) 1 (Year)

7. AGE About 60 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Sweden

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (State or Country) Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) P. O. Swanson
(Address) Bonners Ferry Idaho.

15. Filed Aug. 8-th 1921 E E Fry Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 4 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 1 1921 to Aug. 4 1921, that I last saw h im alive on Aug. 4 1921, and that death occurred on the date stated above, at 12.05 M.

The CAUSE OF DEATH* was as follows:

Cerebral haemmorhage

24 hours

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Arteris Sclerosis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E E Fry M. D.

8/5/1921 (Address) Bonners Ferry, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Bonners Ferry Ida	Aug 6 1921

20. UNDERTAKER	ADDRESS
A L Looney	Bonners Ferry, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
SEP 15 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35215
Registered No.

1. PLACE OF DEATH
Registration District No. 58d
Primary Registration District No. 7138
County of Canas
City of Fairfield (No. ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Colonel Case Ryuzo Kato

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: Japanese

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Divorced

6. DATE OF BIRTH: — — 1857 (Month) (Day) (Year)

7. AGE: 64 Yrs. ... Mos. ... ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Restaurant Keeper
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Keeper Japan

10. NAME OF FATHER: —

11. BIRTHPLACE OF FATHER (State or Country): Japan

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): Japan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) M Kato (per LW)
(Address) Oakland, Calif.

15. Filed Sept 9th 1921 — L Wellencheck, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 28th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ... 19..., to ... 19...
that I last saw h... alive on ... 19...,
and that death occurred on the date stated above, at ... M.
The CAUSE OF DEATH* was as follows: Death occured here in annual

Don't Know — probably Chronic myocarditis

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) L Wellencheck M. D.
Aug 31 1921 (Address) Fairfield Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL ... 19...

20. UNDERTAKER | ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35216
Registered No. 84

RECEIVED
SEP 15 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
Registration District No. 3
Primary Registration District No. 2005
County of Canyon
City of Caldwell (If outside limits, give township) St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Bertha Lorraine Chaney

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: (Write the word.)

6. DATE OF BIRTH: Aug (Month) 8 (Day) 1910 (Year)

7. AGE: 11 Yrs. 0 Mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: J. R. Chaney

11. BIRTHPLACE OF FATHER (State or Country): Missouri.

12. MAIDEN NAME OF MOTHER: Anna L. Smith

13. BIRTHPLACE OF MOTHER (State or Country): Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. R. Chaney
(Address) Caldwell #3

15. Filed Aug. 26 1921 John L. Meyer Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 23 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 21 1921, to Aug 23 1921, that I last saw h.er alive on Aug 23 1921, and that death occurred on the date stated above, at 5:30 P.M.

The CAUSE OF DEATH* was as follows:

Pressure of tuberculous origin on Basal 5th pair of cranial ganglia leading to acute heart block -

(Duration) ..... Yrs. ..... mos. 3 ds.

Contributory (Secondary) Don't Know.

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. B. Dudley M. D.

19 ..... (Address) Caldwell

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? -

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill — DATE OF BURIAL: 8-26 1921

20. UNDERTAKER: C. V. Peckham — ADDRESS: Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35217
Registered No. 90

1. PLACE OF DEATH

County of Canyon

City of Caldwell

Registration District No. 9

Registration District No. 1005

(No. ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

RECEIVED
SEP 15 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME Mary Abbott Hills

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widowed

6. DATE OF BIRTH: Sept (Month) 23 (Day) 1840 (Year)

7. AGE: 80 Yrs. 11 Mos. 15 ds.

IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER: Samuel W. Abbott

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Ursula Bryan

13. BIRTHPLACE OF MOTHER (State or Country): New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ursula A. Robinson

(Address) Caldwell Ida

15. Filed Sept 9 1921

John L. Meyers
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 8 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 29 1921 to Sept 8 1921 that I last saw h[illegible] alive on Sept 8 1921 and that death occurred on the date stated above, at 6:30 P.M.

The CAUSE OF DEATH* was as follows:

Senility

(Duration) Yrs 8 mos 9 ds.

Contributory (Secondary) Flu

(Duration) yrs. mos. 10 ds.

(Signed) [illegible] M. D.

9-9 1921 (Address) Caldwell Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Manchester Ida — DATE OF BURIAL: 9-14 1921

20. UNDERTAKER: CASE FURNITURE CO. — ADDRESS: Caldwell

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 3

Primary Registration District No. 2005

File No. 35218

County of Canyon

City of Notus (No. ..... St.)

Registered No. 89

If death occurs away from usual residence, give facts called for under special information.

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SEP 15 1921
BUREAU OF VITAL STATISTICS

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mrs Martha J. Folwell

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	

6. DATE OF BIRTH: March (Month) 28 (Day) 1856 (Year)

7. AGE: 65 Yrs. 5 Mos. 7 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment, in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: James Violet

11. BIRTHPLACE OF FATHER (State or Country): Ohio.

12. MAIDEN NAME OF MOTHER: Jemima Downing.

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Eunice Talbot
(Address) R. 1. Notus Idaho

15. Filed Sept. 6th 1921 John L. Meyer
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 5 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows: Paralysis

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Paul L. Case M. D.
19 (Address) Caldwell

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill. DATE OF BURIAL: 9-7 1921

20. UNDERTAKER: CASE FURNITURE Co. ADDRESS: Caldwell, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35219

Registered No. 89

RECEIVED
SEP 15 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 3

Primary Registration District No. 2005

County of Canyon

City of Caldwell (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John A. Nelson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M.	White	Widower

6. DATE OF BIRTH: March (Month) 4 (Day) 1832 (Year)

7. AGE: 89 Yrs. 6 Mos. ..... ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Merchant- Feed Store
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER: Nelson

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) D. W. Allen
(Address) 503 6th South Nampa Ida

15. Filed Sept. 5 1921 John D. Meyers Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 4 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Drowning — Suicide in canal South of Boise river bridge — Home residence of Will Welch
(Duration)
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Paul L. Cavanah M. D.
Coroner — Caldwell
19..... (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill — DATE OF BURIAL: Sept 6 1921

20. UNDERTAKER: CASE FURNITURE CO. — ADDRESS: Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
SEP 15 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 3
Primary Registration District No. 2005
File No. 35220
Registered No. 87

County of Canyon
City of Caldwell (No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Calvin James Coffin

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.):

6. DATE OF BIRTH: March (Month) 28 (Day) 1915 (Year)

7. AGE: 6 Yrs. 5 Mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Washington

10. NAME OF FATHER: Floyd James Coffin

11. BIRTHPLACE OF FATHER (State or Country): Nebraska

12. MAIDEN NAME OF MOTHER: Vay Kindig

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Floyd J. Coffin
(Address) Caldwell Ida Rt #2

15. Filed Sept. 2- 1921 John L. Meyers. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. (Month) 1- (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1 1921 to Sept 1 1921
that I last saw h[illegible] alive on ..... 19..
and that death occurred on the date stated above, at 4:30 P.M.
The CAUSE OF DEATH* was as follows:
Poliomyelitis
(Duration) ..... Yrs. ..... mos. 3 ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) J. M. Coe M. D.
9/1 1921 (Address) Caldwell Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mica, Washington — DATE OF BURIAL ..... 19..

20. UNDERTAKER: C. V. Peckham — ADDRESS: Caldwell, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35221
Registered No. 86

RECEIVED
SEP 15 1921
BUREAU OF VITAL STATISTICS

Registration District No. 3
Primary Registration District No. 1005

1. PLACE OF DEATH
County of Canyon
City of Caldwell (If outside limits, give township) St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Clara May Phillips

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): ~~(Write the word.)~~

6. DATE OF BIRTH: July (Month) 21 (Day) 1921 (Year)

7. AGE: ____ Yrs. 1 Mos. 10 ds.
IF LESS than 1 day how many ____ hrs. or ____ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Caldwell Ida

10. NAME OF FATHER: B. H. Phillips

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Jessie Shaw

13. BIRTHPLACE OF MOTHER (State or Country): Washington

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs B. H. Phillips
(Address) Caldwell Ida

15. Filed Aug. 31 1921 John L. Meyers. Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 31 (Day) 1921 (Year)

I HEREBY CERTIFY, That I attended deceased from ~~Dec~~ ____ 19____, to ____ 19____, that ~~I last saw h~~ ____ alive on ____ 19____, and that death occurred on the date stated above, at ____ M.

The CAUSE OF DEATH* was as follows: Pernicious anemia

Contributory (Secondary)

(Duration) ____ Yrs. ____ mos. ____ ds.

(Signed) L. B. Stewart M. D.

Aug 31 1921 (Address) Caldwell Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill — DATE OF BURIAL: 9-1 1921

20. UNDERTAKER: E. V. Peckham — ADDRESS: Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

RECEIVED SEP 13 1921 BUREAU OF VITAL STATISTICS

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 3

Primary Registration District No. 2005

File No. 35222

County of Canyon

City of Wilder (Ward, St.)

Registered No. 85

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Harvey Le Roy Davis

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Jan 7 1909 (Month) (Day) (Year)

7. AGE: 12 Yrs. 7 Mos. 19 ds.

IF LESS than 1 day how many..... hrs. or.....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Thomas T. Davis

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Sarah Hewitt

13. BIRTHPLACE OF MOTHER (State or Country): Utah —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Henry Holgerson

(Address) Wilder, Idaho.

15. Filed Aug. 27- 1921 Jos. H. Meyer - Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug 26 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from .....19....., to .....19.....,

that I last saw h..... alive on .....19.....,

and that death occurred on the date stated above, at .....M.

The CAUSE OF DEATH* was as follows: Pneumonia

.....(Duration) .....Yrs.....mos.....ds.

Contributory (Secondary).....

.....(Duration) .....yrs.....mos.....ds.

(Signed) Paul L. Case M. D.

.....19..... (Address) Caldwell Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Salt Lake Utah

DATE OF BURIAL: 8-29 1921

20. UNDERTAKER: CASE FURNITURE CO.

ADDRESS: Caldwell Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED
SEP 15 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 1005
File No. 35223
Registered No. 83

1. PLACE OF DEATH
County of Canyon
City of Caldwell
(No. STATISTICS St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Hale Floyd Sanderson
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: American
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: July (Month) 9 (Day) 1920 (Year)

7. AGE: 1 Yrs. 1 Mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Wm J Sanderson

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Anna M Peterson

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W J Sanderson
(Address) Caldwell Ida

15.
Filed Aug 24 1921 John L. Meyer.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 22 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 22 1921, to Aug 22 1921, that I last saw h— alive on ..... 19....., and that death occurred on the date stated above, at 4 30 P.M.
The CAUSE OF DEATH* was as follows:
Pneumonia
(Duration) — Yrs. — mos. — ds.
Contributory (Secondary)
(Duration) — yrs. — mos. — ds.
(Signed) Simeon Hoffer M. D.
19..... (Address) Homedale Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill — DATE OF BURIAL: 8-24-1921

20. UNDERTAKER: C. T. Peckham — ADDRESS: Caldwell Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 1005
File No. 35224
Registered No. 82

RECEIVED
SEP 15 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Canyon
City of Caldwell (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Margaret Virginia Schenck

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: July (Month) 3 (Day) 1847 (Year)

7. AGE: 74 Yrs. 1 Mos. 17 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Pennsylvania

10. NAME OF FATHER: Wm. Jenkins.

11. BIRTHPLACE OF FATHER (State or Country): Don't know.

12. MAIDEN NAME OF MOTHER: Candace Miller

13. BIRTHPLACE OF MOTHER (State or Country): Pennsylvania

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ida I. Schenck
(Address) Caldwell, Idaho.

15. Filed Aug. 22-1921 John V. Meyer Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 20 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 15- 1921, to Aug. 20- 1921
that I last saw h.. alive on Aug 20- 1921,
and that death occurred on the date stated above, at 11-45 M.

The CAUSE OF DEATH* was as follows:
Brights disease with Hematuria.

(Duration) 3 Yrs. ..... mos. ..... ds.
Contributory (Secondary) old age.
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John V. Meyer M. D.
8-22-1921 (Address) Caldwell-Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Canyon Hill.	8-22-1921
20. UNDERTAKER	**ADDRESS**
O. V. Peckham	Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35225

Registered No. 81

RECEIVED
SEP 15 1921
BUREAU OF VITAL STATISTICS

Registration District No. 9

Primary Registration District No. 2005

1. PLACE OF DEATH

County of Canyon

City of Caldwell

(No. ... Poor Farm ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charles Edwards

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: 8 (Month) 22 (Day) 1859 (Year)

7. AGE: 61 Yrs. 11 Mos. 24 ds.

IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Stoughton Mass

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W A Perkins

(Address) Caldwell Idaho

15. Filed Aug. 16 1921 John L. Meyer Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 8 (Month) 16 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 10 1921, to Aug 16 1921, that I last saw h. alive on Aug 14 1921, and that death occurred on the date stated above, at ... M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ... Yrs. ... mos. 6 ds.

Contributory (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) J M Cox M. D.

19... (Address) ...

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill

DATE OF BURIAL: 8-17 19...

20. UNDERTAKER: CASE FURNITURE CO.

ADDRESS: Caldwell

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
SEP 15 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 3

Primary Registration District No. 2005

File No. 35226

County of Canyon

City of Caldwell (No. ... St.)

Registered No. 60

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME J. William Hinds

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	W	married

6. DATE OF BIRTH: March (Month) 23 (Day) 1872 (Year)

7. AGE: 41 Yrs. 4 Mos. 20 ds. IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Hotelman
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: John Hinds

11. BIRTHPLACE OF FATHER (State or Country): Kentucky

12. MAIDEN NAME OF MOTHER: Margaret McHenry

13. BIRTHPLACE OF MOTHER (State or Country): Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chas J. Hinds
(Address) Caldwell Idaho

15. Filed Aug. 15 1921 John L. Meyer Local Registrar

SUNS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 13 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1921, to Aug 13 1921, that I last saw h.im alive on Aug 13 1921, and that death occurred on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:
Following Surgical Op.
Gastro Enterostomy
(Duration) ... Yrs. ... mos. 14 ds.
Contributory (Secondary) Ulcer of Stomach
(Duration) 5 yrs. ... mos. ... ds.

(Signed) J. W. Gee M. D.
8/15 1921 (Address) Caldwell Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Blackfoot Ida — DATE OF BURIAL: 8-17 1921

20. UNDERTAKER: CASE FURNITURE CO. — ADDRESS: Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Mitchell Parma

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
SEP 18 1921
BUREAU OF VITAL STATISTICS

Registration District No. 3
Primary Registration District No. 2605
File No. 35227
Registered No. 79

1. PLACE OF DEATH

County of Canyon
City of Roswell (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME David Burton Blakley

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
male	White	single

6. DATE OF BIRTH: April (Month) 7 (Day) 1920 (Year)

7. AGE: 1 Yrs. 4 Mos. — ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Caldwell Ida.

10. NAME OF FATHER: Geo Blakley

11. BIRTHPLACE OF FATHER (State or Country): Kansas

12. MAIDEN NAME OF MOTHER: Stella Vensan

13. BIRTHPLACE OF MOTHER (State or Country): Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) George Blakley
(Address) Parma R# 1

15. Filed Aug 8 1921 John L. Meyers. Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 7 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 6 1921, to Aug 7 1921, that I last saw h. im alive on Aug 7 1921, and that death occurred on the date stated above, at 2P. M.

The CAUSE OF DEATH* was as follows:

Kerosene poisoning

(Duration) 1 Yrs. ..... mos. 1 ds.

Contributory (Secondary) Peritonitis

(Duration) ..... yrs. ..... mos. 1 ds.

(Signed) W. M. Mitchell M. D.

8-8 1921 (Address) Parma

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Canyon Hill	8-8 1921

20. UNDERTAKER	ADDRESS
C. V. Peckham	Caldwell

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED
SEP 15 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 1006
File No. 35228
Registered No. .....

1. PLACE OF DEATH.
County of Canyon
City of Nampa (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ruby Hudkins

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F. M.
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH. June (Month) 12 (Day) 1898 (Year)
7. AGE: 23 Yrs. 2 Mos. 18 ds. IF LESS than 1 day how many ..... hrs. or ..... min.
8. OCCUPATION
(a) Trade, profession or particular kind of work... None
(b) General nature of industry, business, or establishment in which employed (or employer).....
9. BIRTHPLACE (State or Country) Colo. Salmon Idaho
10. NAME OF FATHER J. S. Hudkins
11. BIRTHPLACE OF FATHER (State or Country) W. Va.
12. MAIDEN NAME OF MOTHER Mary Manfull
13. BIRTHPLACE OF MOTHER (State or Country) Minn
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Dora Byrnes
(Address) Nampa
15. Filed Sept 10 1921 Pearle Dodds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Sept (Month) 1 (Day) 1921 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Dec 16 1920, to Sept 1 1921, that I last saw her alive on Aug 31 1921, and that death occured on the date stated above, at 4 a M.
The CAUSE OF DEATH* was as follows:
Status Epilepticus
(Duration) 20 Yrs. mos. ds.
Contributory (Secondary) .....
(Duration ..... yrs. mos. ds.
(Signed) Dora Byrnes M. D.
19..... (Address) Nampa Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs 11 mos. 21 days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death? Salmon Idaho
Former or usual residence Salmon Idaho

19. PLACE OF BURIAL OR REMOVAL: Kohlerdown Cem — DATE OF BURIAL: 9-3 1921
20. UNDERTAKER: Fred K Robinson — ADDRESS: Nampa Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24653

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35229

Registered No.

1. PLACE OF DEATH

County of Canyon

City of H (No. St.)

Registration District No. 17

Primary Registration District No. 506

RECD SEP 1 BUREAU OF VITAL STATISTICS

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Rebecca Elizabeth Clark

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: July (Month) 4 (Day) 1846 (Year)

7. AGE: 75 Yrs. Mos. 27 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): N. C.

10. NAME OF FATHER: L. Gillam

11. BIRTHPLACE OF FATHER (State or Country): N. C.

12. MAIDEN NAME OF MOTHER: Rosanna Young

13. BIRTHPLACE OF MOTHER (State or Country): N. C.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) R. J. Clark

(Address) Melba Ida

15. Filed Sept. 4 1921 Pearle Dodds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 24 (Day) Aug 1 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 24 1921, to July 24 1921, that I last saw her alive on July 29 1921, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Apoplexy.

(Duration) ..... Yrs. ..... mos. 5 ds.

Contributory (Secondary) Mitral Insufficiency

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Thos. F. Wangsness M. D.

8/1 1921 (Address) Nampa Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Kohlerlawn — DATE OF BURIAL: 8-4 1921

20. UNDERTAKER: Fred K Robinson — ADDRESS: Nampa Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED SEP 16 1921 BUREAU OF STATISTICS

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35230

Registered No. .....

1. PLACE OF DEATH.

County of Canyon Registration District No. 4

City of Nampa Primary Registration District No. 1806

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Harry Fox

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH. June (Month) 6 (Day) 1895 (Year)

7. AGE 26 Yrs. 3 Mos. ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work. Farm Hand
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Jackson N.Y.

10. NAME OF FATHER T A Fox

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Don Boyd
(Address) Nampa Idaho

15. Filed Sept. 16 1921 Pearle D. Dodds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 9 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mch 1 1920, to Sept 9 1921,
that I last saw him alive on Sept 9 1921,
and that death occured on the date stated above, at 9 P M.
The CAUSE OF DEATH* was as follows:
Tuberculosis (Pulmonary)

(Duration) Yrs. 1/2 mos. 10 ds.
Contributory (Secondary) Influenza
(Duration ..... yrs. ..... mos. 21 ds.
(Signed) Don Boyd M. D.
9/9 1921 (Address) Nampa

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 1 yrs. 5 mos. 9 days In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence Nampa Idaho

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Kohlerlawn	Sept 12 1921

20. UNDERTAKER	ADDRESS
J K Robinson	Nampa

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYMS - YORK CO., PTRS. & STRS. 24653

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35231
Registered No.

1. PLACE OF DEATH

RECEIVED SEP 15 BUREAU OF VITAL STATISTICS

Registration District No. 7
Primary Registration District No. 1006

County of Canyon
City of Nampa (No. 215 Diamond St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elaine Emma Dunkley

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	

6. DATE OF BIRTH: April 26 1921
(Month) (Day) (Year)

7. AGE: — Yrs. 4 Mos. — ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Geo. Dunkley

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER Gertrude Lefever

13. BIRTHPLACE OF MOTHER (State or Country) Mont.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Geo Dunkley
(Address) Nampa Ida.

15. Filed Sept 10 19 Pearle Dodds
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug. 26 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11 30 am. 8/26 1921 to 2 30 P.M. 9/26 1921 that I last saw her alive on 8/26 1921 and that death occurred on the date stated above, at 2 30 P.M.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(Duration) — Yrs. — mos. 2 ds.

Contributory (Secondary) —

(Duration) — yrs. — mos. — ds.

(Signed) Leo W Chilton M. D.
9/10 1921 (Address) Nampa Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Nampa Ida Rosedale Cem	8-27 1921

20. UNDERTAKER	ADDRESS
Fred K Robinson	Nampa Ida

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

C

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35232
Registered No.

RECEIVED
SEP 15 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Canyon
Registration District No. 7
Primary Registration District No. 1066
City of Nampa (No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Belle C Pheasant
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem.
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widow

6. DATE OF BIRTH: Apr (Month) 18 (Day) 1840 (Year)

7. AGE: 81 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Penn.

10. NAME OF FATHER: Isaac Smith

11. BIRTHPLACE OF FATHER (State or Country): Penn

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country): Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. E. Pheasant
(Address) Nampa Ida.

15. Filed Sept 15 1921 Pearle Dodds Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sep (Month) 9 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from August 8 1921, to Sept 9 1921, that I last saw her alive on Sept 6 1921, and that death occurred on the date stated above, at 8-30 A.M.

The CAUSE OF DEATH* was as follows:
Cancer of mouth

(Duration) Yrs. 4 mos. ds.
Contributory (Secondary): Senility
(Duration) yrs. mos. ds.

(Signed) H A Robinson M. D.
19 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Norfolk Nebr. DATE OF BURIAL: 9-a 19

20. UNDERTAKER: F K Robinson ADDRESS: Nampa Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED
SEP 15 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 7
Primary Registration District No. 2006
File No. 35233
Registered No.

County of Canyon
City of Nampa (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Marion Francis Jones

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH: Aug 17 1847
(Month) (Day) (Year)

7. AGE: 74 Yrs. - Mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ind.

10. NAME OF FATHER: Jacob Jones

11. BIRTHPLACE OF FATHER (State or Country): -----

12. MAIDEN NAME OF MOTHER: -------

13. BIRTHPLACE OF MOTHER (State or Country): --------

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R. E. Jones
(Address) Nampa Ida.

15. Filed Sept. 16 1921 Pearle Dodds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept 2 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1 1921, to Sept 2 1921 that I last saw him alive on Sept 1 1921 and that death occurred on the date stated above, at 1 A. M.

The CAUSE OF DEATH* was as follows: Hypostatic Congestion. Following Senile Indigestion

(Duration) 1 Yrs. 2 mos. - ds.

Contributory (Secondary) (Duration) - yrs. - mos. - ds.

(Signed) J. B. Smith M. D.

9/2 1921 (Address) Nampa Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Olathe Kansas	Sept 2 1921

20. UNDERTAKER	ADDRESS
Fred K Robinson	Nampa Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 82
Primary Registration District No. 2159
File No. 3528
Registered No. 8

1. PLACE OF DEATH.
County of Bonneau
City of Soda Springs (If outside city limits, give township.) St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Hannah Louisa Rowley

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. ~~SINGLE~~, MARRIED, WIDOWED OR ~~DIVORCED~~. (Write the word.)

6. DATE OF BIRTH. July 25 1860 (Month) (Day) (Year)

7. AGE 60 Yrs. 6 Mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer) Housewife

9. BIRTHPLACE (State or Country) Utah

10. NAME OF FATHER Alfred Bennett

11. BIRTHPLACE OF FATHER (State or Country) Tenn.

12. MAIDEN NAME OF MOTHER — ? Lucie

13. BIRTHPLACE OF MOTHER (State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Nellie Hawley
(Address) Soda Springs Idaho

15.
Filed Aug 27 1921 Ellis Keeley Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24655

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Aug (Month) 27. (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 1. 1921, to Aug 27. 1921, that I last saw h[e]r alive on Aug 27. 1921, and that death occured on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:
Carcinoma of Sigmoid Flexure

(Duration) Yrs. 6 mos. — ds.
Contributory (Secondary) None
(Duration yrs. mos. ds.
(Signed) Ellis Keeley M. D.
Aug 31 1921 (Address) Soda Springs Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Soda Springs Idaho — DATE OF BURIAL: Aug 30 1921

20. UNDERTAKER: Ed Wehrman — ADDRESS: Soda Springs Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated in YEARS, MONTHS and DAYS. Exact statement should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-18

RECEIVED OCT 1 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35235

Registered No. 7

1. PLACE OF DEATH. Registration District No. 82

County of Caribou Primary Registration District No. 2159

City of Soda Springs, ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Henry K. Thatcher

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Aug. 23, 1878
(Month) (Day) (Year)

7. AGE: 43 Yrs. 1 Mos. 4 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Logan, Utah

10. NAME OF FATHER: John B. Thatcher

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Rachel Davis

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant): Cora Thatcher
(Address): Thatcher, Idaho

15. Filed Sep 27 1921

Eric Kandy
Local Registrar

BYRNE - YORK CO., PTRS. & STRS. 24655

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Sep. 27, 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sep. 12, 1921 to Sep. 27, 1921, that I last saw him alive on Sep. 27, 1921, and that death occured on the date stated above, at 3P M.

The CAUSE OF DEATH* was as follows:

Wound of Rectum due to falling on the end of the handle of a pitch fork

(Duration) ..... Yrs. ..... mos. 15 ds.

Contributory (Secondary): None

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

19 ..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Thatcher, Idaho — DATE OF BURIAL: 9/30 1921

20. UNDERTAKER: None — ADDRESS: —

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

RECEIVED OCT 1 1921 BUREAU OF VITAL STATISTICS

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 82
Primary Registration District No. 2159
File No. 35236
Registered No. 9

1. PLACE OF DEATH.
County of Canbun
City of Soda Springs Ida (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Thomas Francis Sheetz

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. June 19 1854 (Month) (Day) (Year)

7. AGE: 67 Yrs. 8 Mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): W. Va.

10. NAME OF FATHER: Jacob Sheetz

11. BIRTHPLACE OF FATHER (State or Country): W. Va

12. MAIDEN NAME OF MOTHER: Sarah Corbin

13. BIRTHPLACE OF MOTHER (State or Country): Don't Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Calyan Sheetz
(Address) Soda Springs Ida

15. Filed Sep 29 1921 Ellis Kinney Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept 27 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 25 1921, to Sept 27 1921, that I last saw h.s alive on Sept 25 1921, and that death occured on the date stated above, at 11:30 P.M.

The CAUSE OF DEATH* was as follows:
Organic Heart Disease
(Duration) Yrs. 6 mos. ds.
Contributory (Secondary): None
(Duration yrs. mos. ds.
(Signed) Ellis Kinney M. D.
9/29 1921 (Address) Soda Springs Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Soda Springs Ida — DATE OF BURIAL: Oct 1 1921

20. UNDERTAKER: None — ADDRESS

N. B.—Every item of information should be carefully supplied. Special attention should be given to the statement of OCCUPATION and exact statement should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED SEP 19 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 117

Primary Registration District No. 2196

File No. 35237

Registered No. 628

County of Cassia

City of Burley (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William George Cole

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. June (Month) 27 (Day) 1865 (Year)

7. AGE: 56 Yrs. 1 Mos. 17 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: J. B. Cole

11. BIRTHPLACE OF FATHER (State or Country): .....

12. MAIDEN NAME OF MOTHER: Lucy Ward

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Geo Cole
(Address) Burley

15. Filed Aug. 9 1921 W. J. Patterson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August (Month) 8 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 5 1921, to Aug. 8 1921, that I last saw him alive on Aug. 8 1921, and that death occured on the date stated above, at 6 P M.

The CAUSE OF DEATH* was as follows:
Chronic Interstitial Nephritis
(Duration) 4 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. E. Patterson M. D.
8-9 1921 (Address) Burley, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Ogden Utah — DATE OF BURIAL: on arrival 1921

20. UNDERTAKER: R. N. Watt — ADDRESS: Burley Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYNS - YORK CO., PTRS. & BORS. 24653

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED
SEP 14 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 117
Primary Registration District No. 2196
File No. 35238
Registered No. 529

1. **PLACE OF DEATH**

County of Cassia
City of Burley (No. ....., St.)

If death occurs away from usual residence, give facts called for under special information.

2. **FULL NAME** Frederick Joseph Suter.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Male	White	Single (Write the word.)

6. **DATE OF BIRTH** May. 25 — 1921.
(Month) (Day) (Year)

7. **AGE** 73 Yrs. 2 Mos. 25 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. **OCCUPATION**
(a) Trade, profession or particular kind of work: Dairyman
(b) General nature of industry, business or establishment in which employed (or employer): Retired.

9. **BIRTHPLACE** (State or Country) Bath England.

10. **NAME OF FATHER** Benjamin Suter.

11. **BIRTHPLACE OF FATHER** (State or Country) Bath England.

12. **MAIDEN NAME OF MOTHER** Eliza Elborn.

13. **BIRTHPLACE OF MOTHER** (State or Country) Wellington.

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**
(Informant) Henry W. Tucker
(Address) Burley Ida.

15. Filed Aug. 22 1921 Dr. J. C. Patterson
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH** Aug. 20 — 1921.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from August 12 1921, to August 20 1921, that I last saw him alive on August 19 1921, and that death occurred on the date stated above, at 4:30 P. M.

The CAUSE OF DEATH* was as follows:

Apoplexy.
(Cerebral Hemorrhage)

(Duration) ..... Yrs. ..... mos. 7 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. A. Rich M. D.
8-21 1921 (Address) Burley Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Salt Lake City Utah	Aug. 23 1921.
20. UNDERTAKER	**ADDRESS**
L. B. Talcott	Burley Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35239

Registered No. 530

RECEIVED
SEP 14 1921
BUREAU OF VITAL STATISTICS

Registration District No. 117

Primary Registration District No. 2196

1. PLACE OF DEATH.

County of Cassia

City of Burley (St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Heizow Miyagishima

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: Japanese

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1891 (Year)

7. AGE: 30 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Japan

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miyagishima

(Address) Burley

15. Filed Sept. 3. 1921 Dr. J. C. Patterson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 2 (Month) 2 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 23 1921, to Sept 2 1921, that I last saw h[illegible] alive on Sept 2 1921, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Obstruction of Bowels
Sarcoma
appendix

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Suppuration Peritonitis

(Duration) ..... yrs. ..... mos. 2 ds.

(Signed) Joseph Timstead M.D.

19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Ogden Utah

DATE OF BURIAL: Sept 4 1921

20. UNDERTAKER: R W Watt

ADDRESS: Burley Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYNS - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

35240 Cuter

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 535

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No. 117

Primary Registration District No. 2196

County of Cassia

City of Burley (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
SEP 19 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME Martin Sandberg

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Feby (Month) 28 (Day) 1920 (Year)

7. AGE: 1 Yrs. 5 Mos. 18 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): Burley

10. NAME OF FATHER: George Sandberg

11. BIRTHPLACE OF FATHER (State or Country): Norway

12. MAIDEN NAME OF MOTHER: Lois Dixon

13. BIRTHPLACE OF MOTHER (State or Country): Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George Sandberg

(Address) Burley Ida

15. Filed Aug. 20 1921

Dr. J. C. Patterson
Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 10 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 6 1921, to Aug 12 1921, that I last saw him alive on Aug 12 1921, and that death occured on the date stated above, at 10 a. M.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

..... (Duration) ..... Yrs. ..... mos. 14 ds.

Contributory (Secondary) None

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) F. K. Cutler M. D.

19..... (Address) Burley Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Pleasant View Cemetery — DATE OF BURIAL: Aug 16 1921

20. UNDERTAKER: R W Mace — ADDRESS: Burley Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35241
Registered No. 536

RECEIVED
SEP 19 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH.
Registration District No. 117
Print Registration District No. 2196
County of Cassia
City of Burley (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Elizabeth Foster

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH.
Aug (Month) 14 (Day) 1921 (Year)

7. AGE
..... Yrs. 2 Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE
(State or Country) Idaho

10. NAME OF FATHER
C A Foster

11. BIRTHPLACE OF FATHER
(State or Country)

12. MAIDEN NAME OF MOTHER
Mamie Elizabeth Baird

13. BIRTHPLACE OF MOTHER
(State or Country) Ill

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) C A Foster
(Address) Burley Ida

15.
Filed 8-16-21 1921 Per J C Patterson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Aug. (Month) 14 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 14 1921, to Aug. 16 1921, that I last saw h.. alive on Aug. 16 1921, and that death occured on the date stated above, at 10a M.

The CAUSE OF DEATH* was as follows:
Premature (7 months)

..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration ..... yrs. ..... mos. ..... ds.
(Signed) J. C. Patterson M. D.
8-16 1921 (Address) Burley, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Pleasant Views Cemetery — DATE OF BURIAL: Aug 17 1921

20. UNDERTAKER: R W Wate — ADDRESS: Burley

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

EVANS - YORK CO., PTRS. & BOOKS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35242

Registered No. 537

RECEIVED
SEP 19 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH.

County of Cassia — Registration District No. 117

City of Burley — Registration District No. 2196 (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Maurice Elizabeth Foster

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. June (Month) 15 (Day) 1884 (Year)

7. AGE: 37 Yrs. 2 Mos. 0 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ill

10. NAME OF FATHER: George R Baird

11. BIRTHPLACE OF FATHER (State or Country): Ia

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country): Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) C.H. Foster
(Address) Burley Ida

15. Filed 8-15-21 191.... By J.C. Patterson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH ~~July~~ Aug (Month) 14 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 10 1921, to Aug 14 1921, that I last saw h.. alive on Aug 14 1921 and that death occured on the date stated above, at 5 p. M.

The CAUSE OF DEATH* was as follows:
Hemmorrhage (Placenta Praevia Centralis

(Duration) Yrs. 7 mos. ds.

Contributory (Secondary)

(Duration yrs. mos. ds.

(Signed) J. C. Patterson M. D.

8-15 1921 (Address) Burley, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Pleasant View Cemetery — DATE OF BURIAL: Aug 17 1921

20. UNDERTAKER: R W Watt — ADDRESS: Burley Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYNS - YORK CO., PTRS. & BORS. 24658

FORM V. S. No. 6-A—25 M. 1-19.

RECEIVED SEP 10 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 117

County of Cassia

Primary Registration District No. 2196

File No. 35243

City of Burley (If outside limits, give township) (Ward) (St.)

Registered No. 538

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Angela Belasques.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: Mexican

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: May (Month) 27 (Day) 1914 (Year)

7. AGE: 7 Yrs. 3 Mos. # ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): California

10. NAME OF FATHER: Juan Belasquez

11. BIRTHPLACE OF FATHER (State or Country): Old Mexico.

12. MAIDEN NAME OF MOTHER: Antonia Sesvaraca.

13. BIRTHPLACE OF MOTHER (State or Country): Old Mexico.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Juan Belasquez
(Address) Burley Ida.

15. Filed Aug. 28 1921 Dr. J. C. Patterson Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug. (Month) 27 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 22 19..., to Aug 27 1921, that I last saw h~~im~~ alive on Aug 27 1921, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Peritonitis

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Appendicitis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. K. Patterson M. D.

19..... (Address) Burley Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Burley Ida. DATE OF BURIAL: Aug 27 1921

20. UNDERTAKER: L. B. Talloghy. ADDRESS: Burley Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED SEP 15 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH.

Registration District No. 120 — 3524

Primary Registration District No. 2199

State of Idaho BOARD OF HEALTH Bureau of Vital Statistics

File No. X44

Registered No. 17

1. PLACE OF DEATH.

County of Cassia

City of Oakley (St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Geo. Wm Hardy

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Dec. (Month) 2 (Day) 63 (Year)

7. AGE: 57 Yrs. 6 Mos. 6 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Blacksmith

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Josiah Hardy

11. BIRTHPLACE OF FATHER (State or Country): Massachusetts

12. MAIDEN NAME OF MOTHER: Ann Dunston

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Gilbert Hardy

(Address) Oakley Idaho

15. Filed Sept. 5 1921 — A. W. Nelson, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 18 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...

that I last saw h— alive on June 18 1921

and that death occured on the date stated above, at 6 M.

The CAUSE OF DEATH* was as follows:

Cerebral Embolism

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Myocarditis

(Duration) 2 yrs. ..... mos. ..... ds.

6/18 1921 (Signed) A. W. Nelson M. D.

(Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Oakley Idaho — DATE OF BURIAL: 6/20 1921

20. UNDERTAKER: B. P. Adams — ADDRESS: Oakley Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

BYNS - YORK CO., PTRS. & BORS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. X 11

Registered No. 16

1. PLACE OF DEATH.

County of Cassia — Registration District No. 129 - 35245

City of Cottonwood — Primary Registration District No. 2/94

(No. St.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED SEP 15 1921 BUREAU OF VITAL STATISTICS

2. FULL NAME Charles Graham Parkinson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH. August (Month) 18 (Day) 1855 (Year)

7. AGE: 65 Yrs. 9 Mos. 27 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Charles Graham Parkinson

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Hannah Clark

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. L. L. Farnard

(Address) Oakley, Idaho

15. Filed Sept. 5 1921 A. O. Nielson Local Registrar

SYMS - YORK CO., FTRS. & SORS. 24854

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 14 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That ~~I attended deceased from~~ ~~1921~~, to ~~1921~~, ~~that I last saw h~~ alive on ~~1921~~, ~~and that~~ death occured on the date stated above, at 9:30 P.M.

The CAUSE OF DEATH* was as follows:

Arterioscelerosis

(Duration) ? Yrs. mos. ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed) Jesse L. Raines M. D.

6/15 1921 (Address) Oakley, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Oakley, Idaho — DATE OF BURIAL: June 16 1921

20. UNDERTAKER: Boyd Harper — ADDRESS: Oakley, Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

D. W. DAVIS, GOVERNOR

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BOISE, IDAHO

PUBLIC HEALTH SERVICE
FOOD AND DRUG INSPECTION
BACTERIOLOGICAL LABORATORY
CHEMICAL LABORATORY
BUREAU OF CHILD HYGIENE
VITAL STATISTICS
MEDICAL ADVISOR

October 15, 1921.

To,
Dr. J. C. Patterson,
Local Registrar at Burley, Idaho.

Dr. A. F. O. Nielson,
Local Registrar at Oakley, Idaho.

Dear Doctor:

Certificate of Death of Charles Graham Parkinson who died June 14th, 1921, has been filed by each of you as Registrars. The one sent in by Dr. Nielson is signed by Dr. Jesse L. Rains of Oakley, and the one filed by Dr. Patterson is signed by L. B. Gallogly, Coroner of Burley, Idaho. Dr. Rains signs as the attending physician and gives the cause of death as Arteriosclerosis, while the Coroner gives the cause of death as "Valvular Heart Disease".

The Undertaker on the certificate of Dr. Patterson is given as L. B. Gallogly and on the certificate filed by Dr. Nielson the Undertaker is given as B. Harper and the date of burial as June 16th while Mr. Gallogly gives the date of burial as June 20th, 1921.

From all the above you will note some discrepancies and we are at a loss to know which certificate to accept as the facts in the matter. The date of birth is the same on both certificates so we feel it is the same person.

We enclose herewith a self-addressed stamped envelope and would be glad to hear from each of you for you can realize our position if we

were ever called upon to furnish a certified copy of the death certificate.

Thanking you for usual promptness, we are,

Yours very truly,

F. W. Almond.

F. W. Almond, M. D.
Medical Advisor.

Oakley, Idaho Oct 17 - 24

Gentlemen :- Mr. Parkinson died at Oakley and was buried at Oakley, I was not aware that Mr. Galloyly was the undertaker, and took it for granted that Mr. Harper was, so give Galloyly credit for the date and burial. Give Dr. Rhines the credit for the diagnosis, you know he is an M. D., Galloyly is a good fellow also but he guesses at our mistakes, as Parkinson died in my district, and he quotes to me and I will give Dr. Patterson a drink, so everybody is taken care of-

Yours truly, F. W. Almond

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

35246

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. X644

Registered No. 19

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

RECEIVED SEP 15 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH.

County of Cassia

City of Oakley (If not in incorporated city or village write the word "Not" before it.)

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 130

Primary Registration District No. 2199

(No. ..... St.)

2. FULL NAME Orville Durfee

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. November (Month) 16 (Day) 1920 (Year)

7. AGE — Yrs. 9 Mos. 1 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Oakley Idaho

10. NAME OF FATHER: Miles Durfee

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Leola Allene Merriman

13. BIRTHPLACE OF MOTHER (State or Country): Florida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miles Durfee

(Address) Oakley Idaho

15. Filed Sept 5 1921

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August (Month) 17 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from August 17 1921, to August 17 1921, that I last saw h[illegible] alive on August 17 1921, and that death occured on the date stated above, at 6:30 P.M.

The CAUSE OF DEATH* was as follows:

Acute gastro-enteritis

(Duration) ..... Yrs. ..... mos. 4 ds.

Contributory (Secondary) Malnutrition

(Duration) ..... Yrs. 9 mos. ..... ds.

(Signed) Jesse L. Rains M. D.

Aug 19 1921 (Address) Oakley Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Oakley Idaho — DATE OF BURIAL: Aug 19 1921

20. UNDERTAKER: Byd Severe — ADDRESS: Oakley Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

35247

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 120

County of Cassia Primary Registration District No. 2199 File No. XVII

City of Oakley (No. ..... St.) Registered No. 18

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

RECEIVED SEP 15 1921 BUREAU OF VITAL STATISTICS

2. FULL NAME LeRoy Day

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Aug (Month) 4th (Day) 1921 (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho (Oakley)

10. NAME OF FATHER: LeRoy Day

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Martha Hansen

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) LeRoy Day

(Address) Oakley, Idaho

15. Filed Sept 5 1921 H. O. Nielson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 7 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...
and that death occured on the date stated above, at 12:50 M.

The CAUSE OF DEATH* was as follows:

Premature Birth
(Atelectasis)

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

8/7 (Signed) ..... M. D.

1921 (Address) H. O. Nielson

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Burial Idaho — DATE OF BURIAL: Aug 9 1921

20. UNDERTAKER: B. Martin — ADDRESS: Oakley Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24853

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 117
Primary Registration District No. 2196
File No. 35248
Registered No. 533

1. PLACE OF DEATH

County of Cassia
City of Burley (If outside limits of city or village, give township.) St.)

If death occurs away from usual residence, give facts called for under special information.

BUREAU OF VITAL STATISTICS

2. FULL NAME Jared Burton Pike.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH: Nov. (Month) 5 (Day) 1875 (Year)

7. AGE: 45 Yrs. 8 Mos. 15 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Life Ins. Agent.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Siota Co. N. Y.

10. NAME OF FATHER: Calvin H. Pike.

11. BIRTHPLACE OF FATHER (State or Country): Utah.

12. MAIDEN NAME OF MOTHER: Jennie Angell

13. BIRTHPLACE OF MOTHER (State or Country): New York.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A. A. Pike.
(Address) Burley Ida.

15. Filed July 22 1921 Dr. J. C. Patterson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 20 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19....., that I last saw h..... alive on ..... 19....., and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Quick Consumption.

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) L. B. Talbot, (Coroner) M. D.
July 22 1921. (Address) Burley Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Burley Ida.	July 22 1921.

20. UNDERTAKER	ADDRESS
L. B. Talbot.	Burley Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED
SEP 15 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35249
Registered No. 534

1. PLACE OF DEATH
Registration District No.
County of Cassia Registry Registration District No.
City of Burley (If not in incorporated limits, give township.) 112 So. Miller Ave. (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Rollin Ray Trowbridge.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Sing. (Write the word.)

6. DATE OF BIRTH: May (Month) 20 (Day) 1921 (Year)

7. AGE: # Yrs. 1 Mos. 17 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Burley Ida.

10. NAME OF FATHER: Jay Trowbridge

11. BIRTHPLACE OF FATHER (State or Country): Idaho Falls Ida.

12. MAIDEN NAME OF MOTHER: Esther Hokanson.

13. BIRTHPLACE OF MOTHER (State or Country): Pocatello Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jay Trowbridge
(Address) 112 So. Miller Burley Ida.

15. Filed July 7 1921 Dr. J. C. Patterson Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 6 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 20 1921, to July 6 1921, that I last saw h[illegible] alive on July 6 1921, and that death occurred on the date stated above, at 12:20 M.

The CAUSE OF DEATH* was as follows:
Malnutrition, premature baby,

(Duration) ..... Yrs. ..... mos. 47 ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. C. Patterson M. D.
July 6 1921 (Address) Burley, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Burley Ida. DATE OF BURIAL: July 7 1921

20. UNDERTAKER: L. B. Galloway. ADDRESS: Burley Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED SEP 15 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

35250

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. #117

County of Cassia — Primary Registration District No. 2196

File No. 8532

City of Okla (No. ..... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Abner D. Wallahan

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Dec. (Month) 12 (Day) 1870. (Year)

7. AGE: 50 Yrs. 7 Mos. 10 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Wisconsin

10. NAME OF FATHER: Orland Wallahan

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Currence Johnson

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Grace L. Ferguson
(Address) Box 1266 Pocatello Ida.

15. Filed July 22 1921 D. J. Sullivan Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 21 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Fracture Of Skull At Base Of Brain
Accidental.

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) L. B. Talbert — Coroner — M. D.
July 23 1921 (Address) Burley Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Dayton Wisconsin — DATE OF BURIAL: July 30 1921

20. UNDERTAKER: W. A. Goodman — ADDRESS: Burley Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

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Rich

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 117

Primary Registration District No. 2196

File No. 35251

Registered No. 531

County of Cassia

City of Burley (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Melvin Fairchild

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Sept. (Month) 15 (Day) 1921 (Year)

7. AGE: 11 Yrs. 10 Mos. 9 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: In School.

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Cassia Co. Ida.

10. NAME OF FATHER: Marlin Fairchild

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Maudell Beamis

13. BIRTHPLACE OF MOTHER (State or Country): Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. F. Beamis

(Address) Burley Ida.

15. Filed July 9 1921 W. J. Patterson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 7 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 6 1921, to July 7 1921, that I last saw him alive on July 7 1921, and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Intussception (following operation)

..... (Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. A. Rich M. D.

July 8 1921 (Address) Burley Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Burley Ida. DATE OF BURIAL: July 9 1921.

20. UNDERTAKER: L. B. Talboy ADDRESS: Burley Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

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Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35252
Registered No. 42

RECEIVED SEP 15 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH. Registration District No. 90
County of Clearwater, Primary Registration District No. 7168
City of Orofino, (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William Gray

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: About (Month) ..... (Day) 1846 (Year)

7. AGE: About 75 yrs. ~ mos. ~ ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Logging in Woods
(b) General nature of industry business or establishment in which employed (or employer): Working in Woods

9. BIRTHPLACE (State or Country): California

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. W. Atteberry
(Address) Orofino, Idaho.

15. Filed Sept 7 1921 J. M. Faul Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: August Eighth 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 17 1916, to August 8 ~~1921~~ 1921 that I last saw h~~e~~r alive on August 8 ~~1921~~ 1921 and that death occurred on the date stated above, at 10:45 P. M.

The CAUSE OF DEATH* was as follows:
Epilepsy

over
(Duration) 5 yrs. ..... mos. ..... ds.

Contributory (Secondary) Insanity
(Duration) over 1 yrs. ..... mos. ..... ds.

(Signed) John A Tyrrell M. D.
Aug 9th 1921 (Address) Orofino, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 5 yrs. 1 mos. 22 ds. In the State over 12 yrs. ~ mos. ~ ds.
Where was disease contracted, if not at place of death?
Former or usual residence Lochsa, Idaho

19. PLACE OF BURIAL OR REMOVAL: Grave # 20 Row # 4 New Addition Northern Lights Sanitarium Cemetery
DATE OF BURIAL: Aug. 10 1921

20. UNDERTAKER: J. W. Atteberry,
ADDRESS: Orofino, Idaho

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35253
Registered No. 39

RECEIVED SEP 13 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Clearwater Registration District No. 90
Primary Registration District No. 2168
City of Orofino (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lester Lloyd Lortved
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
male	white	Single

6. DATE OF BIRTH Oct (Month) 23 (Day) 1894 (Year)

7. AGE 26 Yrs. 9 Mos. 8 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Timber man
(b) General nature of industry, business or establishment in which employed (or employer) Packing for Government

9. BIRTHPLACE (State or Country) Minn

10. NAME OF FATHER James P Lortved

11. BIRTHPLACE OF FATHER (State or Country) Denmark

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John P Lortved
(Address) Pierce Idaho

15. Filed Sept 13, 1921 J M Tracy Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 1 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....
and that death occurred on the date stated above, at 7:30 P.M.
The CAUSE OF DEATH* was as follows:
Accidental Drowning
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) J C Bullock M. D.
Aug 2 1921 (Address) Orofino Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF ~~BURIAL~~ OR REMOVAL Spokane West — DATE OF BURIAL ..... 19.....

20. UNDERTAKER Boldt Mortuary — ADDRESS Orofino

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 90
Primary Registration District No. 7168
File No. 35254
Registered No. 40

1. PLACE OF DEATH

County of Clearwater
City of Orofino (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED SEP 13 1921 VITAL STATISTICS

2. FULL NAME George Dennis

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: May 9 1894 (Month) (Day) (Year)

7. AGE: 27 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Ruben Dennis

11. BIRTHPLACE OF FATHER (State or Country): Oregon

12. MAIDEN NAME OF MOTHER: Ann

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Annie Dennis
(Address) Orofino Idaho

15. Filed Sept 1 1921 J. M. Daily Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug 1 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Diabetes Mellitus 19..., that I last saw h..... alive on ..... 19....., and that death occurred on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:
Chronic pancreatitis
and pulmonary tuberculosis
(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Earle W Roswell M. D.
Aug 1 1921 (Address) Orofino Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Fraser — DATE OF BURIAL: Aug 3 1921

20. UNDERTAKER: C. A. Bobo — ADDRESS: Orofino Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D. W. DAVIS, GOVERNOR

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BOISE, IDAHO

PUBLIC HEALTH SERVICE
FOOD AND DRUG INSPECTION
BACTERIOLOGICAL LABORATORY
CHEMICAL LABORATORY
BUREAU OF CHILD HYGIENE
VITAL STATISTICS
MEDICAL ADVISOR

October 15, 1921.

RECEIVED
OCT 31 1921
BUREAU OF VITAL STATISTICS

Dr. Earl E. Horswell,
Orofino, Idaho.

Dear Doctor:

Certificate of Death of George Dennis who died August 1, 1921, has been filed in this office. You signed the certificate as attending physician. The date of birth of the deceased is not given. It states May 9th, but does not give the year of birth. We enclose herewith self-addressed stamped envelope and would ask that you kindly give us the desired information as soon as possible.

Yours very truly,

F. W. Almond

F. W. Almond, M. D.
Medical Advisor.

1921
1922

R Born in 1894 May 9
27 years of age.
E. E. Horswell

Record taken from this age by undertaker, not correct.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35255
Registered No. 71

RECEIVED SEP 15 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Ayoma Registration District No. 90

City of Orofino (No.) St.) Primary Registration District No. 2168

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Marguerite Cloud

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Wid

6. DATE OF BIRTH: Sept 2 (Month) (Day) 1837 (Year)

7. AGE: 83 Yrs. 11 Mos. 18 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ind.

10. NAME OF FATHER: —

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: Miss Conway

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W E Fuqua

(Address) Orofino Idaho

15. Filed Aug 30 1921 J M Tainly Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 20 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 19 1921, to Aug 20 1921, that I last saw h[er] alive on Aug 17 1921, and that death occurred on the date stated above, at — M.

The CAUSE OF DEATH* was as follows:

Injuries resulting from a fall

(Duration) Yrs. 2 mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. M. Tainly M. D.

8/31/1921 (Address) Orofino Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Orofino Idaho — DATE OF BURIAL: Aug 31 1921

20. UNDERTAKER: Orofino Und Sns — ADDRESS: Orofino

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

RECEIVED OCT 1 1921 BUREAU OF VITAL STATISTICS

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 91

County of Elmer Wallace Primary Registration District No. 1164

City of Elk River (If outside limits, give township) St.)

File No. 35256

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs Gust. Danielson

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: November 22 1871 (Month) (Day) (Year)

7. AGE: 49 yrs. 8 mos. 7 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Norway

10. NAME OF FATHER: Mathew Olson

11. BIRTHPLACE OF FATHER (State or Country): Norway

12. MAIDEN NAME OF MOTHER: Margaret Skrudhus

13. BIRTHPLACE OF MOTHER (State or Country): Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Gust. Danielson
(Address): Elk River Idaho

15.
Filed July 9 1921 Mrs F. S McConnell Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: July (Month) 7 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 1914, to July 1921, that I last saw h.E.r alive on July 6 1921 and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:
Pernicious Anaemia

(Duration) 2 yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) F. P. McConnell M. D.

July 9 1921 (Address) Elk River

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs....mos....days. In the State....yrs....mos....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Sand Point Idaho | DATE OF BURIAL ....191...

20. UNDERTAKER: Hunt. & Morris Rem. | ADDRESS: St Maries Id. Elk River

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SDRS. 19760

Form V. S. No. 5 20M.1-16-12

RECEIVED OCT 1 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 71

County of Clearwater Primary Registration District No. 216

City of Elk River (No. ....., ... St.)

File No. 35257

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Eva M. Paige

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: June (Month) 29 (Day) 1867 (Year)

7. AGE: 54 yrs. 2 mos. 6 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Edward O Nutt

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Martha J. Paige

13. BIRTHPLACE OF MOTHER (State or Country): Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Manford H Paige

(Address) Elk River Idaho

15.

Filed Sept 6 1921 Mrs. F. P. McCormick Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: September 5th (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from August 30 1921, to September 4th 1921, that I last saw h[illegible] alive on September 30 1921 and that death occurred on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(Duration) 8 yrs. mos. ds.

Contributory (Secondary) Small Pox

(Duration) yrs. 7 mos. ds.

(Signed) F. P. McCormick M. D.

Sept 6 1921 (Address) Elk River Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Moscow Idaho

DATE OF BURIAL: Sept. 7 1921

20. UNDERTAKER: E. S. Morris & Son

ADDRESS: Elk River Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35258

RECEIVED OCT 1 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH. Registration District No. 91
County of Edmonds Primary Registration District No. 216
City of Elk River (If not in incorporated city or village give township) St.)
Registered No.
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Helen Solberg

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: February (Month) 17 (Day) 1908 (Year)

7. AGE: 13 yrs. 4 mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: School girl
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wisconsin

10. NAME OF FATHER: Lewis Solberg

11. BIRTHPLACE OF FATHER (State or Country): Norway

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Lewis Solberg
(Address) Elk River

15.
Filed Jun 22 1921 John F. McComick
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June (Month) 19 (Day) 1921 (Year)

17. I HEREBY CERTIFY, ~~That I attended~~ deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occurred on the date stated above, at 8 A.M.

The CAUSE OF DEATH* was as follows:
Killed riding down steep grade on push car thrown from car killed instantly
(Duration) ... yrs. ... mos. ... ds.

Contributory (Secondary)
(Duration) ... yrs. ... mos. ... ds.

(Signed) P. P. McCormick M. D.
June 20 1921 (Address) Elk River

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Elk River Idaho — DATE OF BURIAL: June 21 1921

20. UNDERTAKER: C. G. Morris & Son — ADDRESS: Elk River

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
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SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 10M. 6-20-11.

RECEIVED

SEP 1 1921

BUREAU OF STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35259
Registered No.

1. PLACE OF DEATH.
County of Elmore
City of Glenn's Ferry (N., S., E., W.) St.)
Registration District No. 35
Primary Registration District No. 2021
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lith C. Canfield

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Sept. (Month) 26 (Day) 1859 (Year)

7. AGE: 61 yrs. 11 mos. 3 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Indiana

10. NAME OF FATHER: Hiram Canfield

11. BIRTHPLACE OF FATHER (State or Country): America

12. MAIDEN NAME OF MOTHER: Mary E. McCarty

13. BIRTHPLACE OF MOTHER (State or Country): America

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Charles Canfield
(Address) Grading Idaho

15.
Filed Aug. 28. 1921 J. W. Doris Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Aug. (Month) 26th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 12 1921, to Aug. 27 1921, that I last saw him alive on Aug. 24 1921, and that death occurred on the date stated above, at 7 A M.

The CAUSE OF DEATH* was as follows:
Carcinoma right side of face

(Duration) One yrs. mos. ds.
Contributory (Secondary) & Possibly Surgery
(Duration) yrs. mos. ds.

(Signed) J. W. Doris M. D.
Aug. 27 1921 (Address) Glenns Ferry Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and 2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Glenns Ferry Idaho
DATE OF BURIAL: Aug. 29. 1921

20. UNDERTAKER: Joe Rubsam
ADDRESS: Glenns Ferry Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

EVANS-YORK CO., PRINTERS & RULERS, BOISE 16872

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35260
Registered No. 72

RECEIVED
SEP 15 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
Registration District No.
County of Elmore
Primary Registration District No.
City of Mtn Home Ida (No. St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Infant of P. A. Moraleda
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write one word.): Infant

6. DATE OF BIRTH: Aug (Month) 15 (Day) 1921 (Year)

7. AGE: ....Yrs. ....Mos. 2½ Wds.
IF LESS than 1 day how many....hrs. or....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Mtn Home Ida

10. NAME OF FATHER: P. A. Moraleda

11. BIRTHPLACE OF FATHER (State or Country): Cuba

12. MAIDEN NAME OF MOTHER: Alice Harbin

13. BIRTHPLACE OF MOTHER (State or Country): Morristown Tenn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs P. A. Moraleda
(Address) [redacted] Mtn Home Ida

15.
Filed....19....
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug. (Month) 17 (Day) 19 21 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 15 19 21 to Aug 17 19 21
that I last saw h[illegible] alive on Aug 17 19 21
and that death occurred on the date stated above, at 1130 M.
The CAUSE OF DEATH* was as follows: Congenitally ill fed + broken
Complete double hair lip.
Sepsis - private -
Sepsis - externally - arm + feet
(Duration) ....Yrs. ....mos. ....ds.
Contributory (Secondary)
(Duration) ....yrs. ....mos. ....ds.
(Signed) O S Hamilton M. D.
Aug 18 19 21 (Address) Mtn Home Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mtn. Home Ida — DATE OF BURIAL: 8-18 19 21
20. UNDERTAKER: A. W. Conover — ADDRESS: Mtn Home Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35261

Registered No. 15

RECEIVED
SEP 15 1921
BUREAU OF VITAL STATISTICS

Registration District No. 34

Primary Registration District No. 2020

1. PLACE OF DEATH

County of Elmore

City of ..... (If outside limits of city or village, give township.) ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Margrett Barrutia

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: June (Month) 28 (Day) 1921 (Year)

7. AGE: ..... Yrs. ..... Mos. 1/2 ds.

IF LESS than 1 day how many 7 hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Mt. Home Ida

10. NAME OF FATHER: Sipriano Barrutia

11. BIRTHPLACE OF FATHER (State or Country): Spain

12. MAIDEN NAME OF MOTHER: Juanita

13. BIRTHPLACE OF MOTHER (State or Country): Spain

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Juanita Barrutia

(Address) Mtn Home Ida.

15. Filed 8-31-1921

J E Evans
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 29 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 28 1921, to June 29 1921 that I last saw her alive on June 29 1921, and that death occurred on the date stated above, at 1A M.

The CAUSE OF DEATH* was as follows:

Premature - 7 mo

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D O Hamilton M. D.

June 29 1921 (Address) Mtn Home Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mtn Home Ida — DATE OF BURIAL: 7-1-1921

20. UNDERTAKER: A B Conover — ADDRESS: Mtn Home

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 2119

County of Franklin

Primary Registration District No. 27

File No. 35262

City of Preston (No. , St.)

Registered No. 31

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
OCT 5 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME Paul L. Forman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M.	W.	

6. DATE OF BIRTH: Sep. (Month) 15 (Day) 1921 (Year)

7. AGE: Yrs. Mos. 5 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business or establishment in which employed (or employer) —

9. BIRTHPLACE (State or Country) Preston Ida

10. NAME OF FATHER Albert A. Forman

11. BIRTHPLACE OF FATHER (State or Country) Perry Ida

12. MAIDEN NAME OF MOTHER Mabell Snider

13. BIRTHPLACE OF MOTHER (State or Country) Bedford Wyoming

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Albert A. Forman
(Address) Preston Idaho

15. Filed Sept 30 1921 — Dr. A. R. Rulle, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 17 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 15 1921, to Sept 17 1921, that I last saw h.. l.. alive on Sept 17 1921, and that death occurred on the date stated above, at 6:00 P.M.

The CAUSE OF DEATH* was as follows:

Bronco-Pneumonia

(Duration) Yrs. mos. 1 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Curtis Blank M. D.

9/19/1921 (Address) Preston, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Cleveland Ida	Sep. 19 1921
20. UNDERTAKER	ADDRESS
W. W. Henderson	Preston Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35263

Registered No. 52

RECEIVED
OCT 5 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 2119

Primary Registration District No. 27

County of Franklin

City of Preston (Or Village, or Township, or Precinct, and St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Naoma Archibald

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F.	W	Single

6. DATE OF BIRTH: Dec. (Month) 6 (Day) 1906 (Year)

7. AGE: 14 Yrs. 9 Mos. 20 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Clarkston Utah

10. NAME OF FATHER: James M. Archibald

11. BIRTHPLACE OF FATHER (State or Country): Cache Co Utah

12. MAIDEN NAME OF MOTHER: Catharine J. Godfrey

13. BIRTHPLACE OF MOTHER (State or Country): Clarkston Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Robt Archibald
(Address) Dayton Idaho

15. Filed Sept 30 1921 D.A. Cullen Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 26 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 24 1921, to Sept 26 1921, that I last saw her alive on Sept 26 1921, and that death occurred on the date stated above, at 6:30 A.M.

The CAUSE OF DEATH* was as follows:
acute suppurative peritonitis

(Duration) Yrs. mos. 2 ds.

Contributory (Secondary) acute suppurative appendicitis

(Duration) yrs. mos. 6 ds.

(Signed) A. K. Cutler M. D.

9-26 1921 (Address) Preston Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Dayton Idaho	Sep 28 1921
20. UNDERTAKER: W. W. Hardmore	ADDRESS: Preston Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35265
Registered No. 149

RECEIVED
SEP 15 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 3119
Primary Registration District No. 27
County of Franklin
City of Preston (Ward, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Rosina Noakes

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
F	W.	Married (Write the word.)

6. DATE OF BIRTH: Dec (Month) 27 (Day) 1857 (Year)

7. AGE: 63 Yrs. 8 Mos. 3 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Switzerland

10. NAME OF FATHER: Christean Hunney

11. BIRTHPLACE OF FATHER (State or Country): Switzerland

12. MAIDEN NAME OF MOTHER: Miss Foster

13. BIRTHPLACE OF MOTHER (State or Country): Switzerland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) George W. Noakes
(Address) Charleston Wasatch Co. Utah

15. Filed ..... 19 .....
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 29 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 23 1921, to Aug 30 1921, that I last saw h.r alive on Aug 25 1921, and that death occurred on the date stated above, at 1:00 P. M.

The CAUSE OF DEATH* was as follows:
Mitral insufficiency

(Duration) — Yrs. ..... mos. ..... ds.
Contributory (Secondary) Rheumatism
(Duration) — yrs. ..... mos. ..... ds.

(Signed) Curtis Blanch M. D.
8-30 1921 (Address) Preston Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Charleston Wasatch Co Ut.	Sept 1st 1921
20. UNDERTAKER W. A. Skidmore	ADDRESS Preston Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

$1.30

FORM V. S. No. 5-25 M. 1-19.

RECEIVED SEP 15 19-1 REGISTRATION

35266

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Fremont

City of Ashton

(No. ..... St.)

Registration District No. 102

Primary Registration District No. 6

File No. 2

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mattie Seeley

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Feb. (Month) 23 (Day) 1884 (Year)

7. AGE: 37 Yrs. 5 Mos. 16 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Payson Utah

10. NAME OF FATHER: C. H. Whiteman

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Lavina Callett

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Alvira Seeley

(Address) Ashton Idaho

15. Filed Aug 8 - 1921

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 7 (Day) 1921 (Year)

July 24

17. I HEREBY CERTIFY, That I attended deceased from July 24 1921, to Aug 7 1921, that I last saw her alive on Aug 7 1921, and that death occurred on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Hemorrhage of lungs.

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) S. L. Hagan M. D.

Aug 8 1921 (Address) Ashton Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Pine View Cemetery

DATE OF BURIAL: 8-10 1921

20. UNDERTAKER: Ellis Riser

ADDRESS: Ashton Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED SEP 15 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH 35267

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of FREMONT.
City of ASHTON
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 102
Primary Registration District No. 6
(No. ..... St.)
File No. 2
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Arthur Clarence Ashley

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single. (Write the word.)

6. DATE OF BIRTH: January (Month) 28th (Day) 1909 (Year)

7. AGE: 12 Yrs. 6 Mos. 24 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: lived on Farm.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Roseville Ill.

10. NAME OF FATHER: Clarence Ashley

11. BIRTHPLACE OF FATHER (State or Country): Missouri,

12. MAIDEN NAME OF MOTHER: Elfell Anderson.

13. BIRTHPLACE OF MOTHER (State or Country): Good Hope Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Clarence Ashley
(Address) Felt Idaho.

15. Filed 8-24 1921 — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 23 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to Aug 23 1921
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at 6 P.M.
The CAUSE OF DEATH* was as follows:
Thrown from wagon
producing fracture of skull

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E. L. Hayes, M. D.
Aug 26 1921 (Address) Ashton Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Pine View Cemetery
DATE OF BURIAL: 8.26 1921

20. UNDERTAKER: Lewis Kiser
ADDRESS: Ashton Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35269

1. PLACE OF DEATH

County of Gem — Registration District No. 6

City of Emmett — Primary Registration District No. ____

(St.) — Registered No. ____

If death occurs away from usual residence, give facts called for under special information.

RECEIVED OCT 6 1921 BUREAU OF VITAL STATISTICS

2. FULL NAME Margaret Eliza Goold

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
female	white	child

6. DATE OF BIRTH — Feb (Month) 19 (Day) 1911 (Year)

7. AGE — 10 Yrs. 6 Mos. 29 ds. — IF LESS than 1 day how many ____ hrs. or ____ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: child
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER L. L. Goold

11. BIRTHPLACE OF FATHER (State or Country) Idaho

12. MAIDEN NAME OF MOTHER Bertha Moyer

13. BIRTHPLACE OF MOTHER (State or Country) Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) L L Goold
(Address) Emmett Ida

15. Filed 9/20 1921 — J. L. Reynolds, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH — Sept (Month) 19 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 5 1921, to Sept 19 1921, that I last saw h.. alive on Sept 19 1921, and that death occurred on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:
Mitral heart lesion

(Duration) 2 or longer Yrs. ____ mos. ____ ds.

Contributory (Secondary) ____ (Duration) ____ yrs. ____ mos. ____ ds.

(Signed) J. L. Reynolds M. D.

9/20 1921 (Address) Emmett Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Emmett Idaho — DATE OF BURIAL: 9/19 1921

20. UNDERTAKER: C. D. Tuckerman — ADDRESS: Emmett Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED OCT 6 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 6

County of Gem

Registration District No.

File No. 35270

City of Emmett (St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Evaline Glass

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): widow

6. DATE OF BIRTH: March (Month) 13 (Day) 1855 (Year)

7. AGE: 66 Yrs. 6 Mos. 3 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Pennsylvania

10. NAME OF FATHER: Levi Myers

11. BIRTHPLACE OF FATHER (State or Country): Pennsylvania

12. MAIDEN NAME OF MOTHER: Kelly

13. BIRTHPLACE OF MOTHER (State or Country): Pennsylvania

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C. L. Anderson

(Address) Emmett

15.

Filed 9/20 1921 J. L. Reynolds Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 16 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 16 1921, to Sept 16 1921, that I last saw her alive on Sept 16 1921, and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(Duration) Yrs. mos. ds.

Contributory (Secondary) Atheromatous arteries

(Duration) yrs. mos. ds.

(Signed) R. H. Cummings M.D.

9/18 1921 (Address) Emmett Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Emmett Idaho

DATE OF BURIAL: 9/19 1921

20. UNDERTAKER: C. D. Bucknum

ADDRESS: Emmett Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35271

RECEIVED
OCT 6 1921
BUREAU OF VITAL STATISTICS

Registration District No. 6
Primary Registration District No. 6

1. PLACE OF DEATH
County of Gem
City of Emmett (Ward....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Alexander Decker
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: married (Write the word.)

6. DATE OF BIRTH: May (Month) 2 (Day) 1881 (Year)

7. AGE: 40 Yrs. 4 Mos. 27 ds.
IF LESS than 1 day how many..... hrs. or..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New Jersey

10. NAME OF FATHER: Jacob Decker

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER: Jennie L. Bird

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Elisa Decker
(Address) Emmett Idaho

15. Filed 10/3/ 1921 J. L. Reynolds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 29 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows: Skull crushed by wagon
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) W. M. Brown - Coroner M. D.
..... 19..... (Address) Emmett,

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Emmett Idaho — DATE OF BURIAL: 10/1 1921

20. UNDERTAKER: O. R. Buckmun — ADDRESS: Emmett Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED OCT 6 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35272
Registered No.

1. PLACE OF DEATH
County of Gem
City of Emmett (No. ..... St.)
Registration District No. .....
Registration District No. 6

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Elizabeth Stahl

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Sept (Month) 7 (Day) 1881 (Year)

7. AGE: 40 Yrs. — Mos. 24 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: James Simpson

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Elizabeth A. Horner

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ernest Stahl
(Address) Emmett Ida

15. Filed 10/4 1921 J. L. Reynolds Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. (Month) 1 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 5 1921, to Oct 1 1921
that I last saw her alive on Oct 1 1921
and that death occurred on the date stated above, at 3:30 P. M.

The CAUSE OF DEATH* was as follows:
Unknown - Probably brain tumor or abscess
(Duration) Don't know Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) R. H. Cummings M. D.
10/4 1921 (Address) Emmett Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Emmett Idaho	10/3 1921
20. UNDERTAKER: O. Buckner	ADDRESS: Emmett Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35273
Registered No.

1. PLACE OF DEATH
County of Gem
City of Emmett
(No. ... St.)
If death occurs away from usual residence, give facts called for under special information.

RECEIVED
OCT 6 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME Henry Mortimer Shearer
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): married

6. DATE OF BIRTH: Mar (Month) 13 (Day) 1850 (Year)

7. AGE: 71 Yrs. 6 Mos. 20 ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wisconsin

10. NAME OF FATHER: Mortimer Shearer

11. BIRTHPLACE OF FATHER (State or Country): unknown

12. MAIDEN NAME OF MOTHER: Angeline Thorp

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Lillian M Shearer
(Address) Emmett Ida

15. Filed 10/4 1921 J. L. Reynolds Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 3 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 5 1921, to Oct 1 1921, that I last saw him alive on Oct 1 1921, and that death occurred on the date stated above, at 9:30 A.M.

The CAUSE OF DEATH* was as follows:
Uraemia - following
Chronic nephritis - Atheromatous arteries
(Duration) ... Yrs. ... mos. ... ds.
Contributory (Secondary) Apoplexy
(Duration) ... yrs. 2 mos. ... ds.

(Signed) R N Cummings M. D.
10/4 1921 (Address) Emmett Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Boise Idaho
DATE OF BURIAL: 10/4 1921

20. UNDERTAKER: C D Buckner
ADDRESS: Emmett Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED SEP 15 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. .....
Primary Registration District No. 6
File No. 35274
Registered No. .....

1. PLACE OF DEATH.

County of Gem
City of Emmett (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME James Lifford Beckman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Infant

6. DATE OF BIRTH. July (Month) 26 (Day) 1921 (Year)

7. AGE: ..... Yrs. 1 Mos. 1 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Sweet Ida

10. NAME OF FATHER: Albert C Beckman

11. BIRTHPLACE OF FATHER (State or Country): Kansas

12. MAIDEN NAME OF MOTHER: Lilyen Ivy Hilbert

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Lilyen Beckman
(Address) Sweet Ida

15. Filed 8/27 1921 J. L. Reynolds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Aug (Month) 27 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 27 1921, to Aug 27 1921, that I last saw h[illegible] alive on Aug 27 1921, and that death occured on the date stated above, at 8-10 M.

The CAUSE OF DEATH* was as follows:
Immation
.....
.....
.....
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Premature birth
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) J. L. Reynolds M. D.
8/27 1921 (Address) Emmett Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Brownlee Cemetery — DATE OF BURIAL: 8/29 1921

20. UNDERTAKER: C. E. Brockman — ADDRESS: Emmett

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY; PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

BYRD - YORK CO., PTRS. & BDRS. 24654

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED SEP 15 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35275

Registered No.

1. PLACE OF DEATH

County of Gem Registration District No.

City of Emmett Primary Registration District No. 6

(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William M. Kloth

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH: Feb (Month) 5 (Day) 1893 (Year)

7. AGE: 28 Yrs. 6 Mos. 15 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: Herman Kloth

11. BIRTHPLACE OF FATHER (State or Country): Not known

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs G W Franklin
(Address) New Plymouth Idaho

15.
Filed 9 17 1921

Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 20 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 18 1921, to Aug 20 1921, that I last saw him alive on Aug 20 1921, and that death occurred on the date stated above, at 11 AM.

The CAUSE OF DEATH* was as follows:

Multiple lacerated wounds of left thigh hip & various other parts due to explosion of dynamite.

(Duration) Yrs. mos. 2½ ds.

Contributory (Secondary) Gas bacillus infection

(Duration) yrs. mos. 2 ds.

(Signed) R N Cummings M. D.

8/21 1921 (Address) Emmett Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Emmett Idaho

DATE OF BURIAL: 8/22 1921

20. UNDERTAKER: O L Bucknum

ADDRESS: Emmett Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 24
Primary Registration District No.
File No. 35276
Registered No.

1. PLACE OF DEATH
County of Gooding
City of Gooding (No. , St.)
If death occurs away from usual residence, give facts called for under special information.

RECEIVED SEP 15 1921 BUREAU OF STATISTICS

2. FULL NAME Charles Sumner Osborn

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Male	White	Married

6. DATE OF BIRTH: Aug (Month) 11 (Day) 1857 (Year)

7. AGE: 63 Yrs. 11 Mos. 22 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farming
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: Alfred Osborn

11. BIRTHPLACE OF FATHER (State or Country): Don't know

12. MAIDEN NAME OF MOTHER: Elizabeth Bugbee

13. BIRTHPLACE OF MOTHER (State or Country): Maine

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mary A Osborn
(Address) Gooding Ida

15. Filed 8 – 10 – 1921 F. J. Caymt. M.D. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug. (Month) 3 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 2 1921, to Aug 3 1921, that I last saw him alive on Aug 3 1921, and that death occurred on the date stated above, at 6 P. M.
The CAUSE OF DEATH* was as follows:
Acute perforation of gastric ulcer
(Duration) Yrs. mos. 2 ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) J H Cromwell M. D.
8/4 1921 (Address) Gooding Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Gooding
DATE OF BURIAL: Aug 4 1921

20. UNDERTAKER: A E Thompson
ADDRESS: Gooding

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

Registration District No. 24

Primary Registration District No. ____

(No. ____, ____ St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35277

Registered No. ____

1. PLACE OF DEATH

County of Gooding

City of Gooding

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Rhoda Ellen Taylor

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): widow

6. DATE OF BIRTH: Nov. (Month) 10th (Day) 1844 (Year)

7. AGE: 76 Yrs. 8 Mos. 28 ds.

IF LESS than 1 day how many ____ hrs. or ____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business or establishment in which employed (or employer): ____

9. BIRTHPLACE (State or Country): Henry Co Indiana

10. NAME OF FATHER: John Jackson Davis

11. BIRTHPLACE OF FATHER (State or Country): Indiana

12. MAIDEN NAME OF MOTHER: Mary Atkinson

13. BIRTHPLACE OF MOTHER (State or Country): Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) L E Taylor

(Address) Gooding Ida

15. Filed 8 — 10 — 1921 J F Carey M.D. Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August (Month) 8th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from August 1919 to August 1921 that I last saw her alive on Aug 7th 1921, and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis -

(Duration) 2 Yrs. ____ mos. ____ ds.

Contributory (Secondary) Uremia

(Duration) ____ yrs. ____ mos. 5 ds.

(Signed) J H Cromwell M. D.

8/8 1921 (Address) Gooding, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days

Where was disease contracted if not at place of death? ____

Former or usual residence ____

19. PLACE OF BURIAL OR REMOVAL: Gooding Cemetary — DATE OF BURIAL: 8/10 1921

20. UNDERTAKER: A E Thompson — ADDRESS: Gooding.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 24

Primary Registration District No. .....

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35278

Registered No. .....

1. PLACE OF DEATH.

County of Gooding

City of Gooding (No. .... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ingred Beatrice Thompson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. April (Month) 18 (Day) 1917 (Year)

7. AGE: 4 Yrs. 3 Mos. 22 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...

(b) General nature of industry, business, or establishment in which employed (or employer)...

9. BIRTHPLACE (State or Country) Gooding, Idaho

10. NAME OF FATHER Joseph Thompson

11. BIRTHPLACE OF FATHER (State or Country) Canton South Dakota

12. MAIDEN NAME OF MOTHER Sigred M. Olson

13. BIRTHPLACE OF MOTHER (State or Country) Longmont Colorado

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph Thompson

(Address) Gooding, Idaho

15. Filed 8 - 11 - 1921

F. E. Caum M.D.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August (Month) 11 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 24 1917, to August 11 1921, that I last saw h... alive on Aug. 10 1921, and that death occured on the date stated above, at 1AM M.

The CAUSE OF DEATH* was as follows:

Inanition secondary to
Infantile stomach and
Congenital Stricture of Pylorus

(Duration) 4 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Dr H. E. Caum M. D.

8/11 1921 (Address) Gooding, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Gooding

DATE OF BURIAL: 8/13 1921

20. UNDERTAKER: A E Thompson

ADDRESS: Gooding, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SOBS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 24
Primary Registration District No.
(No. ..... St.)

File No. 35279
Registered No. .....

1. PLACE OF DEATH.
County of Gooding
City of Gooding
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ralph Oscar Amos

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Aug. (Month) 1 (Day) 1921 (Year)

7. AGE ..... Yrs. ..... Mos. 25 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: ✓
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Benjamin Franklin Amos

11. BIRTHPLACE OF FATHER (State or Country): Oregon

12. MAIDEN NAME OF MOTHER: Brooks Peterson

13. BIRTHPLACE OF MOTHER (State or Country): Wis

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. B. J. Amos
(Address) Gooding Idaho

15. Filed 8-16-1921 F. J. Carey M.D. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug. (Month) 25 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 25 1921, to Aug 25 1921, that I last saw him alive on Aug 25 1921, and that death occured on the date stated above, at 3 P M.

The CAUSE OF DEATH* was as follows:

Gastro-Enteritis, Acute

(Duration) ..... Yrs. ..... mos. 8 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) L. W. Carey M. D.
8/16 1921 (Address) Gooding, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Gooding Cemetery — DATE OF BURIAL: 8/16 1921

20. UNDERTAKER: A E Thompson — ADDRESS: Gooding

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24658

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED
SEP 22 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 18
Primary Registration District No. 2176
File No. 35281
Registered No. 38

1. PLACE OF DEATH

County of Jefferson
City of Rigby (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Eldon Ward Garn

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Infant (Write the word.)

6. DATE OF BIRTH: July 5 (Month) (Day) 1921 (Year)

7. AGE: Yrs. Mos. 4 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Elmer G. Garn

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Eliza Bacon

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. G. Garn
(Address) Rigby, Ida.

15. Filed 9/10 1921 Ray H Fisher Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July 8 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 4 1921 to July 8 1921 that I last saw h... alive on July 8 1921 and that death occurred on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:

Laryngitis Stregulas
(Duration) Yrs. mos. 4 ds.
Contributory (Secondary) Respiratory paralysis
(Duration) yrs. mos. ds.

(Signed) C. F. Call M. D.
9/9 1921 (Address) Rigby

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs ... mos ... days. In the State ... yrs ... mos ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL, OR REMOVAL: Milo, Ida — DATE OF BURIAL: 9/9 1921

20. UNDERTAKER: D A Harris — ADDRESS: Rigby

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED
SEP 22 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 98
Idaho Registration District No. 2176
File No. 35282
Registered No. 43

1. PLACE OF DEATH
County of Jefferson
City of Rigby
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Phyllis Marie Jones
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Infant (Write the word.)

6. DATE OF BIRTH: June 2 1919 (Month) (Day) (Year)

7. AGE: 2 Yrs. 2 Mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Joe. V. Jones

11. BIRTHPLACE OF FATHER (State or Country): Ida.

12. MAIDEN NAME OF MOTHER: Verna Randall

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Joe. V. Jones
(Address) Bone Ida

15. Filed 9/10 1921 Ray H. Fisher Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug 28 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 18 1921 to Aug 28 1921 that I last saw h. l. alive on Aug 27 1921 and that death occurred on the date stated above, at 2 A.M.

The CAUSE OF DEATH* was as follows:

Cholera Infantum

(Duration) ..... Yrs. ..... mos. 10 ds.
Contributory (Secondary) Ileo colitis
(Duration) ..... yrs. ..... mos. 2 ds.

(Signed) O. F. Call M. D.
8/30 1921 (Address) Rigby, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Annis — DATE OF BURIAL: 8/28 1921

20. UNDERTAKER: D. A. Harris. — ADDRESS: Rigby

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 98

County of Jefferson

Primary Registration District No. 2176

City of Rigby (No. St.)

File No. 35283

Registered No. 40

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
SEP 22 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME Laree Finch

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Infant

6. DATE OF BIRTH: Jan 23 (Month) (Day) 1921 (Year)

7. AGE: Yrs. 6 Mos. 13 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ida

10. NAME OF FATHER: Theodore Finch

11. BIRTHPLACE OF FATHER (State or Country): Penn.

12. MAIDEN NAME OF MOTHER: Ruth Barber

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Theodore Finch

(Address) Rigby, Ida

15. Filed 9/10-21 19.... Ray H Fisher Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 8 (Month) - 17 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 5 1921 to Aug 8 1921 that I last saw h.... alive on Aug 8 1921 and that death occurred on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Cholera Infantum

(Duration) ... Yrs. ... mos. 3 ds.

Contributory (Secondary) Intestinal Paralysis

(Duration) ... yrs. ... mos. 1 ds.

(Signed) A. F. Call M. D.

8/1921 (Address) Rigby Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rigby Ida — DATE OF BURIAL: 8/8 1921

20. UNDERTAKER: D. A Harris — ADDRESS: Rigby Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
SEP 22 1921
BUREAU OF VITAL STATISTICS

Registration District No. 98
Primary Registration District No. 2176
File No. 35284
Registered No. 35

1. PLACE OF DEATH
County of Jefferson
City of Menan (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Benton Poole
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): married
6. DATE OF BIRTH: April 25 (Month) (Day) 1875 (Year)
7. AGE: 46 Yrs. 2 Mos. 14 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Mechanic
(b) General nature of industry, business or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Utah
10. NAME OF FATHER: John R. Poole
11. BIRTHPLACE OF FATHER (State or Country): Iowa
12. MAIDEN NAME OF MOTHER: Harriet Benton
13. BIRTHPLACE OF MOTHER (State or Country): England
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Bert Smith
(Address) Menan, Ida
15. Filed 9/10 1921 Ray H. Fisher Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 8 (Day) 1921 (Year)
17. I HEREBY CERTIFY, That I attended deceased from July 4 1921 to July 8 1921
that I last saw h.. alive on July 8 1921,
and that death occurred on the date stated above, at 1 P.M.
The CAUSE OF DEATH* was as follows:
Rocky Mt Tick Fever
(Duration) ..... Yrs. ..... mos. 8 ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Chas. S. Moody M. D.
7/9 1921 (Address) Menan Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Unna — DATE OF BURIAL: 7/9 1921
20. UNDERTAKER: D. A. Harris — ADDRESS: Rigby

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
SEP 29 1921
BUREAU OF VITAL STATISTICS

Registration District No. 98
Primary Registration District No. 2176

File No. 35285
Registered No. 33

1. PLACE OF DEATH

County of Jefferson

City of Rigby #3 (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Brigham Alvin Hickman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): married

6. DATE OF BIRTH: 1 (Month) — 6 (Day) 1859 (Year)

7. AGE: 62 Yrs. 6 Mos. 24 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Wm Hickman

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Bishop W. M. Carr
(Address) Lorenzo Ida #1

15. Filed Sept 1921 Ray H Fisher Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 30 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from no physician 19.....
that I last saw h..... alive on ..... 19.....
and that death occurred on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:
Probably acute dilatation of the heart

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) 15 min yrs. ..... mos. ..... ds.

(Signed) Ray H Fisher M. D.
8/1 1921 (Address) Rigby, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Shelton — DATE OF BURIAL: 8/1 1921

20. UNDERTAKER: D. A. Harris — ADDRESS: Rigby

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED
SEP 22 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 98
Primary Registration District No. 2176
File No. 35288
Registered No. 37

1. PLACE OF DEATH

County of Jefferson
City of Rigby (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Edwin Delroy Hill

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	W	married

6. DATE OF BIRTH Apr (Month) 6 (Day) 1887 (Year)

7. AGE 34 Yrs. 3 Mos. 13 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Ida.

10. NAME OF FATHER Geo. E Hill

11. BIRTHPLACE OF FATHER (State or Country) New Hampshire

12. MAIDEN NAME OF MOTHER Ellen Nelson

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. E. Hill
(Address) Rigby, Ida.

15. Filed 9/10 1921 Ray H Fisher Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 19 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 20 1921 to July 19 1921 that I last saw h.. alive on July 19 1921 and that death occurred on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver and Pancreas

(Duration) One Yrs. ..... mos. ..... ds.

Contributory (Secondary) unknown

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. A. Anderson M. D.

7/20 1921 (Address) Rigby Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Rigby	7/21 1921
20. UNDERTAKER D. A. Harris	ADDRESS Rigby

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED
SEP 22 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 98
Primary Registration District No. 12176
File No. 35289
Registered No. 36

County of Jefferson
City of Rigby (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elma Olga Fullmer

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: June (Month) 9 (Day) 1921 (Year)

7. AGE: ..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many 3 hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: U. G. Fullmer

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Olga Hansen

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) U. G. Fullmer
(Address) Rigby, Ida.

15. Filed 9/10 1921 Ray H. Fisher Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 6 (Month) 9 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 9 1921 to June 9 1921 that I last saw h[illegible] alive on June 9 1921 and that death occurred on the date stated above, at 7 a M.

The CAUSE OF DEATH* was as follows:

Blue Baby (6 mo)

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary): 3 hours

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) O. F. Call M. D.

6/10 1921 (Address) Rigby Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rigby — DATE OF BURIAL: 6/10 1921

20. UNDERTAKER: L. A. Harris — ADDRESS: Rigby

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1919.

RECEIVED
SEP 22 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Jefferson — Registration District No. 98
City of Rigby — Primary Registration District No. 2176 — St.)
File No. 35290
Registered No. 34
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Reno Alfonzo Beck

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: May 15 1904 (Month) (Day) (Year)

7. AGE: 17 Yrs. 2 Mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ida

10. NAME OF FATHER: Theodore Beck

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Elizabeth Smithies

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Claud J Beck
(Address) Rexburg Ida

15. Filed 9/10 1921 Hayth Fisher Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 25 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 21 1921 to July 25 1921 that I last saw h. alive on July 25 1921 and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:
Suppurative Appendecitis

(Duration) ..... Yrs. ..... mos. 4 ds.
Contributory (Secondary) General Peronitis
(Duration) ..... yrs. ..... mos. 4 ds.

(Signed) O. F. Call M. D.
7/27 1921 (Address) Rigby, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Annis — DATE OF BURIAL: 7/28 1921

20. UNDERTAKER: D. A. Harris — ADDRESS: Rigby

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED
SEP 22 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 18

County of Jefferson — Primary Registration District No. 2176

City of Camas (N.) (E.) (W.) (S.) St.)

File No. 35291

Registered No. 41

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Henry M. Jones

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Feb (Month) 9 (Day) 1845 (Year)

7. AGE: 76 Yrs. 5 Mos. 26 ds.

IF LESS than 1 day how many..... hrs. or.....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ill.

10. NAME OF FATHER: —

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs A. R. Young

(Address) Camas, Ida.

15. Filed 9/10 1921 Ray H Fisher Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 6 (Day) 21 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 2 1921 to Aug 2 1921 that I last saw h.. alive on Aug 2 1921 and that death occurred on the date stated above, at .....M.

The CAUSE OF DEATH* was as follows:

Uremia

.....(Duration) .....Yrs. .....mos. 7 ds.

Contributory (Secondary)

.....(Duration) .....yrs. .....mos. .....ds.

(Signed) O. F. Call M. D.

8/6 1921 (Address) Rigby, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Camas — DATE OF BURIAL: 8/6 1921

20. UNDERTAKER: D. A. Harris — ADDRESS: Rigby

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED
SEP 22 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 98
Primary Registration District No. 2176
File No. 35292
Registered No. 39

1. PLACE OF DEATH
County of Jefferson
City of Rigby (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Oliver Purser
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Bach (Write the word.)

6. DATE OF BIRTH: Apr. (Month) 20 (Day) 1920 (Year)

7. AGE: 1 Yrs. 3 Mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Baby.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: LeRoy Purser

11. BIRTHPLACE OF FATHER (State or Country): Idaho.

12. MAIDEN NAME OF MOTHER: Helen Clark.

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) LeRoy Purser
(Address) Rigby, Idaho

15. Filed Aug 10 1921 Ray M. Fisher Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 28 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....
and that death occurred on the date stated above, at 3:30 P. M.
The CAUSE OF DEATH* was as follows:

Drowning. No physician called as death was evident

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Ray M. Fisher M. D.
July 29 1921 (Address) Rigby, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rigby, Ida. DATE OF BURIAL: July 29 1921

20. UNDERTAKER: Friends. ADDRESS: Rigby, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED
SEP 22 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Jefferson
City of Rigby
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 98
Primary Registration District No. 2116
(No. ..... St.)
File No. 35293
Registered No. 42

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Minerva L. Bandt

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: single (Write the word.)

6. DATE OF BIRTH: July (Month) 20 (Day) 1887 (Year)

7. AGE: 34 Yrs. ..... Mos. 24 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Waitress
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: unknown

11. BIRTHPLACE OF FATHER (State or Country): ——

12. MAIDEN NAME OF MOTHER: ——

13. BIRTHPLACE OF MOTHER (State or Country): ——

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. W. Wiggell
(Address) Rigby, Ida

15. Filed 9/10 1921 Ray H. Fisher Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 13 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 10 1921 to Aug 13 1921 that I last saw h.er alive on Aug 13 1921 and that death occurred on the date stated above, at 3 P.M.
The CAUSE OF DEATH* was as follows:
General Peronitis
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Pelvic abscess
(Duration) ..... yrs. ..... mos. 10 ds.
(Signed) H. A. Anderson M. D.
8/14 1921 (Address) Rigby, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Salt Lake Utah
DATE OF BURIAL ..... 19.....

20. UNDERTAKER: W.S. Young
ADDRESS: Rexburg

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35295
Registered No. 45

1. PLACE OF DEATH

Registration District No. 98

Primary Registration District No. 2176

County of Jefferson

City of Rigby (St.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
SEP 29 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME Newell Hill

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Child

6. DATE OF BIRTH: March 26 (Month) (Day) 1916 (Year)

7. AGE: 5 Yrs. 5 Mos. 6 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Delroy Hill

11. BIRTHPLACE OF FATHER (State or Country): Ida

12. MAIDEN NAME OF MOTHER: Delilah Edater

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Peter Later
(Address): Rigby, Ida

15. Filed 9/10 1921 Ray H Fuhrer Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 1 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 20 1921 to Sept 1 1921 that I last saw h...live on Sept 1 1921 and that death occurred on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:

Entero-colitis

(Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. A. Anderson M. D.

9/2 1921 (Address) Rigby

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Rigby	9/3 1921
20. UNDERTAKER: L. A. Harris	ADDRESS: Rigby

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

RE SEP 1[illegible] BUREAU OF V[illegible] STATISTICS

CERTIFICATE OF DEATH

117 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35296
Registered No. 956

1. PLACE OF DEATH
County of Kootenai (Name)
City of Coeur d'Alene. (No. ..... St.)
Registration District No. 30
Subdistrict or Registration District No. 1057
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Percy Bowns
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: married (Write the word.)

6. DATE OF BIRTH: Oct. 1 1886 (Month) (Day) (Year)

7. AGE: 34 Yrs. 10 Mos. 9 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) England

10. NAME OF FATHER Bowns

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER Jane Margaret ——

13. BIRTHPLACE OF MOTHER (State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ada L. Bowns
(Address) Coeur D'Alene, Idaho.

15. Filed Sept 4 1921 A D Brenen Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August 11 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 7 1921, to Aug 11 1921, that I last saw h[illegible] alive on Aug 11 1921, and that death occurred on the date stated above, at 6 P. M.
The CAUSE OF DEATH* was as follows:

Diffuse Peritonitis

(Duration) ..... Yrs. ..... mos. 2 ds.
Contributory (Secondary) Gangrenous Appendicitis
(Duration) ..... yrs. ..... mos. 2 ds.

(Signed) J. C. Dwyer M. D.
Aug 19 21 (Address) Coeur d'Alene Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Forest Cem. CDAlene | DATE OF BURIAL: 8-14 1921

20. UNDERTAKER: C. Cassedy | ADDRESS: CDAlene.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED SEP 15 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35297
Registered No. 955

1. PLACE OF DEATH
Registration District No. 30
Primary Registration District No. 1017
County of Kootenai
City of Coeur d'Alene (St.) Lakeside (St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John A. McKay

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widower

6. DATE OF BIRTH: Oct (Month) 15 (Day) 1836 (Year)

7. AGE: 83 Yrs. 9 Mos. 21 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Prince Edward Island

10. NAME OF FATHER: Geo McKay

11. BIRTHPLACE OF FATHER (State or Country): Scotland

12. MAIDEN NAME OF MOTHER: Christina McKay

13. BIRTHPLACE OF MOTHER (State or Country): Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Christina McKay
(Address) Coeur d'Alene Idaho

15. Filed Sept 4 1921 D D Drennan Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 6 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 5 1921, to Aug 6 1921, that I last saw h~~im~~. alive on Aug 5 1921, and that death occurred on the date stated above, at 9:50 A.M.

The CAUSE OF DEATH* was as follows:

Organic Heart lesion

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Senility

(Duration) — yrs. — mos. — ds.

(Signed) J. W. Hoedemaker M. D.

8/6 1921 (Address) Coeur d'Alene Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State 70 yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetery — DATE OF BURIAL: Aug 8 1921

20. UNDERTAKER: R B Mooney — ADDRESS: Coeur d'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35298

Registered No. 954

RECEIVED
SEP 15 1921
BUREAU OF VITAL STATISTICS

Registration District No. 30

Primary Registration District No. 1037

1. PLACE OF DEATH

County of Kootenai

City of Coeur d'Alene (No.) Indiana (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Francis Ayotte

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Aug (Month) 13 (Day) 1845 (Year)

7. AGE: 75 Yrs. 11 Mos. 20 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Canada

10. NAME OF FATHER: Frank Ayotte

11. BIRTHPLACE OF FATHER (State or Country): France

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): France

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jennie Groves
(Address)

15. Filed Sept 4 1921 L.D. Drema Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 3 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 17, 1919, to Aug 1920 that I last saw h[illegible] alive on Aug 1920 and that death occurred on the date stated above, at 7.50 A.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of bladder (Probable)
(Is attending Physician during last year of his life) (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J.C. Wynn M. D.

Aug 4 1921 (Address) Coeur d'Alene Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: St. Thomas. C. D'Alene — DATE OF BURIAL: 8-5 1921

20. UNDERTAKER: Casseedy — ADDRESS: C'D'alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

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FORM V. S. No. 5-25 M. 1-19.

RECEIVED SEP 15 1921 BUREAU OF VITAL STATISTICS STATE OF IDAHO

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Kootenai — Registration District No. 30

City of Coeur d Alene — Primary Registration District No. 1051 — File No. 35299

(No.) Park & Bay in Lake Coeur d'Alene — Registered No. 953

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Unknown Man

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH: unknown (Month) 1 (Day) (Year)

7. AGE: About 50 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business or establishment in which employed (or employer) —

9. BIRTHPLACE (State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) R B Mooney Coroner

(Address) Coeur d Alene, Ida.

15. Filed Sept 7 1921 — D D Dreana Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 31 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....

that I last saw h..... alive on ..... 19.....,

and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Body found July 31st 1921
Gun shot Wound in Head
(murdered)

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) R B Mooney Coroner M. D.

19..... (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death — yrs. mos. days. In the State — yrs. mos. days

Where was disease contracted if not at place of death? —

Former or usual residence —

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetery — DATE OF BURIAL: Aug 1 1921

20. UNDERTAKER: R B Mooney — ADDRESS: Coeur d Alene Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

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MARGIN RESERVED FOR BINDING

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FORM V. S. No. 5-A—25 M. 1-19.

35300

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED SEP 10 1921 BUREAU OF VITAL STATISTICS

Registration District No. 2147
Primary Registration District No. 64
File No. 3
Registered No. 38

1. PLACE OF DEATH
County of Latah
City of Deary. (St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs. Fred Beyer

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Nov 30 1856 (Month) (Day) (Year)
Aug. 10" 1921

7. AGE: 64 Yrs. 8 Mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housekeeper.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Germany.

10. NAME OF FATHER: August Schoonstein

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Not known

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Lillian Ferguson
(Address) Deary, Ida.

15. Filed 8/13 1921 R. E. Garnett
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug. 10" 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 9" 1921, to Aug. 10" 1921 that I last saw her alive on Aug. 9" 1921, and that death occurred on the date stated above, at 10 a. M.

The CAUSE OF DEATH* was as follows:

Valvular Disease of Heart.

(Duration) Yrs. 6 mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) W. H. Carithers M. D.
Aug 11 1921 (Address) Moscow, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Elwood Cem — DATE OF BURIAL: Aug 13 1921

20. UNDERTAKER: L. M. Irwin. — ADDRESS: Potlatch

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

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FORM V. S. No. 1-15 ...-19.

RECEIVED SEP 15 1921 BUREAU OF VITAL STATISTICS

...of Idaho ...of HEALTH ...Statistics

1. PLACE OF DEATH County of Latah ... Precinct No. ... Village or Town District No. 67 ... File No. 3

City of Avon (No. ... St.) Registered No. 37

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Henry Brantug

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): single

6. DATE OF BIRTH: Nov. 11 1856 (Month) (Day) (Year)

7. AGE: 64 Yrs. 9 Mos. 0 ds. IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER: John Anderson

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Mary Leave

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. W. Esterberg
(Address) Troy R. 2

15. Filed 8/11 1921 P. V. Faust Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug. 11 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 8/9 1921 to 8/11 1921 that I last saw h. im alive on 8/11 1921 and that death occurred on the date stated above, at 930 M.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage

(Duration) 0 Yrs. 0 mos. 2 ds.

Contributory (Secondary)
(Duration) ... yrs. ... mos. ... ds.

(Signed) P. V. Faust M. D.
8/11 1921 (Address) Deary

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Dry Ridge Cem. DATE OF BURIAL: 8/13 1921

20. UNDERTAKER: ... ADDRESS: ...

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED SEP 15 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35303

1. PLACE OF DEATH
County of Latah — Registration District No. 65
City of ..... (No. ..... St.) — Primary Registration District No. 2145
Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George A Henderson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Widowed

6. DATE OF BIRTH — Dec (Month) 15 (Day) 1 (Year)

7. AGE — 70 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country) Ohio

10. NAME OF FATHER Not known

11. BIRTHPLACE OF FATHER (State or Country) " " "

12. MAIDEN NAME OF MOTHER " " "

13. BIRTHPLACE OF MOTHER (State or Country) " " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Miss Mabel Henderson
(Address) Princeton Idaho

15. Filed 8/20/1921 — Dr. J.W. Thompson — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH — 8 (Month) 19 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 24 1921, to aug 19 1921, that I last saw h.... alive on aug 19 1921, and that death occurred on the date stated above, at 1.0 M.

The CAUSE OF DEATH* was as follows:
Cancer of the Stomach
(Duration) ..... Yrs. 9 mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. S. Le Pard M. D.
8/19/1921 (Address) Potlatch Idaho

*State the **Disease Causing Death**; or in deaths from **Violent Causes**, state (1) **Means of Injury**; and (2) whether **Accidental, Suicidal or Homicidal.**

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL — Freeze Cemetery — DATE OF BURIAL 8/21/1921

20. UNDERTAKER E. M. Freeze — ADDRESS Palouse

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 61
Primary Registration District No. 1011
File No. 35304
Registered No. 46

RECEIVED
SEP 15 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Latah
City of Moscow (St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Vandermale

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: May (Month) 6 (Day) 1870 (Year)

7. AGE: 51 Yrs. 3 Mos. 16 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Machine Worker
(b) General nature of industry, business or establishment in which employed (or employer): Furniture Factory

9. BIRTHPLACE (State or Country): Netherlands

10. NAME OF FATHER: Peter Vandermale

11. BIRTHPLACE OF FATHER (State or Country): Netherlands

12. MAIDEN NAME OF MOTHER: Lucy DE Roos

13. BIRTHPLACE OF MOTHER (State or Country): Netherlands

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs John Vandermale
(Address) Moscow

15. Filed 8/23 1921 W H Carothers Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 22 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 13, 1921, to July 26 1921. that I last saw him alive on July 21 1921. and that death occurred on the date stated above, at 7:40 P.M.

The CAUSE OF DEATH* was as follows:

Cancer of Stomach

(Duration) 1 Yrs. 3 mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. 00 mos. ..... ds.

(Signed) [signature] M. D.
8/23 1921 (Address) Spokane, Wash.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Moscow — DATE OF BURIAL: 8/24 1921

20. UNDERTAKER: Elam & Gray — ADDRESS: Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED SEP 15 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 61

Primary Registration District No. 1011

File No. 35305

Registered No. 45

County of Latah

City of Moscow, (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ernest Fuel,

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M.

4. COLOR OR RACE W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH Nov (Month) 24 (Day) 1849 (Year)

7. AGE 71 Yrs. 8 Mos. 27 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho,

10. NAME OF FATHER Edward Fuel,

11. BIRTHPLACE OF FATHER (State or Country) Kansas,

12. MAIDEN NAME OF MOTHER Mary Grauli.

13. BIRTHPLACE OF MOTHER (State or Country) Idaho,

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Edward Fuel,

(Address) Moscow,

15. Filed 9/22 1921 W H Carothers Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 21 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 18, 1921, to Aug. 21 1921, that I last saw h.im alive on Aug 21 1921, and that death occurred on the date stated above, at 11 09 M.

The ~~CAUSE~~ OF DEATH* was as follows:

Tubercular Meningitis

(Duration) —— Yrs. —— mos. 14 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. Stacy Erickson M. D.

9/22 1921 (Address) Moscow Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL ..... 19..

20. UNDERTAKER | ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

RECEIVED SEP 13 1921 BUREAU OF VITAL STATISTICS

Registration District No. 61

Primary Registration District No. 1011

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35306

Registered No. 47

1. PLACE OF DEATH

County of Latah

City of Moscow (If outside limits of city or village, give township) St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Malissa A. Crawford

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widowed

6. DATE OF BIRTH: Dec 30 1837 (Month) (Day) (Year)

7. AGE: 83 Yrs. 8 Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business or establishment in which employed (or employer): With Children

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER: Samuel H Collins

11. BIRTHPLACE OF FATHER (State or Country): Conn.

12. MAIDEN NAME OF MOTHER: Elizabeth Wheller

13. BIRTHPLACE OF MOTHER (State or Country): New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E. J. Crawford

(Address) Kendrick Idaho

15. Filed Aug 31 1921 M Hawthorn Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August 30 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 15 1919, to Aug 30th 1921 that I last saw her alive on Aug 30 1921 and that death occurred on the date stated above, at 8 P M.

The CAUSE OF DEATH* was as follows:

Cancer of Breast and Stomach

(Duration) Two Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. W. Havenson M. D.

8/31 1921 (Address) Moscow Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Moscow — DATE OF BURIAL: 9/1 1921

20. UNDERTAKER: Neill Bros — ADDRESS: Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED SEP 15 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 61

Primary Registration District No. 1011

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 3367

Registered No. 44

1. PLACE OF DEATH

County of Latah

City of Moscow (If outside limits, give township) St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Alba Alfred Haymond

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M.	White	Married

6. DATE OF BIRTH Sept. (Month) 16 (Day) 1864 (Year)

7. AGE 56 Yrs. 11 Mos. ~~20~~ 4 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Farmer.

(b) General nature of industry, business or establishment in which employed (or employer) Retired.

9. BIRTHPLACE (State or Country) Illinois.

10. NAME OF FATHER Edward Haymond

11. BIRTHPLACE OF FATHER (State or Country) Penn.

12. MAIDEN NAME OF MOTHER Mary McClure.

13. BIRTHPLACE OF MOTHER (State or Country) New York.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. A. A. Haymond

(Address) Moscow Idaho

15. Filed 8/21 1921 M. H. Carothers Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 20 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 17th, 1921, to Aug 20 1921

that I last saw him alive on Aug 20 1921

and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Uremia Caused by Nephritis

(Duration) Yrs. 3 mos. ..... ds.

Contributory (Secondary) Paralysis

(Duration) 4 yrs. ..... mos. ..... ds.

(Signed) W. A. Adair M. D.

8/24 1921 (Address) Moscow Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL — DATE OF BURIAL 19...

20. UNDERTAKER — ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33308

Registered No. 43

Registration District No. 101

Primary Registration District No. 1011

RECEIVED
SEP 15 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Latah

City of Moscow (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Anna Knudson.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F	White	Married

6. DATE OF BIRTH June (Month) 12 (Day) 1869 (Year)

7. AGE 52 Yrs. 2 Mos. 1 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Norway

10. NAME OF FATHER Peter Knudson

11. BIRTHPLACE OF FATHER (State or Country) Norway

12. MAIDEN NAME OF MOTHER Not known

13. BIRTHPLACE OF MOTHER (State or Country) Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Martin Knudson
(Address) Moscow

15. Filed Aug 15 1921 M H Smithers Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 13 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Died not attended by 19.. to 19.. that I last saw h.. alive on 19.., and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorage

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. N. Clarke M. D.

8/15 1921 (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Moscow	8/17 1921
20. UNDERTAKER	ADDRESS
Allen	

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11

RECEIVED SEP 10 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35309
Registered No. 41

1. PLACE OF DEATH. Registration District No. 61
County of Latah Primary Registration District No. 1011
City of Moscow (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John N Roush

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): Married

6. DATE OF BIRTH ..... 1 (Month) (Day) (Year)

7. AGE 76 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Carpenter
(b) General nature of industry business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): See

10. NAME OF FATHER: —

11. BIRTHPLACE OF FATHER (State or Country): See

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A Wunkle
(Address) Kendrick Ida

15. Filed Sept 1 1921 M. Carithers Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Aug 31 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 17 1921, to Aug 31 1921 that I last saw him alive on Aug 31 1921 and that death occurred on the date stated above, at 2:30 P.M.

The CAUSE OF DEATH* was as follows:

Paralysis due to Apoplexy

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

..... 19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place Gauthiers Hosp In the of death 76 yrs ..... mos ..... ds. State Ida yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? Kendrick Ida
Former or usual residence Kendrick Ida

19. PLACE OF BURIAL OR REMOVAL: Kendrick Ida
DATE OF BURIAL ..... 191...

20. UNDERTAKER: Glen Grice
ADDRESS: Moscow

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

FORM V. S. No. 5-25 M. 1-19.

RECEIVED SEP 6 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Clair 16.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35310

Registered No. 42

1. PLACE OF DEATH

County of Latah — Registration District No. 61

City of Moscow (No. ..... St.) — Primary Registration District No. 1011

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary E. Barnett

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Fem	White	Married

6. DATE OF BIRTH: Jan (Month) 29 (Day) 1842 (Year)

7. AGE: 79 Yrs. 6 Mos. ..... ds. — IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Home wife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Spangenburg

11. BIRTHPLACE OF FATHER (State or Country): Penn.

12. MAIDEN NAME OF MOTHER: Elizabeth Phillips

13. BIRTHPLACE OF MOTHER (State or Country): New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Fred Barnett
(Address) Moscow

15. Filed Aug 3 1921 W H Carithers Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August (Month) 2 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1 1921 to Aug 2 1921 that I last saw h.. alive on July 2 1921 and that death occurred on the date stated above, at 3 P M.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis

(Duration) Four Years. ..... mos. ..... ds.
Contributory (Secondary) Arteriosclerosis Rheumatism
(Duration) 12 yrs. ..... mos. ..... ds.

(Signed) J. N. Clark M. D.
8/3 1921 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Moscow — DATE OF BURIAL: 8/4 1921

20. UNDERTAKER: Neill Parlor — ADDRESS: Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

RECEIVED SEP 15 BUREAU OF VITAL STATISTICS

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35311

Registered No. 65

1. PLACE OF DEATH.

County of Lewis

Registration District No. 47

Primary Registration District No.

City of Nezperce Idaho No. St.)

If death occurs away from usual residence, give facts called for under special information. Route 2

2. FULL NAME Louis Ray Funkhauser

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	white	Single

6. DATE OF BIRTH. Aug. 4 (Month) (Day) 1921. (Year)

7. AGE ....Yrs. ....Mos. 22 ds. IF LESS than 1 day how many ....hrs. or ....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work....
(b) General nature of industry, business, or establishment in which employed (or employer) Infant

9. BIRTHPLACE (State or Country) Nezperce, Ida.

10. NAME OF FATHER George W. Funkhauser

11. BIRTHPLACE OF FATHER (State or Country) Nebraska.

12. MAIDEN NAME OF MOTHER Etta Marie Buer

13. BIRTHPLACE OF MOTHER (State or Country) Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Geo W Funkhauser
(Address) Nezperce R F D 2

15. Filed Sept 1 1921 Albert Huff Local Registrar

SYMS - YORK CO., PTRS. & BOOK. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug 26 (Month) (Day) 1921. (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 4 1921, to Aug 26 1921, that I last saw him alive on Aug 19 1921, and that death occured on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:

premature, weak child, developement that of 7 1/2 month intra-uterine

(Duration) Yrs. mos. 22 ds.

Contributory (Secondary)

(Duration yrs. mos. ds.

(Signed) P. C. Reuelata M. D.

9-7-1921 (Address) Craigmont, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death....yrs....mos....days. In the State....yrs....mos....days

Where was disease contracted if not at place of death?....

Former or usual residence ....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Nezperce Cemetery	Aug 27 1921
20. UNDERTAKER A. Huff	ADDRESS Nezperce,

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

Form V. S. No. 5. 12½M.7-24-11 RECEIVED SEP 10 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35312
Registered No. 67

1. PLACE OF DEATH. Registration District No. 47
County of Lewis Primary Registration District No.
City of Nezperce (No. , St.)
If death occurs away from usual residence, give facts called for under special information. Idaho

2. FULL NAME Florence Elmore Cargill

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
female	white	Child

6. DATE OF BIRTH Oct 8. 1909
11 (Month) 10 (Day) 3 (Year)

7. AGE ..... yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... Child
(b) General nature of industry business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Nezperce Idaho

10. NAME OF FATHER James T Cargill

11. BIRTHPLACE OF FATHER (State or Country) Monmouth Ill.

12. MAIDEN NAME OF MOTHER Jeane Sophi Steinfadten

13. BIRTHPLACE OF MOTHER (State or Country) Pendleton Ore

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs James Cargill
(Address) Nezperce

15.
Filed Sept 1 1921 Albert Huff Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Aug. 26, 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 26, 1921, to Aug. 26, 1921 that I last saw her alive on Aug 26, 1921 and that death occurred on the date stated above, at 10:30 P.M.

The CAUSE OF DEATH* was as follows:
Diphtheria (Laryngeal)

..... (Duration) — yrs. — mos. 3 ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) S. J. Darby, M. D.
Aug 31, 1921 (Address) Nezperce Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds.
In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Nezperce Catholic Cemetery	Aug 28 1921
20. UNDERTAKER	**ADDRESS**
Albert Huff	Nezperce Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

RECEIVED OCT 3 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35313
Registered No. 69

1. PLACE OF DEATH. Registration District No. 47
County of Lewis Primary Registration District No.
City of Nezperce Village (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Russel Lee Flora

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Child

6. DATE OF BIRTH: April (Month) 11 (Day) 1913 (Year)

7. AGE: 8 yrs. 5 mos. 10 ds. IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Twin Falls Idaho

10. NAME OF FATHER: Fred A. Flora

11. BIRTHPLACE OF FATHER (State or Country): Maxwell Iowa

12. MAIDEN NAME OF MOTHER: Maud Fahrney

13. BIRTHPLACE OF MOTHER (State or Country): Maryland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant):
(Address):

15. Filed 9-29 1921 Albert Huff Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Sept. (Month) 21, (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 16, 1921, to Sept. 21, 1921 that I last saw h[illegible] alive on Sept. 21, 1921 and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:
Poliomyelitis, Acute.

(Duration) — yrs. — mos. 5 ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) J. J. Darby M. D.
Sept 29 1921 (Address) Nezperce Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: At Nezperce Cemetery — DATE OF BURIAL: 9-22-1921

20. UNDERTAKER: Albert Huff — ADDRESS: Nezperce Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35315

1. PLACE OF DEATH.
County of Latah
City of Kamiah (No. St.)
Registration District No. 49
Primary Registration District No. 4924
If death occurs away from usual residence, give facts called for under special information.

RECEIVED SEP 13 1921 BUREAU OF VITAL STATISTICS

2. FULL NAME Thomas William Shaw
Registered No.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: ½ Indian White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH. Aug (Month) 9 (Day) 1921 (Year)
7. AGE ..... Yrs. ..... Mos. 19 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work... Child
(b) General nature of industry, business, or establishment in which employed (or employer).....
9. BIRTHPLACE (State or Country) Idaho
10. NAME OF FATHER Asa Shaw
11. BIRTHPLACE OF FATHER (State or Country) Arkansas
12. MAIDEN NAME OF MOTHER Clotilda Ingenly
13. BIRTHPLACE OF MOTHER (State or Country) Utah
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) .....
(Address) A S Shelton
15. Filed 8/29 1921 C J Johnson Local Registrar

SYMS - YORK CO., PTRS. & SDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 28 (Day) 1921 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Aug 25th 1921, to Aug 28 1921, that I last saw him alive on Aug 28 1921, and that death occured on the date stated above, at 5 P.M.
The CAUSE OF DEATH* was as follows: Tuberculosis Intestinal
(Duration) ..... Yrs. ..... mos. 7 ds.
Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) C J Bergren M. D.
Aug 29 1921 (Address) Kamiah Ida

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Nez Perce Kamiah Ida — DATE OF BURIAL: 8/29 1921
20. UNDERTAKER: C J Johnson — ADDRESS: Kamiah Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35317
Registered No.

RECEIVED
SEP 15 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Lewis
City of Kamiah (No. St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 41
Primary Registration District No. 141

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Welch

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
male	White	single (Write the word.)

6. DATE OF BIRTH: Aug (Month) 23 (Day) 1921 (Year)

7. AGE: ....Yrs....Mos....ds. IF LESS than 1 day how many 11 hrs. or ....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Henry Welch

11. BIRTHPLACE OF FATHER (State or Country) Iowa

12. MAIDEN NAME OF MOTHER Vinnie Hawkins

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Henry Welch
(Address)

15. Filed 9/24 1921
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 23 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from August 19..., to August 19..., that I last saw him alive on August 19..., and that death occurred on the date stated above, at ....M.
The CAUSE OF DEATH* was as follows:
Pneumonia
(8 months)
(Duration) ....Yrs....mos....ds.
Contributory (Secondary)
(Duration) ....yrs....mos....ds.
(Signed) [illegible] M. D.
Aug 22 1921 (Address) Kamiah

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the State ....yrs....mos....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Jos. J. Cem. Kamiah Ida	8/24 1921
20. UNDERTAKER	ADDRESS
[illegible]	Kamiah

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

Form V. S. No. 5 20M.1-16-12

RECEIVED

SEP 1921

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 100

County of Madison Registration District No. 2178

File No. 35320

City of Rexburg (No. , St.)

Registered No. 70

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John R. Watson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)
Male	White	Single

6. DATE OF BIRTH: August (Month) 27. (Day) 1921 (Year)

7. AGE: XX yrs. XX mos. 3 ds. IF LESS than 1 day how many ..... *hrs. or* ..... *mins.*

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... child
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Rexburg, Idaho.

10. NAME OF FATHER Geo. Watson

11. BIRTHPLACE OF FATHER (State or Country) Iowa

12. MAIDEN NAME OF MOTHER Ruby Martin

13. BIRTHPLACE OF MOTHER (State or Country) Rexburg, Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Geo. Watson.

(Address) .....

15. Filed 8/30 1921 G. L. Eske Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: August (Month) 30 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 27 1921, to Aug 30 1921, that I last saw h~~im~~ alive on Aug 30 1921 and that death occurred on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:

Hemorrhage of Bowel
(Hemophelia)

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory .....
(Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Parley Nelson M. D.

Aug 30 1921 (Address) Rexburg Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rexburg City Cemetery — DATE OF BURIAL: Aug. 31, 1921

20. UNDERTAKER Rexburg Furn. — ADDRESS Rexburg, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-18

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
SEP 15 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH. Registration District No. 100
County of Madison Subdivision Registration District No. 2178
City of Rexburg (If not in incorporated city or village give township) St.)
File No. 35321
Registered No. 69

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Martha Fern Proctor

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE:

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Infant

6. DATE OF BIRTH. August (Month) 21 (Day) 1921 (Year)

7. AGE: Yrs. ..... Mos. 12 Ds. ..... IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: L. H. Proctor

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Nora Irvine Godfrey

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) L. H. Proctor
(Address) Rexburg, Ida.

15. Filed 9/15 1921 G. L. Espe Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. (Month) 5, (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Hemoplegia
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... Yrs. ..... mos. ..... ds.
(Signed) G. L. Espe M. D.
19... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rexburg, Idaho — DATE OF BURIAL: 9-6 1921

20. UNDERTAKER: David Young — ADDRESS: Rexburg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

M...VED FOR BINDING

BYRD - YORK CO., PTRS. & BDRS. 24954

FORM V. S. No. 5-12 M-6-1921

CERTIFICATE OF DEATH

RECEIVED
SEP 15 1921
BUREAU OF VITAL STATISTICS

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 100
Primary Registration District No. 2178
File No. 35322
Registered No. 628

1. PLACE OF DEATH
County of Fremont
City of Marysville
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lucile Hibbard

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Bale

6. DATE OF BIRTH. Aug (Month) 4 (Day) 1921 (Year)

7. AGE ..... Yrs. ..... Mos. 27 ds.
IF LESS than 1 day how many .... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Bale
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Rexburg

10. NAME OF FATHER: Willis Hibbard

11. BIRTHPLACE OF FATHER (State or Country): Rexburg

12. MAIDEN NAME OF MOTHER: Alice Jones

13. BIRTHPLACE OF MOTHER (State or Country): Rexburg

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Willis Hibbard
(Address) Marysville

15. Filed 9/2 1921. G B Tempe Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 31 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 3 1921 to Aug 10 1921
that I last saw her alive on Aug 10 1921
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Peritonitis

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... Yrs. ..... mos. ..... ds.

9/2 1921. (Signed) Louise F Riehl M. D.
(Address) Rexburg Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Sugar — DATE OF BURIAL: 9/3 1921

20. UNDERTAKER: J T Young — ADDRESS: Rexburg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
SEP 15 1921
BUREAU OF VITAL STATISTICS

Registration District No. 100
Primary Registration District No. 7178

File No. 35323
Registered No. 71

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Madison
City of Rexburg (or) (Ward) (St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elizabeth Ann Afford Van Dreele

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Widowed

6. DATE OF BIRTH: June (Month) 27 (Day) 1842 (Year)

7. AGE: 81 yrs. 1 mos. 29 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: John Afford

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Fannie Wheeler

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ernest Shields
(Address) Rexburg Ida

15. Filed 8/22 1921 G G Espe
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Aug (Month) 21 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1 1919, to Aug 21 1921, that I last saw her alive on Aug 19 1921 and that death occurred on the date stated above, at 4:15 P.M.

The CAUSE OF DEATH* was as follows:
Carcinoma of Rectum

(Duration) yrs. 2 mos. 2 ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) G G Parkinson M.D.
19 (Address) Rexburg Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Rexburg Ida.	Aug 23 1921
20. UNDERTAKER: Rexburg Furn Co. John Phillips	ADDRESS: Rexburg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35324
Registered No. 92

1. PLACE OF DEATH
County of Madison
City or ###### Pincock Springs
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 100
Primary Registration District No. 2178
No. ..... St.)

RECEIVED
SEP 15 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME Matilda J. Cluff

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
F	W	Single

6. DATE OF BIRTH. Sept (Month) 25 (Day) 1906 (Year)

7. AGE 14 Yrs. 11 Mos. 5 ds. IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: William D Cluff.

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Mabel E Bates

13. BIRTHPLACE OF MOTHER (State or Country): California.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) [illegible]
(Address) Canyon Creek

15. Filed Sept 2 1921 G L Teape
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
August (Month) 30 (Day) 1921 191 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191 to 191
that I last saw h....alive on 191
and that death occurred on the date stated above, at 5 p. M.

The CAUSE OF DEATH* was as follows:
Acidental Drowing while
bathing at Pincock hot Spring

(Duration) .... Yrs. .... mos. .... ds.

Contributory (Secondary)
(Duration) .... Yrs. .... mos. .... ds.

(Signed) [illegible] Coroner M. D.
19.... (Address) Rexburg Madison C

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the State....yrs....mos....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL [illegible] DATE OF BURIAL 191

20. UNDERTAKER ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED SEP 15 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 19
Primary Registration District No. 2015

File No. 35325
Registered No. 32

1. **PLACE OF DEATH**

County of Minidoka

City of Rupert (If outside limits, give township) St.)

If death occurs away from usual residence, give facts called for under special information.

2. **FULL NAME** Arvilla G Trent

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. **SEX**: Fem

4. **COLOR OR RACE**: White

5. **SINGLE, MARRIED, WIDOWED OR DIVORCED** (Write the word.): Married

6. **DATE OF BIRTH**: May (Month) 16 (Day) 1885 ~~1924~~ (Year)

7. **AGE**: 36 Yrs. 1 Mos. 9 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. **OCCUPATION**
(a) Trade, profession or particular kind of work: House Wife
(b) General nature of industry, business or establishment in which employed (or employer):

9. **BIRTHPLACE** (State or Country): Idaho

10. **NAME OF FATHER**: William Shaw

11. **BIRTHPLACE OF FATHER** (State or Country): Missouri

12. **MAIDEN NAME OF MOTHER**: Lena Whitehouse

13. **BIRTHPLACE OF MOTHER** (State or Country): Nevada

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**
(Informant) William R Shaw
(Address) Counsil Idaho Darting Ranch

15. Filed Sept 16 1921 E H Elmore Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH**: June (Month) 25 (Day) 1921 (Year)

17. **I HEREBY CERTIFY**, That I attended deceased from April 28 1921, to June 25 1921 that I last saw her alive on June 25 1921 and that death occurred on the date stated above, at 2 P. M.

The **CAUSE OF DEATH*** was as follows:
Acute Endocarditis

(Duration) ..... Yrs., ... mos. ..... ds.

Contributory (Secondary) Chronic Migraine

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E H E Elmore M. D.
8 12 1921 (Address) Rupert Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. **PLACE OF BURIAL OR REMOVAL**: K. P. Cemetery Rupert — **DATE OF BURIAL**: June 28 1921

20. **UNDERTAKER**: W. O. Goodman — **ADDRESS**: Rupert Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED SEP 15 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 19
Primary Registration District No. 2015
File No. 35326
Registered No. 31

1. PLACE OF DEATH

County of Minidoka
City of Paul (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Emma K Kuhl

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6. DATE OF BIRTH: Dec (Month) 25 (Day) 1845 (Year)

7. AGE: 75 Yrs. 7 Mos. 7 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House Wife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Russia

10. NAME OF FATHER: Andrew Ruhl

11. BIRTHPLACE OF FATHER (State or Country): Russia

12. MAIDEN NAME OF MOTHER: ~~~~

13. BIRTHPLACE OF MOTHER (State or Country): Russia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Gottfried Kuhl
(Address) Paul Idaho

15. Filed Sept 6 1921 — O W Johnson, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 6 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from aug 4 1921, to aug 6 1921
that I last saw her alive on aug 4 1921
and that death occurred on the date stated above at ..... M.
The CAUSE OF DEATH* was as follows:
Apoplexy followed by Paralysis

(Duration) Yrs. 2 mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H F Adams M. D.
8-9 1921 (Address) Paul, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Paul Cemetery — DATE OF BURIAL: Aug 7 1921
20. UNDERTAKER: W. G. Goodmen — ADDRESS: Rupert

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED SEP 15 1921 BUREAU OF STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Nez Perce — Registration District No. 96

City of Lewiston (No. ..... St.) — Primary Registration District No. 1009

File No. 35327

Registered No. 695

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George Morrison

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word.)
Male	White	Div

6. DATE OF BIRTH ..... (Month) ..... (Day) 1 (Year)

7. AGE 62 (perhaps.) Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) No. Carolina

10. NAME OF FATHER Wm. Harrison Morrison

11. BIRTHPLACE OF FATHER (State or Country) Va.

12. MAIDEN NAME OF MOTHER Lucinda Reed

13. BIRTHPLACE OF MOTHER (State or Country) No. Carolina

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) R. B. Warren

(Address) Lewiston, Idaho

15. Filed Sept-9-21, 1921 — Frank E. Bruce, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 18th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 15 1921, to Aug 18 1921, that I last saw h.m alive on Aug 18 1921, and that death occurred on the date stated above, at 10-35 A.M.

The CAUSE OF DEATH* was as follows:

Gumma of Brain

(Duration) 2 Yrs. ..... mos. ..... ds.

Contributory (Secondary) Syphilis

(Duration) 12 yrs. ..... mos. ..... ds.

(Signed) Edgar L. White M. D.

Aug 20 1921 (Address) Lewiston Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Normal Hill Cemetery	Aug 21 1921
20. UNDERTAKER	ADDRESS Lewiston Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

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FORM V. S. No. 5-25 M. 1-19.

RECEIVED SEP 15 1921 BUREAU OF VITAL STATISTICS

41

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 35328
Registered No. 693

1. PLACE OF DEATH
County of Nezperce
City of Lewiston (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Louisa Wise Defenbach
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6. DATE OF BIRTH: July (Month) 22 (Day) 1870 (Year)

7. AGE: 51 Yrs. 1 Mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer): "

9. BIRTHPLACE (State or Country): Ill.

10. NAME OF FATHER: John Wise

11. BIRTHPLACE OF FATHER (State or Country): N. J.

12. MAIDEN NAME OF MOTHER: Mary Sherwood

13. BIRTHPLACE OF MOTHER (State or Country): N. J.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Byron Defenbach
(Address) 928 Idaho St

15. Filed Sept 9 1921 Simon E Burn Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August (Month) 26th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 12 1921, to Aug 26 1921
that I last saw h[illegible] alive on Aug 26 1921
and that death occurred on the date stated above, at 6 P. M.
The CAUSE OF DEATH* was as follows:
Post operative Shock
following Carcinoma of Sigmoid removal.
6 hrs.
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Carcinoma of Sigmoid
(Duration) 2 yrs. ..... mos. ..... ds.
(Signed) Edgar L White M. D.
Aug 27 1921 (Address) Lewiston Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Normal Hill Cemetery
DATE OF BURIAL: 9/8 1921.
20. UNDERTAKER
ADDRESS: Lewiston Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-A—25 M. 1-19.

Carrsow

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35329

Registered No. 692

RECEIVED
SEP 15 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Nez Perce Registration District No. 96

Primary Registration District No. 1009

City of Lewiston (If outside limits, give township) St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Leona Tabor

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: ~~(Write the word.)~~ Widowed

6. DATE OF BIRTH: June (Month) 9 (Day) 1892 (Year)

7. AGE: 29 Yrs. 2 Mos. 11 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wash

10. NAME OF FATHER: Jas. Bly

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Alma Whitmore

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Joe L Bly

(Address)

15. Filed Sept 9th 1921 Susan E Bruce Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 20th (Day) 1921. (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 8th 1921, to Aug 20th 1921 that I last saw her alive on Aug 20 1921, and that death occurred on the date stated above, at 11:45 M.

The CAUSE OF DEATH* was as follows:

Toxemia

(Duration) Yrs. 1 mos. 26 ds.

Contributory (Secondary) Abscess Pancreas

(Duration) yrs. 1 mos. 2½ ds.

(Signed) O. C. Carrsow M. D.

8/21 1921 (Address) Lewiston Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Normal Hill Cemetery

DATE OF BURIAL: Aug 22 1921

20. UNDERTAKER: [illegible] UNDERTAKING CO

ADDRESS: Lewiston, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
SEP 15 1921
BUREAU OF VITAL STATISTICS

Registration District No. 96
Primary Registration District No. 1009
File No. 35330
Registered No. 683

1. PLACE OF DEATH
County of Nez Perce
City of Lewiston (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Pvt. Edward Fowler
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1 (Year)

7. AGE: 6 5 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Steve Fowler

11. BIRTHPLACE OF FATHER (State or Country): ✓

12. MAIDEN NAME OF MOTHER: Mary

13. BIRTHPLACE OF MOTHER (State or Country): ✓

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. E. Fowler
(Address) 0207 - 6th St. City

15. Filed Sept 9 1921. Susan E. Bruce Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 7th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw him alive on ..... 19.....
and that death occurred on the date stated above, at 7P M.
The CAUSE OF DEATH* was as follows:
Death from accidental drowning. Dead when seen by me about 20 minutes after being taken from water.
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Paul D. Johnson M. D.
8/9 1921 (Address) Lewiston, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Lewiston Ida — DATE OF BURIAL: 8/9 1921

20. UNDERTAKER — ADDRESS: Lewiston Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35331
Registered No. 684

RECEIVED
SEP 15 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
Registration District No. 96
Primary Registration District No. 1009
County of Nez Perce
City of Lewiston (St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Albert L. Fowler
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH July 6 1905
(Month) (Day) (Year)

7. AGE 16 Yrs. 1 Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Student
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Colo

10. NAME OF FATHER P. Edward Fowler

11. BIRTHPLACE OF FATHER (State or Country) Iowa

12. MAIDEN NAME OF MOTHER Fannie Burnham

13. BIRTHPLACE OF MOTHER (State or Country) N. Y.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. E. Fowler
(Address) 0207 - 6th St city.

15. Filed Sept-9 1921 Susan E. Bruce
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August 7th 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ——, 19..., to ——, 19...
that I last saw him alive on ——, 19...
and that death occurred on the date stated above, at 7 P. M.
The CAUSE OF DEATH* was as follows:
Death from accidental drowning. Dead when seen by me about 20 minutes after being taken from the water.
(Duration) hrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) Paul W. Johnson M. D.
8/9 1921 (Address) Lewiston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Lewiston Ida — DATE OF BURIAL 8/9 1921

20. UNDERTAKER — ADDRESS Lewiston Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
SEP 15 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

White

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35332

Registered No. 685

1. PLACE OF DEATH

Registration District No. 96

Primary Registration District No. 1009

County of Nez Perce

City of Lewiston (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Stillborn Harmon

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Aug (Month) 7 (Day) 1921 (Year)

7. AGE: — Yrs. — Mos. — ds.

IF LESS than 1 day how many 0 hrs. or 10 min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Stillborn

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: A. J. Harmon

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER: Alva A.

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15. Filed Sept 9 1921 Susan E. Bruce
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 7 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 7 1921 to Aug 7 1921 that I last saw h.im alive on Aug 7 1921, and that death occurred on the date stated above, at 4:50 A.M.

The CAUSE OF DEATH* was as follows:

Premature birth. 5½ Mo.

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Edgar L. Wheeler M. D.

Aug 7 1921 (Address) Lewiston Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston Cemetery

DATE OF BURIAL ..... 19.....

20. UNDERTAKER

ADDRESS Lewiston, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED
SEP 15 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 35333
Registered No. 686

1. PLACE OF DEATH

County of Nez Perce
City of Lewiston (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Harold J. Mossman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.) Single

6. DATE OF BIRTH Mar 21 1901 (Month) (Day) (Year)

7. AGE 20 Yrs. 4 Mos. 19 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Motor Cycle

(b) General nature of industry, business or establishment in which employed (or employer): Police

9. BIRTHPLACE (State or Country) Uniontown Wash.

10. NAME OF FATHER Adelbert Mossman

11. BIRTHPLACE OF FATHER (State or Country) Holland

12. MAIDEN NAME OF MOTHER Crescencia Lemb

13. BIRTHPLACE OF MOTHER (State or Country) Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A. Mossman

(Address) Uniontown Wash

15. Filed Sept-9 1921 Susan E Bruce Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug 9 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 7 1921 to Aug 9 1921 that I last saw h[e] alive on Aug 9 1921, and that death occurred on the date stated above, at 6 P M.

The CAUSE OF DEATH* was as follows: Fracture base of Skull.

(Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary) Accidental Fall from Motor Cycle.

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas W. Alley M. D.

9 9 1921 (Address) Lewiston

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Uniontown Wash — **DATE OF BURIAL** 8/11 1921

20. UNDERTAKER [illegible] UNDERTAKING CO. — **ADDRESS** Lewiston Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

Broddock

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35334

Registered No. 667

RECEIVED
SEP 10 1921
BUREAU OF VITAL STATISTICS

Registration District No. 7 6

Primary Registration District No. 7 2 2

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Nez Perce

City of Lewiston (No.) (St.)

2. FULL NAME Rena Livingston

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Dec 25 1874 (Month) (Day) (Year)

7. AGE: 46 Yrs. 7 Mos. 11 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mo.

10. NAME OF FATHER: Riley Towe

11. BIRTHPLACE OF FATHER (State or Country): Kentucky

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Orville Livingston

(Address) 522 6th Ave.

15. Filed Sept-9 1921

Pearl E Bruce
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug 11 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 11 1921 to Aug 11 1921 that I last saw h.er alive on Aug 11 1921 and that death occurred on the date stated above, at 8-2 M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 40 Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) E H Broddock M. D.

Aug 12 1921 (Address) Lewiston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston Ida — DATE OF BURIAL: 8/11/1921

20. UNDERTAKER — ADDRESS: Lewiston Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED SEP 19 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 35335
Registered No. 688

1. PLACE OF DEATH
County of Nez Perce
City of Lewiston (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Isabelle E. Bassar

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: May (Month) 14 (Day) 1850 (Year)

7. AGE: 71 Yrs. 3 Mos. 7 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Nova Scotia Canada

10. NAME OF FATHER: Chas McClellan

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Sl Elizabeth [illegible]

13. BIRTHPLACE OF MOTHER (State or Country): Nova Scotia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Conn. Bassar Williamson
(Address) 407 - 6th Ave Lewiston

15.
Filed Sept 9 1921 Susan E Busse
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 13th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 26th. 1921, to Aug. 13th. 1921, that I last saw her alive on Aug. 13th. 1921, and that death occurred on the date stated above, at 2.20 P.M.

The CAUSE OF DEATH* was as follows:
Peritonitis
(Duration) ..... Yrs. ..... mos. 3 days ds.
Contributory (Secondary) Operative
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. F. McMahan M. D.
19..... (Address) Lewiston, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston Ida — DATE OF BURIAL: 8/16.1921

20. UNDERTAKER: Bassar Undertaking Co. — ADDRESS: Lewiston Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35336

Registered No. 689

1. PLACE OF DEATH

County of Nez Perce — Registration District No. 96

City of Lewiston (No. ..... St.) — Primary Registration District No. 1009

RECEIVED SEP 15 1921 BUREAU OF VITAL STATISTICS

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Peter John Estvoldt

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: June (Month) 14 (Day) 1886 (Year)

7. AGE: 35 Yrs. 2 Mos. 2 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Merchant.

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Nithoorn Holland

10. NAME OF FATHER: John Peter

11. BIRTHPLACE OF FATHER (State or Country): Holland

12. MAIDEN NAME OF MOTHER: Henrietta Munnik

13. BIRTHPLACE OF MOTHER (State or Country): Holland.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Golda Estvoldt

(Address) Bovill Idaho

15. Filed Sept-9 1921 — Susan E Bruce, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 16th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 19 1921, to Aug 16 1921, that I last saw he was alive on Aug 14 1921, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Paul W Johnson M. D.

Aug 18 1921 (Address) Lewiston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston Ida — DATE OF BURIAL: 8/17 19

20. UNDERTAKER: Bassett Und. Co — ADDRESS: Lewiston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35337
Registered No. 691

RECEIVED
SEP 15 192
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Nez Perce
City of Lewiston, (No. / St.)
Registration District No. 96
Primary Registration District No. 1009
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Florence White Scudder
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Sept. (Month) 20th (Day) 1899 (Year)

7. AGE: 21 Yrs. 9 Mos. 29 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ames, Iowa

10. NAME OF FATHER: Frank E. White

11. BIRTHPLACE OF FATHER (State or Country): Lenona, Ill

12. MAIDEN NAME OF MOTHER: Marion Burton

13. BIRTHPLACE OF MOTHER (State or Country): Rock, Co. Wis.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Frank E. White
(Address) Clarkston, Wash.

15. Filed Sept 9 1921 Susan E. Bruce
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 8 (Month) — 18 (Day) — 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 8-17-1921, to 8-18-1921, that I last saw h[illegible] alive on 8-18-1921, and that death occurred on the date stated above, at 1:50 P.M.

The CAUSE OF DEATH* was as follows:
Acute intestinal obstruction

(Duration) ..... Yrs. ..... mos. 2 ds.
Contributory (Secondary) Adhesions
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. F. McNaughton M. D.
8-20 1921 (Address) Lewiston

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Clarkston, Wash
DATE OF BURIAL: 8/21/21 19

20. UNDERTAKER: L. L. Merchant
ADDRESS: Clarkston, Wn.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35338
Registered No. 27

1. PLACE OF DEATH

County of Oneida
City of Malad (If outside limits of city or village, give township.) St.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
SEP 15 1921
BUREAU OF VITAL STATISTICS

Registration District No.
Primary Registration District No.

2. FULL NAME Samuel Ruegsetter

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	White	Widowed

6. DATE OF BIRTH: June (Month) 6 (Day) 1843 (Year)

7. AGE: 78 Yrs. 1 Mos. 24 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Switzerland

10. NAME OF FATHER: Samuel Ruegsetter

11. BIRTHPLACE OF FATHER (State or Country): Switzerland

12. MAIDEN NAME OF MOTHER: Elizabeth Mutti

13. BIRTHPLACE OF MOTHER (State or Country): Switzerland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Rudolph Ruegsegger
(Address) Daniels Ida

15.
Filed ..... 19 .....
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 3 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 3 1921, to Aug 3 1921, that I last saw h— alive on Aug 3 1921, and that death occurred on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:
Concussion of Brain
6 hours.
(Duration) Yrs. mos. ds.
Contributory (Secondary) Hit by Runaway Pole.
(Duration) yrs. mos. ds.

(Signed) J. M. Stevens M. D.
8/4 1921 (Address) Malad Ida

*State the **Disease Causing Death**; or in deaths from **Violent Causes**, state (1) ***Means of Injury***; and (2) whether ***Accidental, Suicidal or Homicidal.***

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Riverdale Mt. — DATE OF BURIAL: 8-7 1921

20. UNDERTAKER: D. E. Johnson — ADDRESS: Malad

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35339
Registered No. 28

1. PLACE OF DEATH
County of Oneida
City of Malad
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 26
Primary Registration District No. 2069
No. ..... St.)

RECEIVED
SEP 15 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME Mary MacDaniels.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: married (Write the word.)

6. DATE OF BIRTH: Dec 18 (Month) 1876 (Day) 1 (Year)

7. AGE: 44 Yrs. 8 Mos. 6 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Oneida Co Idaho

10. NAME OF FATHER: Charles Bolingbroke

11. BIRTHPLACE OF FATHER (State or Country): Missouri.

12. MAIDEN NAME OF MOTHER: Margaret Roberts

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) George Macdaniels
(Address) Malad Idaho.

15. Filed Sept 6 1921 — J. T. Mavee M.D. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 22 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 20 1921, to Aug 22 1921, that I last saw her alive on Aug 22 1921, and that death occurred on the date stated above, at 8 P.M.

The CAUSE OF DEATH* was as follows:
Placenta Previa.
Hemorrhage

(Duration) ..... Yrs. ..... mos. 2 ds.
Contributory (Secondary) Placenta Previa

(Duration) ..... yrs. ..... mos. 2 ds.

(Signed) J. M. Jones M. D.
8/25 1921 (Address) Malad Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Malad Ida — DATE OF BURIAL: 8-26 1921

20. UNDERTAKER: D. E. Johnson 129 — ADDRESS: Malad

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35340
Registered No. 29

RECEIVED
SEP 15 19
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Oneida
City of Malad (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 26
Primary Registration District No. 2069

2. FULL NAME Iris Eldorine Fifield

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Child

6. DATE OF BIRTH: Dec (Month) 8 (Day) 1920 (Year)

7. AGE: Yrs. 8 Mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) Child

9. BIRTHPLACE (State or Country) Malad.

10. NAME OF FATHER Albert M. Fifield

11. BIRTHPLACE OF FATHER (State or Country) Weston Idaho

12. MAIDEN NAME OF MOTHER Sarah S Price

13. BIRTHPLACE OF MOTHER (State or Country) Malad Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Albert M Fifield.
(Address) Malad Idaho

15. Filed Sept 6 19 21 — R M Mauer M.D. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 24 (Day) 19 21 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 18 19 21 to Aug 24 19 21, that I last saw h.. alive on Aug 24 19 21, and that death occurred on the date stated above, at 10 M.
The CAUSE OF DEATH* was as follows:
Dysentery
(Duration) ..... Yrs. 1 mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) R T. Mauer M. D.
Aug 25 19 21 (Address) Malad, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Malad — DATE OF BURIAL: Aug 26 19 21

20. UNDERTAKER: Woodland Furn. Co — ADDRESS: Malad

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 3534 1

Registered No. 31

1. PLACE OF DEATH

RECEIVED
OCT 4 1921
BUREAU OF VITAL STATISTICS

Registration District No. 4

Primary Registration District No. 1008

County of Payette

City of Payette (If outside limits of city or village, give township) (No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Unnamed

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	White	Single

6. DATE OF BIRTH: Sept (Month) 4 (Day) 1921 (Year)

7. AGE: ....Yrs....Mos. 2 ds. IF LESS than 1 day how many....hrs. or....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work....
(b) General nature of industry, business or establishment in which employed (or employer)....

9. BIRTHPLACE (State or Country) Payette Idaho

10. NAME OF FATHER Ed Holt

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER Pearl Forbes

13. BIRTHPLACE OF MOTHER Nebraska (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs B. J. Forbes
(Address) 923 N. 7th St.

15. Filed Sept 6 1921 J C Woodward Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 6 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 4 1921, to Sept 6 1921, that I last saw him alive on Sept 6 1921, and that death occurred on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:
Trauma incident to difficult Labor

....(Duration) ....Yrs....mos....ds.

Contributory (Secondary)....

....(Duration) ....yrs....mos....ds.

(Signed) O. H. Avery M. D.

9/6/1921 (Address) Payette Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death....yrs....mos....days. In the State....yrs....mos....days

Where was disease contracted if not at place of death?....

Former or usual residence....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Payette Ida	Sept 7 1921

20. UNDERTAKER	ADDRESS
Mrs B J Forbes	Payette Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED OCT 4 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 4

County of Fayette

Primary Registration District No. 1008

File No. 35342

City of Fayette (No. ..... St.)

Registered No. 32

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Allen E Hood

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6. DATE OF BIRTH: Dec (Month) 18 (Day) 852 (Year)

7. AGE: 69 Yrs. 10 Mos. 2 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Realtor

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Penn

10. NAME OF FATHER: Richardson Hood

11. BIRTHPLACE OF FATHER (State or Country): Penn

12. MAIDEN NAME OF MOTHER: Not Known

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Oldwood.

(Address) Pocatello, Idaho.

15. Filed Sept 24 1921 J C Woodward Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 20 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....

that I last saw h..... alive on ..... 19.....,

and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Accident at R R Crossing about six miles north of Fayette Automobile struck by train

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. F. Knight Coroner

Sept 20 1921 (Address) New Plymouth

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Fayette Ida — DATE OF BURIAL: Sept 23 1921

20. UNDERTAKER: J T Cedarholm — ADDRESS: Fayette Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

RECEIVED OCT 4 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Payette — Registration District No. 4
City of Payette — Primary Registration District No. 1008
(No. ..... St.)
File No. 35343
Registered No. 33

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Bosch

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Nov 22 1860 (Month) (Day) (Year)

7. AGE: 60 Yrs. 10 Mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: John Bosch

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Not Known

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Mrs Wm Bosch
(Address): Payette Idaho

15. Filed Sept 28 1921 J C Woodward Local Registrar

SYMS-YORK CO. PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept 20 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 16 1921, to Sept 20 1921 that I last saw him alive on Sept 19 1921, and that death occurred on the date stated above, at 3 A.M.

The CAUSE OF DEATH* was as follows:
Acute Bulbar Paralysis

(Duration) ..... Yrs. ..... mos. 4 ds.
Contributory (Secondary) Chronic interstitial nephritis (Duration) Indefinite mos. ds.

(Signed) O. H. Avery M. D.
9/24/1921 (Address) Payette Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Payette Ida — DATE OF BURIAL: 9-25 1921
20. UNDERTAKER: J Medair Payette — ADDRESS: Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

RECEIVED OCT 4 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35344

Registered No. 34

1. PLACE OF DEATH

County of Payette Registration District No. 4

City of Payette (No. , St.) Primary Registration District No. 1008

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Cooper

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Sept 20 (Month) (Day) 1839 (Year)

7. AGE: 82 Yrs. — Mos. 9 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer): Retired

9. BIRTHPLACE (State or Country): Penn

10. NAME OF FATHER: Thomas Cooper

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Elizabeth Hare.

13. BIRTHPLACE OF MOTHER (State or Country): Maryland.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Mrs. Lillie E. Doratty.
(Address): Payette Ida.

15. Filed Sept. 30 1921 J. O. Woodward Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: September (Month) 29 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1921, to Sept. 29 1921, that I last saw him alive on Sept 28 1921, and that death occurred on the date stated above, at 1:30 P.M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(Duration) ? Yrs. ? mos. ? ds.

Contributory (Secondary): old age

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F. A. McDonald M. D.

19 ..... (Address) Payette Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
F. A. Payette	9-30 1921
20. UNDERTAKER	ADDRESS
F. A. McLean	Payette Ida

OREGON STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH — State Registered No.

County Payette — State Ida — Local Registered No.

Township ... or Village Fruitland 35345 or

City Fruitland No. ..., ... St., ... Ward

(If death occurred in a hospital or institution, give its name instead of street and number)

2 FULL NAME Everett Gordon Grimes

(a) Residence. No. ... St., ...

(Usual place of abode) (If nonresident, give city or town and state)

Length of residence in city or town where death occurred / yrs. mos 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Boy	white.	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 2" 1916

7 AGE	Years	Months	Days	If less than 1 day, ... hrs. or ... min.
5-		1	10	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer

9 BIRTHPLACE (city or town) Broadwater
(State or country) Morrell Co. Nebr

PARENTS

10 NAME OF FATHER John J Grimes

11 BIRTHPLACE OF FATHER (city or town) Silvas City
(State or country) Iowa

12 MAIDEN NAME OF MOTHER Corrilla Umbenhower

13 BIRTHPLACE OF MOTHER (city or town) Champaign
(State or country) Champaign Co. Ills.

14 Informant J. J. Grimes
(Address) Fruitland Idaho.

15 Filed Sept 14, 1921 C C Paxton
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 12 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug 20, 1921, to Sept 12, 1921, that I last saw him alive on Sept 12, 1921 and that death occurred on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) ... yrs., ... mos., 3 days.

CONTRIBUTORY (Secondary) Syphlod Jeaon

(duration) ... yrs., ... mos., 21 days.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) William J Reese, M. D.

9/12, 1921 (Address) Ontario, Ore

* State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ontario Ore	Sept 13 1921

20 UNDERTAKER R L Peterson — ADDRESS Ontario O.

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED SEP 1 1921

CERTIFICATE OF DEATH. 35346

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 29

BUREAU Registration District No. 2072

File No. 3

Registered No. 123

1. PLACE OF DEATH.

County of Power

City of American Falls, Idaho (No. STATE Dr. any hospital St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Alane Andersen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. June (Month) 29 (Day) 915 (Year)

7. AGE: 6 Yrs. 2 Mos. 22 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Onida Co Ida.

10. NAME OF FATHER: JOhn C. Andersen

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Sena Sorenson

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John C Andersen

(Address) Arbon, Idaho

15. Filed 9 7 1921

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 21 (Day) 21 191 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 7 1921, to Aug 21 1921, that I last saw her alive on Aug 21 1921, and that death occured on the date stated above, at 9 a. M.

The CAUSE OF DEATH* was as follows:

appendicitis

(Duration) Yrs. 1 mos. 18 ds.

Contributory (Secondary) Peritonitis

(Duration) yrs. mos. 14 ds.

(Signed) C F Bench M. D.

8/24 1921 (Address) American Falls, Idaho

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Arbon, Idaho — DATE OF BURIAL: Aug 23 21 191

20. UNDERTAKER: A.W.Davis — ADDRESS: American Falls Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SORS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. RECEIVED SEP 1 1921 BUREAU OF STATISTICS

Registration District No. 23 35347

Primary Registration District No. 2072

County of Power

City of Rockland (No. ..... St.)

File No. 3

Registered No. 132

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Edith May Groom

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. May (Month) 5 (Day) 1919 (Year)

7. AGE: 2 Yrs. 3 Mos. 13 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Power Co Ida.

10. NAME OF FATHER: William C. Groom

11. BIRTHPLACE OF FATHER (State or Country): Washington

12. MAIDEN NAME OF MOTHER: Alda Bright

13. BIRTHPLACE OF MOTHER (State or Country): Neb

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William C Groom

(Address) Rockland, Idaho

15. Filed 9-1 1921 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August (Month) 18th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from August 17th 1921, to August 18th 1921, that I last saw her alive on August 18th 1921, and that death occured on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:

Acute Appendicitis

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) V. G. Logan M. D.

9/1 1921 (Address) American Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rockland, Idaho — DATE OF BURIAL: Aug 20 21

20. UNDERTAKER: A W Davis — ADDRESS: American Falls Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SVMB - YORK CO., PTRS. & STNRS. 24658

TRANSPORTATION OF CORPSE

(Always write with black ink.)

RECEIVED SEP 15 1921 BUREAU OF VITAL S

1. PLACE OF DEATH. CERTIFICATE OF DEATH.

County of Shoshone Registration District No. ~~Shoshone Co.~~ 70

City of Wallace.

Primary Registration District No.

(No. Wallace Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Oscar R. Atness

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35348
Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

The information on this certificate is an exact COPY of the official certificate at place of death.

PERSONAL AND STATISTICAL PARTICULARS.

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed or Divorced. (Write the Word.): Single
6. DATE OF BIRTH. Jan. (Month) 30 (Day) 1895 (Year)
7. AGE. 26 Yrs. 6 Mos. 29 ds. IF LESS than 1 day, how many ..... hrs. or ..... min.?
8. OCCUPATION. (a) Trade, profession or particular kind of work: Miner (b) General nature of industry, business, or establishment in which employed (or employer):
9. BIRTHPLACE. (State or Country) Idaho
10. NAME OF FATHER Ole Atness
11. BIRTHPLACE OF FATHER (State or Country) Norway
12. MAIDEN NAME OF MOTHER Gertrude Hestness
13. BIRTHPLACE OF MOTHER (State or Country) Norway
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ole Atness
(Address) Moscow.
15. Filed Aug. 29, 1921 Leo F. Quigley Local Registrar.

Place Where Remains are to be Sent: Moscow Idaho
Date of Shipment: ....., 191....

SHIPPING UNDERTAKER M.C. Thornhill
ADDRESS Kellogg Firm Name Worstell Co.

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Aug. (Month) 28 (Day) 1921 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Aug 27- 1921, to Aug 28, 1921; that I last saw him alive on 8-27-21, 191..., and that death occurred on the date stated above, at 3:30 A.M.

The CAUSE OF DEATH was as follows:

Rupture both lungs

(Duration) ..... Years ..... mos. 14 hrs ds.

Contributory (Secondary.)

(Duration) ..... Years ..... mos. ..... ds.

Signed Howard C. Stinson M. D.

8-29-21 191... (Address) Wallace Ida.

* State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transient or Recent Residents.)

At place ..... in the ..... of death ..... yrs. ..... mos. ..... days State ..... yrs. ..... mos. 12 Yrs. ..... days.

Where was disease contracted if not at place of death? Hecla Mine

Former or usual residence Burke Idaho

19. PLACE OF BURIAL OR REMOVAL Moscow Date of Burial 9/1, 1921

20. UNDERTAKER M.C. Thornhill Address

FORM V. S. No. 5-12 M. 6-15-17.

RECEIVED
RECEIVED
OCT 4 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35349
Registered No. 38
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH
County of Shoshone Registration District No. 10
City of Wallace Primary Registration District No. 1911
If death occurs away from usual residence, give facts called for under special information. (Wallace Hospital St.)

2. FULL NAME Rosa E. Anderson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. September 30 (Month) (Day) 1859 (Year)

7. AGE: 61 Yrs. 8 Mos. 11 ds.
IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Penn

10. NAME OF FATHER: Roland Potter

11. BIRTHPLACE OF FATHER (State or Country): Mass.?

12. MAIDEN NAME OF MOTHER: Shaeffer

13. BIRTHPLACE OF MOTHER (State or Country): Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Irving Anderson
(Address): Wallace

15. Filed June 13 1921. F. L. Jenkins Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 11 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from October 1908 to June 11 1921 that I last saw h[er] alive on 6/10/21 1921 and that death occurred on the date stated above, at 6:30 A. M.

The CAUSE OF DEATH* was as follows:

Adipose Sarcoma -

(Duration) 20 Yrs. mos. us.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed) Roma C. Stanton M. D.

19.... (Address) Wallace Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs. 1 mos. 7 days. In the state 34 yrs. ....mos. ....days

Where was disease contracted if not at place of death? Residence -

Former or usual residence 524 High St -

19. PLACE OF BURIAL OR REMOVAL: Wallace Ida — DATE OF BURIAL: June 13 1921

20. UNDERTAKER: D. L. Hostetler — ADDRESS

Form V. S. No. 5 20M.1-16-12

RECEIVED OCT 4 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 70

County of Shoshone Primary Registration District No. 1011

City of Wallace (No. Providence Hospital) File No. 35350

If death occurs away from usual residence, give facts called for under special information. Registered No. 47

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Gus Krueger

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M.	white	married

6. DATE OF BIRTH ..... 1 .....
(Month) (Day) (Year)

7. AGE 56 yrs. — mos. — ds. IF LESS than 1 day how many ..... hrs. or ..... mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... miner
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Germany.

10. NAME OF FATHER unknown

11. BIRTHPLACE OF FATHER (State or Country) unknown

12. MAIDEN NAME OF MOTHER unknown

13. BIRTHPLACE OF MOTHER (State or Country) unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Gus Krueger
(Address) Wallace Idaho

15. Filed June 17 1921 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH June 9th 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 9 1921, to June 9 1921
that I last saw him alive on June 9 1921
and that death occurred on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:
Aneurysm of Aorta
Syphilis
Hemorrhage
(Duration) hrs. 12 mos. ds.
Contributory (Secondary) Hard Labor
(Duration) yrs. mos. ds.
(Signed) Dr Mary Ellis M. D.
6/11 1921 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence. near Mullan Idaho

19. PLACE OF BURIAL OR REMOVAL Wallace Ida — DATE OF BURIAL June 13 1921

20. UNDERTAKER Ward Undg Co — ADDRESS Wallace Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

GYMS - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12 RECEIVED OCT 4 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35351

Registered No. 45

1. PLACE OF DEATH. Registration District No. 10

County of Shoshone Primary Registration District No. 10 11

City of Wallace (No. Infirmary St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Robert Robertson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M.	white	single

6. DATE OF BIRTH ..... 1 (Month) (Day) (Year)

7. AGE 58 yrs. — mos. — ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... miner
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Missouri

10. NAME OF FATHER Martin Robertson

11. BIRTHPLACE OF FATHER (State or Country) North Carolina

12. MAIDEN NAME OF MOTHER Mathilda Walker

13. BIRTHPLACE OF MOTHER (State or Country) Tennessee.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) James A. Robertson
(Address) Stevensville Mont.

15. Filed June 9 1921 T. L. Dunlop Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH June (Month) 5 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1919 191 , to June 5 1921, that I last saw him alive on June 4 1921, and that death occurred on the date stated above, at 10 45 P. M.

The CAUSE OF DEATH* was as follows:

Uremic apoplexy
30 min
(Duration) yrs. mos. ds.
Contributory (Secondary) Had first attack during last 3 years.
(Duration) yrs. mos. ds.

(Signed) James R Beard M. D.
6/9 1921 (Address) Wallace

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence Wallace Idaho

19. PLACE OF BURIAL OR REMOVAL Stevensville Montana | DATE OF BURIAL June 9 1921

20. UNDERTAKER Ward Undertaking Co | ADDRESS Wallace Ida

GIBBS-YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35352
Registered No. 46

RECEIVED
OCT 1 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Shoshone Registration District No. 76

City or Wallace Primary Registration District No. 1011

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Helen Ballard

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	white	married

6. DATE OF BIRTH. Feb. (Month) 5 (Day) 1 (Year)

7. AGE 72 Yrs. ..... Mos. ..... ds. IF LESS than 1 day how many .... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Ohio

10. NAME OF FATHER —

11. BIRTHPLACE OF FATHER (State or Country) France

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER (State or Country) —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Lizzie Ballard
(Address) Wallace Idaho

15. Filed June 13 1921 H L Dunlap Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 9 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1915 to June 9 1921
that I last saw h[illegible] alive on June 9 1921
and that death occurred on the date stated above, at 10 A.M.
The CAUSE OF DEATH* was as follows:
Carcinoma of Rectum
Marasmus
(Duration) 6 Yrs. ..... mos. ..... ds.
Contributory (Secondary) None
(Duration) ..... Yrs. ..... mos. ..... ds.
(Signed) Dr. Howard M. D.
6/10 1921 (Address) Wallace Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Wallace DATE OF BURIAL June 13 1921

20. UNDERTAKER E L Hunter ADDRESS Wallace

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

Form V. S. No. 5 20M.1-16-12

RECEIVED OCT 4 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35353
Registered No. 48

1. PLACE OF DEATH. Registration District No. 70
County of Shoshone Registration District No. 1011
City of Wallace (No. Wallace Hospital St.)
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME George A. Chipman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single
6. DATE OF BIRTH: ..... 1 (Month) (Day) (Year)
7. AGE: 87 yrs. — mos. — ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: miner
(b) General nature of industry business, or dstablishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Maine
10. NAME OF FATHER: — Chipman
11. BIRTHPLACE OF FATHER (State or Country): Mass.
12. MAIDEN NAME OF MOTHER: not given
13. BIRTHPLACE OF MOTHER (State or Country): not given
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Frank S. Chipman
(Address) Spokane Wash E-9 25 1921
15. Filed June 13 191 Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June 10 1921 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from May 29 1921, to June 10 1921, that I last saw h[illegible] alive on June 10 1921 and that death occurred on the date stated above, at 10½ A M.
The CAUSE OF DEATH* was as follows:
Uraemia
(Duration) yrs. mos. 3 ds.
Contributory (Secondary) Prostatic Hypertrophy
(Duration) 4 yrs mos. ds.
(Signed) James R Brannan M. D.
6/11 1921 (Address) Wallace Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence Murray Idaho

19. PLACE OF BURIAL OR REMOVAL: Wallace Ida | DATE OF BURIAL: June 13 1921
20. UNDERTAKER: Ward Und Co | ADDRESS: Wallace Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-12 M. 6-15-17. OCT 4 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35354
Registered No. 429

1. PLACE OF DEATH
County of Shoshone Registration District No. 70
City of Wallace Primary Registration District No. 1011
If death occurs away from usual residence, give facts called for under special information. (No. Cameron Ave St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Jessie Cheyne

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	white	Married

6. DATE OF BIRTH. Dec (Month) 15 (Day) 1874 (Year)

7. AGE 47 Yrs. 5 Mos. 27 ds. IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Canada

10. NAME OF FATHER Ben Burgess

11. BIRTHPLACE OF FATHER (State or Country) Canada

12. MAIDEN NAME OF MOTHER -

13. BIRTHPLACE OF MOTHER (State or Country) Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Alex Cheyne
(Address) Wallace

15. Filed June 13 1921 F. L. Jones Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 10 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1 1921 to June 10 1921
that I last saw her alive on June 10 1921
and that death occurred on the date stated above, at .... M.

The CAUSE OF DEATH* was as follows:
Carcinoma of Uterus

(Duration) Yrs. 6 mos. ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed) Chas. L. Sumpf M. D.
6/11/21 19.... (Address) Wallace Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days, In the ,State....yrs....mos....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Wallace Ida — DATE OF BURIAL June 13 1921

20. UNDERTAKER E. G. Hustell — ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-1

RECEIVED OCT 4 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35355

Registered No. 37

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH. Registration District No. 1

County of Shoshone Primary Registration District No.

City of Wallace (No. , St.)

2. FULL NAME James Francis Callahan

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M.	white	Married

6. DATE OF BIRTH

(Month) (Day) 1 (Year)

7. AGE

64 yrs. mos. ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Retired Mine Owner

(b) General nature of industry business, or dstablishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Illinois

10. NAME OF FATHER Thos. Callahan

11. BIRTHPLACE OF FATHER (State or Country) Ireland

12. MAIDEN NAME OF MOTHER Mary Ann Swiney

13. BIRTHPLACE OF MOTHER (State or Country) Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Donald Callahan

(Address) Wallace Ida

15. Filed June 13 1921 H. L. Dee Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH June 12th 1921

(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 11th 1921, to June 12th 1921

that I last saw him alive on June 12 1921

and that death occurred on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Thrombosis

(Duration) yrs. mos. 2 ds.

Contributory (Secondary) Arteriosclerosis

(Duration) yrs. mos. ds.

(Signed) Wm. T. Smith M. D.

6/13/21 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death?

Former or usual residence Wallace Idaho

19. PLACE OF BURIAL OR REMOVAL Wallace Ida DATE OF BURIAL June 14 1921

20. UNDERTAKER Ward Undertaking Co ADDRESS Wallace Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

EVANS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35356
Registered No. .....

RECEIVED
OCT 4 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Shoshone. Registration District No. 20
City of Wallace Primary Registration District No. 1011
If death occurs away from usual residence, give facts called for under special information. (Hospital or Institution Wallace Hospital St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME James F. Hopkins

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single
6. DATE OF BIRTH. April (Month) 24 (Day) 1853 (Year)
7. AGE: 68 Yrs. 1 Mos. 20 ds. IF LESS than 1 day how many .... hrs. or .... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: farmer
(b) General nature of industry, business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): West Virginia
10. NAME OF FATHER: John Hopkins
11. BIRTHPLACE OF FATHER (State or Country): Not Known
12. MAIDEN NAME OF MOTHER: Jane Hopkins
13. BIRTHPLACE OF MOTHER (State or Country): Not Known
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Esther W. Simpson
(Address) Wallace Hospital
15. Filed June 17 1921 F. L. Zunder Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 14 (Day) 1921 (Year)
17. I HEREBY CERTIFY, That I attended deceased from May 31 1921 to June 14 1921 that I last saw h.m. alive on June 14 1921 and that death occurred on the date stated above, at ... P. M.
The CAUSE OF DEATH* was as follows:
Carcinoma of Stomach
(Duration) Yrs. 6 mos. ds.
Contributory (Secondary)
(Duration) Yrs. mos. ds.
(Signed) [illegible] M. D.
6/16/21 (Address) Wallace Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the ,State....yrs....mos....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Wallace, Idaho — DATE OF BURIAL: June 18th 1921
20. UNDERTAKER: Drew G. Mostell. — ADDRESS: Wallace, Id

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
SEP 15 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 77
Primary Registration District No. 2176
File No. 35557
Registered No. 14

1. PLACE OF DEATH
County of Teton
City of Tetonia (Ward, St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Hiram T. Fackrell.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: April 8 1920 (Month) (Day) (Year)

7. AGE: Yrs. 1 Mos. 5 Ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business or establishment in which employed (or employer): Infant

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: Joseph C. Fackrell

11. BIRTHPLACE OF FATHER (State or Country): Utah.

12. MAIDEN NAME OF MOTHER: Ethel Vaughn

13. BIRTHPLACE OF MOTHER (State or Country): Oklahoma.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. L. Vaughan
(Address) Tetonia Idaho

15. Filed Sept 7th 1921 Martha Marker Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: September 2 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 30 - 1921, to Sept 1 1921
that I last saw h.. alive on Sept 1 1921
and that death occurred on the date stated above, at 4:45 A M.
The CAUSE OF DEATH* was as follows:

Cholera Infantum

(Duration) ..... Yrs. ..... mos. 15 ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. Frank Watkins M. D.
Sept 3 1921 (Address) St Anthony, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Tetonia Cemetery | DATE OF BURIAL: Sept 4 1921

20. UNDERTAKER: C. O. Mains | ADDRESS: Driggs

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

RECEIVED OCT 6 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 123
Primary Registration District No.
File No. 35358
Registered No. 26

1. PLACE OF DEATH
County of Shoshone
City of Kellogg (St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Biancolin

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: March (Month) 3 (Day) 1900 (Year)

7. AGE: 21 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Italy

10. NAME OF FATHER: Antone Biancolin

11. BIRTHPLACE OF FATHER (State or Country): Italy

12. MAIDEN NAME OF MOTHER: Anna Bonben

13. BIRTHPLACE OF MOTHER (State or Country): Italy

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Lilly Biancolin
(Address): Rose Lake, Idaho

15. Filed Oct. 6 1921 — E. E. Hardy, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 2 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1 19.., to Oct 2nd 1921, that I last saw h[illegible] alive on Oct 2nd 1921, and that death occurred on the date stated above, at 7:30 A.M.

The CAUSE OF DEATH* was as follows:
Accidental gun-shot wound.

(Duration) Yrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. 1 ds.

(Signed) H. Lindsay M. D.
10/6 1921 (Address) Kellogg Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..yrs..mos..days. In the State ..yrs..mos..days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Kellogg Idaho — DATE OF BURIAL: Oct 4, 1921

20. UNDERTAKER: M. C. Thornhill — ADDRESS: Kellogg, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED SEP 15 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 74

Primary Registration District No. 2174

File No. 35359

County of Teton

City of At Power Site of I.P.&M. Co. (No. ..... St.)

Registered No. 10

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elizabeth Zweifel Bagley.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: November (Month) 5 (Day) 1881 (Year)

7. AGE: 39 Yrs. 9 Mos. 4 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Cooking for

(b) General nature of industry, business or establishment in which employed (or employer): I.V.P.& M. Company.

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: John Zweifel

11. BIRTHPLACE OF FATHER (State or Country): Switzerland

12. MAIDEN NAME OF MOTHER: Susan Coomer

13. BIRTHPLACE OF MOTHER (State or Country): Switzerland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Roy Bagley

(Address) Felt Idaho

15. Filed Aug 12 1921 Martha Marker Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August (Month) 9th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 4 1921, to Aug 9th 1921 that I last saw her alive on Aug 9th 1921 and that death occurred on the date stated above, at 9 A. M.

The CAUSE OF DEATH* was as follows:

Fracture of Base of skull

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas J Martin M. D.

Aug 6 1921 (Address) Driggs Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Driggs Idaho — DATE OF BURIAL: Aug 11th 1921

20. UNDERTAKER: W J King — ADDRESS: Driggs Ida.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 77
Primary Registration District No. 9176
File No. 35360
Registered No. 12

1. PLACE OF DEATH
County of Teton
City of Driggs
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Richard Liman Carter.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Sept. (Month) 26 (Day) 1916 (Year)

7. AGE: 4 Yrs. 10 Mos. 25 ds. 6
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah.

10. NAME OF FATHER: Liman Wayne Carter

11. BIRTHPLACE OF FATHER (State or Country): Utah.

12. MAIDEN NAME OF MOTHER: Doris Gripper

13. BIRTHPLACE OF MOTHER (State or Country): Colorado.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Doris Carter White
(Address) Victor, Idaho

15. Filed Sept 3rd 1921 — Martha Marker, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 20 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 20 1921, to Aug 20 1921
that I last saw him alive on Aug 20 1921
and that death occurred on the date stated above, at 1:45 P. M.
The CAUSE OF DEATH* was as follows:
Fracture of base of skull.

..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Thos. H. Martin, M. D.
Aug 21 1921 (Address) Driggs, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Goshen, Utah. — DATE OF BURIAL ..... 19.....

20. UNDERTAKER: A. Merry — ADDRESS Driggs

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH — Registration District No. 77 — File No. 35361

County of Teton — Primary Registration District No. 2176

City of Tetonia — (No. ..... St.) — Registered No. 19

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lynn K. Mawson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	white	Single

6. DATE OF BIRTH — Dec. 22 — July 3rd (Month) (Day) 1918 (Year)

7. AGE — 3 Yrs. 7 Mos. 28 ds. — IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work — Infant.
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) — Idaho.

10. NAME OF FATHER — James Mawson

11. BIRTHPLACE OF FATHER (State or Country) — Idaho.

12. MAIDEN NAME OF MOTHER — Carenina M. Hoffard

13. BIRTHPLACE OF MOTHER (State or Country) — Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) James Mawson
(Address) Tetonia, Idaho

15. Filed Sept 3rd 1921 — Martha Marker, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH — August 20 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....
and that death occurred on the date stated above, at 7 P. M.
The CAUSE OF DEATH* was as follows:

Acute Gastro Enteritis

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. L. Hooper M. D.
Aug 22 19 21 (Address) Tetonia Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL — Tetonia Cemetery — DATE OF BURIAL — Aug 22 19 21

20. UNDERTAKER — W Kinney — ADDRESS Driggs

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED SEP 15 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 77

Primary Registration District No. 2176

File No. 35362

Registered No. 11

County of Teton

City of Cedron (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Ann Kunz Hibbert

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: June (Month) 23 (Day) 1898 (Year)

7. AGE: 23 Yrs. 1 Mos. 18 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: House Wife, mother

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Samuel Kunz Sr.

11. BIRTHPLACE OF FATHER (State or Country): Switzerland

12. MAIDEN NAME OF MOTHER: Caroline Wutrich

13. BIRTHPLACE OF MOTHER (State or Country): Switzerland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Gerald Lloyde Hibbert

(Address) Victor R.1. Idaho

15. Filed Aug 12th 1921 Martha Marker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 19 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 21 1921 to Aug 19 1921 that I last saw her alive on Aug 17 1921, and that death occurred on the date stated above, at 6:00 P.M.

The CAUSE OF DEATH* was as follows:

Typhoid fever

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas H Martin M. D.

Aug 19 1921 (Address) Cedron Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Cedron cemetery

DATE OF BURIAL: Aug 19 1921

20. UNDERTAKER .....

ADDRESS .....

N. B.—Every item of information should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS CERTIFICATE BECOMES A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED SEP 15 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35363
Registered No. 9

1. PLACE OF DEATH
Registration District No. 77
Primary Registration District No. 2176
County of Teton
City of Driggs (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Joseph Silas Hillman
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6. DATE OF BIRTH: Sept (Month) 29 (Day) 1859 (Year)

7. AGE: 61 Yrs. 10 Mos. ... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Ira Virg Hillman

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Emma Baker

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) M D Driggs
(Address) Driggs Idaho

15. Filed August 10 1921 Martha Marker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 2 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1st 1916, to Aug 2 1921, that I last saw h. alive on Aug 2 1921 and that death occurred on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:
Cerebral Sclerosis

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary)
(Duration) ... yrs. ... mos. ... ds.

(Signed) Jas H Martin M. D.
Aug 3 1921 (Address) Driggs Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Darby Cemetery — DATE OF BURIAL: 8/5 1921
20. UNDERTAKER — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED SEP 15 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 77
Primary Registration District No. 2176
File No. 35364
Registered No. 8

1. **PLACE OF DEATH**
County of Teton
City of Moran Hosp. (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. **FULL NAME** Louis Homer Harding.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. **SEX** Male

4. **COLOR OR RACE** white

5. **SINGLE, MARRIED, WIDOWED OR DIVORCED** Married (Write the word.)

6. **DATE OF BIRTH** May 15 1869 (Month) (Day) (Year)

7. **AGE** 51 Yrs. 11 Mos. 29 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. **OCCUPATION**
(a) Trade, profession or particular kind of work Undertaker
(b) General nature of industry, business or establishment in which employed (or employer) Undertaking

9. **BIRTHPLACE** (State or Country) Ohio

10. **NAME OF FATHER** Coleman Harding

11. **BIRTHPLACE OF FATHER** (State or Country) Ohio

12. **MAIDEN NAME OF MOTHER** Coleman.

13. **BIRTHPLACE OF MOTHER** (State or Country) Do

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**
(Informant) R. McKenzie
(Address) Salt Lake City, Utah

15. Filed Aug 10th 1921 Martha Marker Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH** August 2- 1921 (Month) (Day) (Year)

17. **I HEREBY CERTIFY, That I attended deceased from** ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Accidental Drowning
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Roderick McKenzie M. D.
19..... (Address) W. E. Hewlett Harry J. Horton

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury, and (2) whether Accidental, Suicidal or Homicidal.

Coroner & Justice of Peace

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. **PLACE OF BURIAL OR REMOVAL** Salt Lake City, Utah — **DATE OF BURIAL** ..... 19.....

20. **UNDERTAKER** W. A. Cary — **ADDRESS** Driggs

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 34
Primary Registration District No. 2085
File No. 35365
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of Buhl
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Edward H. Maberly
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: April (Month) 28 (Day) 1853 (Year)

7. AGE: 68 Yrs. 4 Mos. 3 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Dentist
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: Thomas M Maberly

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Mary Steele

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Emma Maberly
(Address) 110 Franklin

15.
Filed Sept 12 1921
John F Loughlin
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. (Month) 1 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....
and that death occurred on the date stated above, at 11:40 A.M.

The CAUSE OF DEATH* was as follows:
Acute Dilatation of Heart.

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) P J Grossman M. D.
Sept 1 1921 (Address) Twin Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence Boise Ida.

19. PLACE OF BURIAL OR REMOVAL: Boise Idaho DATE OF BURIAL: Sept 4 1921

20. UNDERTAKER: P J Grossman ADDRESS: Twin Falls Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35366

Registered No. 7

1. PLACE OF DEATH

County of Twin Falls — Registration District No. 36

Primary Registration District No.

City of Kimberly (No. of House St.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED SEP 10 BUREAU OF VITAL STATISTICS

2. FULL NAME Webster Howard

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	W	Widower

6. DATE OF BIRTH: Sept (Month) 19 (Day) 1841 (Year)

7. AGE: 79 Yrs. 1 Mos. 16 ds. — IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): N. Y

10. NAME OF FATHER: John Howard

11. BIRTHPLACE OF FATHER (State or Country): N.Y.

12. MAIDEN NAME OF MOTHER: Louisa Elwell

13. BIRTHPLACE OF MOTHER (State or Country): N.Y.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John W Howard
(Address) Kimberly

15. Filed Aug 3 1921 J M Davis Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 3 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at 9 A. M.
The CAUSE OF DEATH* was as follows:

Senility

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J M Davis M. D.

19..... (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Ida — DATE OF BURIAL: Aug 4 1921

20. UNDERTAKER — ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED SEP 15 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 36

Primary Registration District No.

File No. 35367

County of Twin Falls

City of Kimberly, (No.) St.)

Registered No. 8

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary V. Parke

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
female	White	widowed

6. DATE OF BIRTH

..... 1.....
(Month) (Day) (Year)

7. AGE

86 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Ohio

10. NAME OF FATHER Anson Call

11. BIRTHPLACE OF FATHER (State or Country) Vermont

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15. Filed Aug. 10, 1921 J. M. Dawson Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51083

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug. (Month) 10 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 28 1921, to Aug 10 1921, that I last saw her alive on Aug. 3, 1921, and that death occurred on the date stated above, at 6 A.M.

The CAUSE OF DEATH* was as follows:

Bronchial asthma, acute,

(Duration) Yrs. mos. ds.

Contributory (Secondary) Senility

(Duration) yrs. mos. ds.

(Signed) M. D.

8/10/1921 (Address) Kimberly, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Albion Idaho	8/11/ 1921

20. UNDERTAKER J.E. DeWitt, ADDRESS Twin Falls, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35368
Registered No.

RECEIVED SEP 15 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Twin Falls Registration District No. 37

City of (No. of St.) Primary Registration District No. 1070

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Hazel Davis

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Single

6. DATE OF BIRTH: June 20 (Month) (Day) 1907 (Year)

7. AGE: 14 Yrs. 1 Mos. 17 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: School Girl
(b) General nature of industry, business or establishment in which employed (or employer): Cafe

9. BIRTHPLACE (State or Country)

10. NAME OF FATHER: Alla Davis

11. BIRTHPLACE OF FATHER (State or Country): Kansas

12. MAIDEN NAME OF MOTHER: Lula Wilson

13. BIRTHPLACE OF MOTHER (State or Country): Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A A Davis
(Address)

15. Filed Aug 8 1921 John H Coughlin Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug 7 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 27 1921, to Aug. 8 1921 that I last saw h[illegible] alive on Aug 6 1921 and that death occurred on the date stated above, at 5 P.M.
The CAUSE OF DEATH* was as follows:

Septic Endocarditis

(Duration) Yrs. mos. ds.
Contributory (Secondary) Peritonitis, Influenza
(Duration) 5 yrs. 8 mos. ds.

(Signed) John R Morgan M. D.
Aug 8 1921 (Address) Twin Falls, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls — DATE OF BURIAL: Aug 8 1921

20. UNDERTAKER: F E Ward — ADDRESS: Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

Beiler

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35369

Registered No.

1. PLACE OF DEATH

County of Twin Falls

City of " "

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 37

Primary Registration District No. 1085

(St.)

RECEIVED
SEP 15 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME Daniel C Sierer.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH June (Month) 8 (Day) 1869 (Year)

7. AGE 52 Yrs. 1 Mos. 28 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Ada Hardin Co. Ohio.

10. NAME OF FATHER John P. Sierer

11. BIRTHPLACE OF FATHER (State or Country) Selinsgrove-Penna

12. MAIDEN NAME OF MOTHER Eleanor Vaughn

13. BIRTHPLACE OF MOTHER (State or Country) Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) D Sierer
(Address) Twin Falls Idaho

15. Filed Aug. 9 1921 John P Coughlin Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug. (Month) 5. (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 7 1921., to Aug. 5 1921., that I last saw him alive on Aug. 5, 1921., and that death occurred on the date stated above, at 7:30 P.M.

The CAUSE OF DEATH* was as follows:

Phlebitis

(Duration) Yrs. 3 mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Haf Beiler M. D.

Aug. 9 1921. (Address) Twin Falls, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Twin Falls | DATE OF BURIAL 8/9 1921

20. UNDERTAKER Roy Grossman | ADDRESS Twin Falls Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35370

Registered No.

RECEIVED
SEP 15 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Twin Falls Registration District No. 37

Primary Registration District No. 1085

City of " (If outside limits of city or village, give township.) St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Hazel R Thompson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: June (Month) 23 (Day) 1899 (Year)

7. AGE: 22 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: School teacher
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: Elmer Thompson

11. BIRTHPLACE OF FATHER (State or Country): Ohio.

12. MAIDEN NAME OF MOTHER: Florence Ross

13. BIRTHPLACE OF MOTHER (State or Country): Iowa.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Herbert Thompson
(Address) Twin Falls,

15. Filed Aug 25 1921 John F Trughber Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 23 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1921, to Aug 23 1921
that I last saw h er alive on July 1921,
and that death occurred on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:
Tuberculosis of lung liver + bowels

(Duration) 2 Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) John R Morgan M. D.
8-24 1921 (Address) Twin Falls, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Ida — DATE OF BURIAL: 8/25 1921

20. UNDERTAKER: J G Grassman — ADDRESS: Twin Falls Ida,

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED SEP 15 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Twin Falls — Registration District No. 37

City of " " — Primary Registration District No. 1085

(No. ..... St.)

File No. 35371

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs Estella Starr.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: June (Month) 26 (Day) 1881 (Year)

7. AGE: 40 Yrs. — Mos. 15 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Sales Lady
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Missouri.

10. NAME OF FATHER: Geo W Buckwalt.

11. BIRTHPLACE OF FATHER (State or Country): Missouri Ohio

12. MAIDEN NAME OF MOTHER: Laura Vinal.

13. BIRTHPLACE OF MOTHER (State or Country): ~~Unknown~~ Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) L. D. Starr
(Address) Twin Falls

15. Filed Aug. 23 1921 John McCaughlin Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 11 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19....., that I last saw h..... alive on ..... 19....., and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Gun shot wound Thru Re heart - suicidal

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) O. J. Grossman Coroner

Aug 12 1921 (Address) Twin Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls. Ida. DATE OF BURIAL: Aug 16 1921

20. UNDERTAKER: O. J. Grossman. ADDRESS: Twin Falls Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35372
Registered No.

RECEIVED
SEP 15 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Twin Falls Registration District No. 37
Primary Registration District No. 1083
City of ' ' ' (Or Town) St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Clara Compton

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word)

6. DATE OF BIRTH: March (Month) 3 (Day) 1862 (Year)

7. AGE: 59 Yrs. 5 Mos. 23 ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: at home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ill.

10. NAME OF FATHER: Jarrad Sandhaus

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Charlott Tragier

13. BIRTHPLACE OF MOTHER (State or Country): Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. B. Compton
(Address) Twin Falls

15. Filed Aug. 27 1921 John H. Coughlin Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August (Month) 23 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ... 19..., to ... 19..., that I last saw h... alive on ... 19..., and that death occurred on the date stated above, at 9:00 P.M.

The CAUSE OF DEATH* was as follows:
Cancer of brain
Determined at post mortem examination

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary)
(Duration) ... yrs. ... mos. ... ds.

(Signed) John H. Coughlin Registrar of Vital Statistics M. D.
8/26 1921 (Address) Box 326 Twin Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Filer Iowa.
DATE OF BURIAL ... 19...
20. UNDERTAKER: J. J. Freeman
ADDRESS: Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED SEP 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 37

Primary Registration District No. 1014

File No. 35373

County of Twin Falls

City of ..... (If outside limits, give township) ..... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Robert W Anderson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	white	married

6. DATE OF BIRTH: Sep (Month) 12 (Day) 1 (Year)

7. AGE: 75 Yrs. 11 Mos. 7 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: ret farmer
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ill

10. NAME OF FATHER: John Anderson

11. BIRTHPLACE OF FATHER (State or Country): Ill

12. MAIDEN NAME OF MOTHER: Elebeth Emerson

13. BIRTHPLACE OF MOTHER (State or Country): Ill

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) M. V. Ritchey

15. Filed Aug. 20 1921 John McCaughey Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 19 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 1920, to Aug 1921, that I last saw him alive on Aug. 18, 1921, and that death occurred on the date stated above, at 7.50 P.M.

The CAUSE OF DEATH* was as follows:

Gastro-intestinal carcinoma.

(Duration) 1 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Hal Bixler M. D.

Aug 20 1921 (Address) Twin Falls, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Twin Falls Ida	aug 21 1921

20. UNDERTAKER: F E Wendt — ADDRESS: Twin Falls

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35375

Registered No.

RECEIVED
SEP 15 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Twin Falls Registration District No. 37

Primary Registration District No. 1085

City of " " (No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jas. A. Grant

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Widower

6. DATE OF BIRTH: Feb. (Month) 4 (Day) 1834 (Year)

7. AGE: 88 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: at home.

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Bermondsey Surry England

10. NAME OF FATHER: John Brooks

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Dorothy Evans

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A. R. Grant

(Address) Twin Falls Ida.

15. Filed Aug 22 1921 John F. Coughlin Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 20 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1 1921, to Aug 20 1921, that I last saw he alive on Aug 20 1921, and that death occurred on the date stated above, at 4 o'clock P.M.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) Yrs. 12 mos. ds.

Contributory (Secondary) Chronic Interstitial Nephritis

(Duration) yrs. mos. ds.

(Signed) H. H. Sawyer M. D.

8-20 1921 (Address) Twin Falls, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Jamestown N. Y. DATE OF BURIAL 19

20. UNDERTAKER: J. F. Brennan ADDRESS Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

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FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Twin Falls — Registration District No. 37

City of " " — Primary Registration District No. 1085

File No. 35376

Registered No.

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

RECEIVED SEP 15 1921 BUREAU OF VITAL STATISTICS

2. FULL NAME Jean Lorain Wallace

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (write word.)

6. DATE OF BIRTH: Aug 16 1921 (Month) (Day) (Year)

7. AGE: ....Yrs. ....Mos. 2 ds.

IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: R. L. Wallace

11. BIRTHPLACE OF FATHER (State or Country): Kan.

12. MAIDEN NAME OF MOTHER: Corinne Searey

13. BIRTHPLACE OF MOTHER (State or Country): Neb.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R. L. Wallace
(Address) Filer, Ida.

15. Filed Aug. 22 1921 John McCaughlin Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug 18 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 17 1921, to Aug. 18 1921, that I last saw h[illegible] alive on Aug. 18 1921, and that death occurred on the date stated above, at 8 a. M.
The CAUSE OF DEATH* was as follows:

Malnutrition

(Duration) .... Yrs. .... mos. 1 ds.

Contributory (Secondary)

(Duration) .... yrs. .... mos. .... ds.

(Signed) Frank A. Wright M. D.

Aug 18 21 (Address) Filer Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .... yrs. .... mos. .... days. In the State .... yrs. .... mos. .... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls — DATE OF BURIAL: Aug 18 1921

20. UNDERTAKER: P. J. Brennan — ADDRESS: Twin Falls Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 5108

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35377
Registered No.

Registration District No. 37
Primary Registration District No. 1085

RECEIVED
SEP 15 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Twin Falls
City of " "
(No. St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Laurence Edward McNichols

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: (Single)
6. DATE OF BIRTH: May (Month) 12 (Day) 1909 (Year)
7. AGE: 12 Yrs. 3 Mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: School boy
(b) General nature of industry, business or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Idaho
10. NAME OF FATHER: J. K. McNichols
11. BIRTHPLACE OF FATHER (State or Country): Wisconsin
12. MAIDEN NAME OF MOTHER: Clara Schrader
13. BIRTHPLACE OF MOTHER (State or Country): Wisconsin
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. K. McNichols
(Address) Twin Falls Ida
15. Filed Aug 22 1921 John P. Coughlin Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 16 (Day) 1921 (Year)
17. I HEREBY CERTIFY, That I attended deceased from ..... 19..., to ..... 19...,
that I last saw h~~im~~ alive on Aug 15, 1921,
~~and that death occurred on the date stated above, at ..... M.~~
The CAUSE OF DEATH* was as follows:
Accidental, run over by automobile, internal injuries
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Geo. H. Caldwell M. D.
8/23, 1921 (Address) Twin Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rosenau — DATE OF BURIAL: Aug 17 1921
20. UNDERTAKER: Twin Falls Ida — ADDRESS —

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED SEP 15 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Twin Falls

City of (,)

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 37

Primary Registration District No. 1085

(No. ..... St.)

File No. 35378

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME James W. Wardell.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	white	Single

6. DATE OF BIRTH: Jan 6 (Month) (Day) 1921 (Year)

7. AGE: Yrs. 6 Mos. 12 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER willard wardell

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Bertha Vass

13. BIRTHPLACE OF MOTHER (State or Country) New York Stat

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. F. Wardell
(Address) .....

15. Filed Aug 19 1921 John Maughan Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug 18 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 17 1921, to Aug 18 1921 that I last saw him alive on Aug 16 1921, and that death occurred on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:
General peritonitis from swallowing open safety pin
(Duration) ..... Yrs. ..... mos. 2 ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E. L. Berry M. D.
8/18 1921 (Address) Hazelton

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. 2 days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? Hazelton Ida
Former or usual residence Hazelton Ida

19. PLACE OF BURIAL OR REMOVAL: Hazelton — DATE OF BURIAL: aug 21 1921

20. UNDERTAKER: J E Wood — ADDRESS: Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35379
Registered No.

RECEIVED SEP 15 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Twin Falls
Registration District No. 37
Primary Registration District No. 1085
City of ... (If outside limits of city or village, give township.) St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Merion C Whaley
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6. DATE OF BIRTH: Oct 6 (Month) 1 (Day) (Year)

7. AGE: 57 Yrs. ... Mos. ... ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mo

10. NAME OF FATHER: Abirham Whaley

11. BIRTHPLACE OF FATHER (State or Country): Conn

12. MAIDEN NAME OF MOTHER: Lovinda Landon

13. BIRTHPLACE OF MOTHER (State or Country): Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. M. Whaley
(Address)

15. Filed Aug. 6 1921 John O'Keefe Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug 8 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 31, 1921, to Aug 3 1921
that I last saw h.im alive on Aug 3 1921,
and that death occurred on the date stated above, at 11 P.M.
The CAUSE OF DEATH* was as follows:
Appendicitis (Gangrenous)

(Duration) ... Yrs. ... mos. 6 ds.
Contributory (Secondary) Acute dilitations of Stomach
(Duration) ... yrs. ... mos. 5 days

(Signed) O. J. Murphy M. D.
8/5 1921 (Address) Twin Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. 4 days. In the State 11 yrs. ... mos. ... days
Where was disease contracted if not at place of death? "
Former or usual residence "

19. PLACE OF BURIAL OR REMOVAL: Jerome Ida — DATE OF BURIAL: Aug 8 1921
20. UNDERTAKER: Edwards — ADDRESS: Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
SEP 10 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Twin Falls. Registration District No. 37
City of Twin Falls Primary Registration District No. 1085
If death occurs away from usual residence, give facts called for under special information.

File No. 35380
Registered No.

2. FULL NAME Lewis McClelland

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Male	White	Married (Write the word.)

6. DATE OF BIRTH: Feby (Month) 27 (Day) 1867 (Year)

7. AGE: 54 Yrs. 5 Mos. 7 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Produce Buyer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Williamsville, Ill.

10. NAME OF FATHER: Robert

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Mets

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Dora [illegible]
(Address) 512 Main Ave

15. Filed Aug 9 1921 John J. Coughlin Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 4 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 3 1921, to Aug 4 1921
that I last saw him alive on Aug 4 1921
and that death occurred on the date stated above, at 11 a. M.
The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(Duration) 1 hour Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo. Jennings M. D.
8-4 1921 (Address) Burley, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Ida. DATE OF BURIAL: 8 [illegible] 1921

20. UNDERTAKER: [illegible] ADDRESS: Twin Falls Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

Wilson

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35381

Registered No.

RECEIVED
SEP 15
BUREAU OF STATIS

Registration District No. 37

Primary Registration District No. 1085

1. PLACE OF DEATH

County of Twin Falls

City of " "

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Henry B Vance

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Male	White	Married

6. DATE OF BIRTH: May (Month) 21 (Day) 1846 (Year)

7. AGE: 75 Yrs. 2 Mos. 17 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer): Retired.

9. BIRTHPLACE (State or Country): Adams Co, Ohio.

10. NAME OF FATHER: David Vance

11. BIRTHPLACE OF FATHER (State or Country): Va.

12. MAIDEN NAME OF MOTHER: Don't Know

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. D. Vance
(Address) Belleview, Kas.

15. Filed Aug. 9 1921 John T. Coghlan Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug. (Month) 7 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 21 1921, to Aug 6 1921, that I last saw h[im] alive on Aug 6 1921, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Senile gangrene, right leg: [redacted]

(Duration) ..... Yrs. 6 mos. ..... ds.

Contributory (Secondary) Surgical shock - amputation

(Duration) ..... yrs. ..... mos. ½ ds.

(Signed) H. W. Wilson M. D.

Aug 8 1921 (Address) Twin Falls, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls — DATE OF BURIAL: 8/9 1921

20. UNDERTAKER: P. J. Grossman — ADDRESS: Twin Falls

Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED SEP 15 1921 BUREAU OF VITAL STATISTICS

Registration District No. 37
Primary Registration District No. 1085
File No. 35382
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of (If outside limits of city or village, give township.) St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Infant McCormick
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Aug 1 1921 (Month) (Day) (Year)

7. AGE: ..... Yrs. ..... Mos. ..... ds. 5 hr
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Charlie McCormick

11. BIRTHPLACE OF FATHER (State or Country): Mo

12. MAIDEN NAME OF MOTHER: Gladys Shafson

13. BIRTHPLACE OF MOTHER (State or Country): Neb

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Charlie McCormick
(Address) 744-2 East

15. Filed Aug 2 1921 John P. Coughlin Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug 1 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 1 1921, to Aug 1 1921
that I last saw h... alive on Aug 1 1921
and that death occurred on the date stated above, at 5 A.M.
The CAUSE OF DEATH* was as follows:
Congenital heart disease

..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) T. E. Wasson M. D.
Aug 2 1921 (Address) Twin Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Ida — DATE OF BURIAL: Aug 2 1921

20. UNDERTAKER: [illegible] — ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
SEP 15 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 37
Primary Registration District No. 1085
File No. 35383
Registered No.

County of Twin Falls
City of " " (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mildred Lack

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Female	White	Single (Write the word.)

6. DATE OF BIRTH: May 5 (Month) (Day) 1900 (Year)

7. AGE: 21 Yrs. 9 Mos. 25 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: School Girl
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kansas

10. NAME OF FATHER: J. F. Lack

11. BIRTHPLACE OF FATHER (State or Country): Ill.

12. MAIDEN NAME OF MOTHER: Mable Haack

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): D F Lack
(Address):

15. Filed Aug 31 1921 John W. Hughes Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug. 30. (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 29 1921, to Aug 30 1921, that I last saw her alive on Aug 30 1921, and that death occurred on the date stated above, at 9 P. M.
The CAUSE OF DEATH* was as follows:

Tuberculosis of the Lungs

(Duration) 1 Yrs. 6 mos. — ds.
Contributory (Secondary): Typhoid Fever
(Duration) — yrs. — mos. 1/2 ds.

(Signed) W J Affordt M.D.
19 (Address) Twin Falls, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs ... mos ... days. In the State ... yrs ... mos ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls — DATE OF BURIAL: Sep 3 1921

20. UNDERTAKER: J E Everett — ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35384
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of (No. St.)
If death occurs away from usual residence, give facts called for under special information.

RECEIVED
SEP 15 1921
BUREAU OF VITAL STATISTICS

Registration District No. 37
Primary Registration District No. 1085

2. FULL NAME Chas. L. Waddell
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: ~~Single~~ Widowed
6. DATE OF BIRTH: Feb 12 (Month) (Day) 19?? (Year)
7. AGE: 10 Yrs. 5 Mos. 16 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: School Boy
(b) General nature of industry, business or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Driggs, Ida
10. NAME OF FATHER: Chas. L. Waddell
11. BIRTHPLACE OF FATHER (State or Country): Utah.
12. MAIDEN NAME OF MOTHER: Jennie Johnson
13. BIRTHPLACE OF MOTHER (State or Country): Sweden
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chas. L. Waddell
(Address) Bergen Ida.
15. Filed Aug. 31 1921 John W. Coughlin Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 28 (Day) 1921 (Year)
17. I HEREBY CERTIFY, That I attended deceased from ..... 19..., to ..... 19...,
that I last saw h... alive on ..... 19...,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Drowned (accidental)
(Irr canal)
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) T. J. Grossman M.D.
8/29 1921 (Address) Twin Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Driggs, Ida.
DATE OF BURIAL ..... 19.....
20. UNDERTAKER: T. J. Grossman
ADDRESS Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35385
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of Hailey (No. St.)
Registration District No. 37
Primary Registration District No. 1085
RECEIVED SEP 15 1921 BUREAU OF VITAL STATISTICS
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James D Faulkner
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Married

6. DATE OF BIRTH: Sept 19 (Month) (Day) 1 (Year)

7. AGE: 45 Yrs. 11 Mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: James D Faulkner

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Mary A Babcock

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant)
(Address) Mrs Laura Faulkner

15. Filed Aug. 25 1921 John P. Coughlin Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug 24 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1 1921 to Aug 24 1921
that I last saw h. alive on Aug 23 1921
and that death occurred on the date stated above, at 5-P M.
The CAUSE OF DEATH* was as follows:
Sarcoma on the neck

(Duration) 3 Yrs. mos. ds.
Contributory (Secondary) Sarcoma was complicated by anuresm
(Duration) 1 yrs. mos. ds.
(Signed) W. C. McGinnis M. D.
1921 (Address) 415-7th E. Twin Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Ida — DATE OF BURIAL: Aug 27 1921

20. UNDERTAKER: L E Jewett — ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35386

Registered No.

1. PLACE OF DEATH

County of Elko

City of Rogerson (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED SEP 15 1921 BUREAU OF VITAL STATISTICS

Registration District No. 37

Primary Registration District No. 1085

2. FULL NAME Infant Goodwin

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Infant

6. DATE OF BIRTH: July (Month) 30 (Day) 1921 (Year)

7. AGE: ....Yrs. ....Mos. 10 ds.

IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Nevada

10. NAME OF FATHER: A B Goodwin

11. BIRTHPLACE OF FATHER (State or Country): MO

12. MAIDEN NAME OF MOTHER: Sarah Grayless

13. BIRTHPLACE OF MOTHER (State or Country): MO

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs J E Burke

(Address)

15. Filed Aug 10 1921

John D. Coughlin
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 10 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 30 1921, to Aug 10 - 1921, that I last saw h.. alive on Aug 10th - 1921, and that death occurred on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Marasmus

(Duration) .... Yrs. .... mos. 10 ds.

Contributory (Secondary): Premature 7½ Mo.

(Duration) .... yrs. .... mos. .... ds.

(Signed) Duncan Graham M. D.

Aug 10 1921 (Address) Twin Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .... yrs. .... mos. .... days. In the State .... yrs. .... mos. .... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Ida — DATE OF BURIAL: Aug 10 1921

20. UNDERTAKER: J E Curtis — ADDRESS: Twin Falls

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED
OCT 3 19
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Twin Falls — Registration District No. 39

City of Buhl — Primary Registration District No. 2-087

(No. ..... Clover Ida St.)

File No. 35387

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary Emily Fox

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: October 7 1859 (Month) (Day) (Year)

7. AGE: 61 Yrs. 9 Mos. 20 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: Edward Wolff

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Meister

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Beckhart

(Address) Buhl Idaho

15. Filed aug 27 1921 — J. W. Murphy, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: aug 26 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from aug 22 1921, to aug 25 1921, that I last saw her alive on aug 26 1921 and that death occurred on the date stated above, at 6 P M.

The CAUSE OF DEATH* was as follows:

Carcinoma

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Ruptured ovarian cyst

(Duration) about 3 yrs. ..... mos. ..... ds.

(Signed) J. W. Murphy M. D.

19..... (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Clover Ida — DATE OF BURIAL: 8-28 1921

20. UNDERTAKER: Homer B Evans — ADDRESS .....

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-12 M. 6-15-17.

RECEIVED SEP 19 1921 BUREAU OF VITAL STATISTICS

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CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35388
Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Twin Falls Registration District No. 58

City of Filer Registration District No. 2056

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Cuthalena Mary Pulley

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female

4. COLOR OR RACE White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.) Married

6. DATE OF BIRTH. Aug. (Month) 2 (Day) 1862 (Year)

7. AGE 54 Yrs. — Mos. 26 ds.

IF LESS than 1 day how many .... hrs. or .... min.?'

8. OCCUPATION

(a) Trade, profession or particular kind of work ..... wife .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Ohio

10. NAME OF FATHER Wm H. Shafer

11. BIRTHPLACE OF FATHER (State or Country) Penn

12. MAIDEN NAME OF MOTHER Mary Finney

13. BIRTHPLACE OF MOTHER (State or Country) Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) B. F. Pulley

(Address) Filer

15. Filed Sept. 1 1921 A. A. Jeuber Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH ..... Aug. (Month) 28 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 27 1921 to Aug. 28 1921 that I last saw h. w. alive on Aug. 24 1921 and that death occurred on the date stated above, at ....., ...M.

The CAUSE OF DEATH* was as follows:

.....

.....

..... Senile Asthes.

..... (Duration) ... 1 ... Yrs. ... mos. ... ds.

Contributory (Secondary) Myocarditis

..... (Duration) ... 5 ... Yrs. ... mos. ... ds.

(Signed) ..... Frank A. Durgin M. D.

Aug 28 21 (Address) ..... Filer, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs....mos....days. In the State....yrs....mos....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Sunset Cemetery **DATE OF BURIAL** Aug 29 1921

20. UNDERTAKER F E Drake **ADDRESS** Filer

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

Form V. S. No. 5 20M.1-16-12

RECEIVED SEP 19 1924 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. .....
Primary Registration District No. .....
File No. 35390
Registered No. .....

1. PLACE OF DEATH.
County of Washington
City of Cambridge (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ina Louise McNeil

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Single

6. DATE OF BIRTH: July (Month) 20 (Day) 1921 (Year)

7. AGE: ..... yrs. ..... mos. 29 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Washington Co Ida

10. NAME OF FATHER: Walter T McNeil

11. BIRTHPLACE OF FATHER (State or Country): Kansas

12. MAIDEN NAME OF MOTHER: Katie L Thayer

13. BIRTHPLACE OF MOTHER (State or Country): Tenn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Walter T McNeil
(Address) Weiser Ida

15. Filed 9/15/24 191 W M McLennan Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Aug (Month) 19 (Day) 1924 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 20 1924, to Aug 19 1924, that I last saw h[illegible] alive on July 20 1924, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Malnutrition

..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Premature Birth
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E A Williams M. D.
8/19 1924 (Address) Cambridge Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Salubria	Aug 19 1924

20. UNDERTAKER	ADDRESS
J V Haralson	Cambridge

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

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FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35391
Registered No.

RECEIVED SEP 19 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No.
Primary Registration District No.
County of
City of (No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs. Ellis Larsen.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Female	White	Widowed

6. DATE OF BIRTH: April (Month) 10 (Day) 1845 (Year)

7. AGE: 76 Yrs. 2 Mos. 15 ds. IF LESS than 1 day, how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Landlady - Farm lands
(b) General nature of industry, business or establishment in which employed (or employer): residing on farm. Housework.

9. BIRTHPLACE (State or Country): Denmark

10. NAME OF FATHER: H. C. Sorenson

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: Amelia Flint

13. BIRTHPLACE OF MOTHER (State or Country): Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ellis B Larsen
(Address) Indian Valley Ida

15. Filed 9/19/21 19.... Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 25 (Day) 21 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 20 1921, to June 25 1921, that I last saw h[illegible] alive on June 25 1921, and that death occurred on the date stated above, at [illegible] M.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis,

(Duration) 1 Yrs. mos. ds.

Contributory (Secondary) Senility - Edema of Legs, 15

(Duration) yrs. mos. ds.

(Signed) W. M. Coleman, M. D.

19.... (Address) Cambridge Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Indian Valley — DATE OF BURIAL: June 26 1921

20. UNDERTAKER: [illegible] — ADDRESS: Cambridge

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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FORM V. S. No. 5-25 M. 1-19.

RECEIVED
SEP 17 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 86
Primary Registration District No. 1010
File No. 35392
Registered No. 36

1. PLACE OF DEATH
County of Washington
City of Weiser (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elsie Katherine Morrison

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Child

6. DATE OF BIRTH: Aug (Month) 12 (Day) 1921 (Year)

7. AGE: — Yrs. — Mos. — ds.
IF LESS than 1 day how many 10 hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ida

10. NAME OF FATHER: Wm Morrison

11. BIRTHPLACE OF FATHER (State or Country): So Dak

12. MAIDEN NAME OF MOTHER: Sphronia Gaggues

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) William Morrison
(Address) Weiser Ida

15. Filed Sept 15 19 21 W. A. Hamilton Local Registrar
M. D.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 13 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 12 1921, to — 19..., that I last saw h[illegible] alive on Aug 12 1921, and that death occurred on the date stated above, at 1 A M.
The CAUSE OF DEATH* was as follows:

Malformed

(Duration) ... Yrs. ... mos. 10 hrs ds.

Contributory (Secondary)
(Duration) ... yrs. ... mos. ... ds.

(Signed) [illegible] M. D.
Aug 13 1921 (Address) Weiser Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Fitterest Country — DATE OF BURIAL: 8-13 1921

20. UNDERTAKER: Northam McCann — ADDRESS: Weiser Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

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FORM V. S. No. 5-25 M. 1-19.

RECEIVED SEP 17 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Washington
City of Weiser
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 86
Primary Registration District No. 1010
(No. ..... St.)

File No. 35393
Registered No. 27.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Martha L. Allebery

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: March 21 1864 (Month) (Day) (Year)

7. AGE: 57 Yrs. 2 Mos. 12 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ill

10. NAME OF FATHER: John Waggoner

11. BIRTHPLACE OF FATHER (State or Country): Ill

12. MAIDEN NAME OF MOTHER: Susan Duty

13. BIRTHPLACE OF MOTHER (State or Country): Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Thomas E Allebery
(Address) Weiser Ida.

15. Filed June 3rd 1921 — W. R. Hamilton, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 3 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 23 1921, to May 1921
that I last saw her alive on May 23 1921
and that death occurred on the date stated above, at 9:30 A.M.
The CAUSE OF DEATH* was as follows:
Unknown Chronic Disease

(Duration) 9 Yrs. 3 mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) G. M. Mulhouse M. D.
6/3 1921 (Address) Weiser Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Fullerest Cmetery — DATE OF BURIAL: 6-5 1921
20. UNDERTAKER: Northam & McCann — ADDRESS: Weiser Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

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FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 86

County of Washington

Primary Registration District No. 1010

File No. 35394

City of Weiser (No. St.)

Registered No. 78

If death occurs away from usual residence, give facts called for under special information.

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BUREAU OF VITAL STATISTICS

2. FULL NAME Stephen Leonard Nielsen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: June (Month) 1 (Day) 1921 (Year)

7. AGE: — Yrs. — Mos. 1 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Ida

10. NAME OF FATHER Francis F Nielsen

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Martha Cahoon

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Francis F Nielsen

(Address) Weiser Ida

15. Filed July 11 1921 H. G. Saunders M.D. Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 3 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1 1921 to June 3 1921 that I last saw h.im alive on June 1 1921 and that death occurred on the date stated above, at 5 a M.

The CAUSE OF DEATH* was as follows:

Premature Birth.

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Explanation

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Guy O. Finney M. D.

6/4 1921 (Address) Weiser, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Fillerest Cemetery — DATE OF BURIAL: 6-4- 1921

20. UNDERTAKER: Northam-McCann — ADDRESS: Weiser Ida

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35395

Registered No. 24

1. PLACE OF DEATH

RECEIVED
SEP 17 1921
BUREAU OF VITAL STATISTICS

Registration District No. 86

Primary Registration District No. 1010

County of Washington

City of Weiser (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Christie B Wardrip

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Sept (Month) 12 (Day) 1891 (Year)

7. AGE: 29 Yrs. 9 Mos. 24 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: John P Smith

11. BIRTHPLACE OF FATHER (State or Country): Canada

12. MAIDEN NAME OF MOTHER: Mary M Mulck

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) G. T. Wardrip

(Address) Weiser Ida

15. Filed Sept 19 21 W. R. Hamilton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 6 (Day) 19 21 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 5 1921 to ..... 19..., that I last saw her alive on July 5 1921, and that death occurred on the date stated above, at 11 A M.

The CAUSE OF DEATH* was as follows: Cancer of breast.

(Duration) about 1 yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G. M. Waterhouse M. D.

7/7 1921 (Address) Weiser Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Fellcrest Cemetery — DATE OF BURIAL: 7-7 1921

20. UNDERTAKER: Northcutt McCann — ADDRESS: Weiser Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

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FORM V. S. No. 5-25 M. 1-19.

RECEIVED
SEP 17 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 76

Primary Registration District No. 2112

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35396

Registered No. 98

1. PLACE OF DEATH

County of Washington

City of Weiser (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ernest Stanley Stover

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH: Feb. (Month) 13. (Day) 1879 (Year)

7. AGE: 42 Yrs. 3 Mos. 29 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: George Stover

11. BIRTHPLACE OF FATHER (State or Country): Indiana

12. MAIDEN NAME OF MOTHER: Artimesia Moore

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) L. Pearl Stover
(Address) Weiser Idaho

15. Filed June 13th 1921 — W R Hamilton, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 12 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1st 1921, to June 11th 1921, that I last saw h.. alive on June 11th 1921, and that death occurred on the date stated above, at 2 A M.

The CAUSE OF DEATH* was as follows:
Rocky Mountain Tick Fever.

..... (Duration) ..... Yrs. ..... mos. 11 ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. R. Hamilton M. D.

6/13 1921 (Address) Weiser Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Hillcrest Cemetary	6.14 1921
20. UNDERTAKER	**ADDRESS**
Northam & McCann	Weiser

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35397

Registered No. 31

1. PLACE OF DEATH

Registration District No. 86

Primary Registration District No. 1010

County of Washington

City of Weiser (St.)

If death occurs away from usual residence, give facts called for under special information.

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SEP 17 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME Ruth S McC Roberts

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widow

6. DATE OF BIRTH: Dec (Month) 15 (Day) 1843 (Year)

7. AGE: 77 Yrs. 6 Mos. 3 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: Thos Mackey

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: Mary Jones

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Lellie Poulson
(Address) Weiser Idaho

15. Filed July 11 1921 H. R. Hamilton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 14 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1921, to June 18 1921, that I last saw her alive on June 18 1921, and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar

(Duration) Yrs. 6 mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) W Brecanrid M. D.

June 18 1921 (Address) Weiser

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Fullerest Cemetry — DATE OF BURIAL: 6-19 1921

20. UNDERTAKER: Northam McCann — ADDRESS: Weiser Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

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FORM V. S. No. 5-25 M. 1-19.

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BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Washington Registration District No. 86
City of Weiser (No. , St.) Primary Registration District No. 1010
File No. 35398
Registered No. 32

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Ellen Hendricks

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Feb (Month) 5th (Day) 1868 (Year)

7. AGE: 53 Yrs. 4 Mos. 14 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Joseph Kay

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: Martha Ellen Kay

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) L. Hendricks
(Address) Declo Idaho

15. Filed July 11 1921 H. P. Hamilton Local Registrar
By D. F.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 19 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 17 1921, to June 19 1921, that I last saw h[er] alive on June 18 1921 and that death occurred on the date stated above, at 6 9 M.
The CAUSE OF DEATH* was as follows:

Cardiac Dilatation

(Duration) Yrs. mos. 9 ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) W. W. Marshall M. D.
June 19 1921 (Address) Weiser

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Hillcrest Cemetery — DATE OF BURIAL: June 22 1921

20. UNDERTAKER: Northam McCann — ADDRESS: Weiser Ida

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

RECEIVED SEP 17 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Washington — Registration District No. 86
City of Weiser (No. ..... St.) — Primary Registration District No. 212
File No. 35399
Registered No. 33
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Marion Kiser

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH: Dec (Month) 2 (Day) 1887 (Year)

7. AGE: 33 Yrs. 9 Mos. 1 ds. — IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: George W Kiser

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Ellen Dickerman

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Charles Kiser
(Address) Weiser Idaho

15. Filed Sept 15 1921 — A. R. Hamilton, Local Registrar

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MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 4 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 3 1921 to Sept 4 1921 that I last saw h[illegible] alive on Sept 3 1921 and that death occurred on the date stated above, at 2 P M.
The CAUSE OF DEATH* was as follows:

Tractive Paralysis

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. H. Marshall M. D.
Sept 4 1921 (Address) Weiser

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Hillcrest Cemetery	9-5 1921

20. UNDERTAKER: Northam & McCann — ADDRESS: Weiser Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

Farney

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Washington — Registration District No. 86

City of Weiser — Primary Registration District No. 2112 — St.)

File No. 35400

Registered No. 34

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George W. Brown

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

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BUREAU OF VITAL STATISTICS

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Wh

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: July (Month) 26 (Day) 1841 (Year)

7. AGE: 79 Yrs. 11 Mos. 25 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Arkansas

10. NAME OF FATHER: Josephus Brown

11. BIRTHPLACE OF FATHER (State or Country): Missouria

12. MAIDEN NAME OF MOTHER: Eliza Hampton

13. BIRTHPLACE OF MOTHER (State or Country): Missouria

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Marshall E. Brown

(Address) Weiser Idaho

15. Filed Sept 15 1921 W. R. Hamilton Local Registrar

M. H.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 21 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 21 1921 to July 21 1921 that I last saw him alive on July 21 1921 and that death occurred on the date stated above, at 5:30 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) Yrs. mos. 1 ds.

Contributory (Secondary) Hyperarterial Tension

(Duration) 6 yrs. mos. ds.

(Signed) Ernest O Farney M. D.

July 22 1921. (Address) Weiser, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mann's Creek — DATE OF BURIAL: 7/22 1921

20. UNDERTAKER: Northam & McCann — ADDRESS: Weiser Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-10.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 86

Primary Registration District No. 101

File No. 35401

Registered No. 35

County of Washington

City of Weiser (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William B Jones

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: September (Month) 1 (Day) 1859 (Year)

7. AGE: 61 Yrs. 11 Mos. 30 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Clerk

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Arkansas

10. NAME OF FATHER: Wm N. Jones

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Hannah Barnes

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Nellie Hayden

(Address) Caldwell Idaho

15. Filed Sept 15 1921 W. R. Hamilton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August (Month) 31 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1 1921, to Aug 31 1921, that I last saw him alive on Aug 31 1921 and that death occurred on the date stated above, at 5:30 P. M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach and Liver

(Duration) — Yrs. 6 mos. — ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C A Garnant M. D.

8/31 1921 (Address) Weiser Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Caldwell Idaho — DATE OF BURIAL ..... 19.....

20. UNDERTAKER: Northam & McCann — ADDRESS: Weiser, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

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FORM V. S. No. 5-25 M. 1-19.

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CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 86
Primary Registration District No. 1010
File No. 35402
Registered No. 37

County of Washington
City of Weiser (If outside limits, give township) St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Evelyn Marie Linder

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: Wht.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single
6. DATE OF BIRTH: May (Month) 9 (Day) 1921 (Year)
7. AGE: — Yrs. 2 Mos. 3 ds. IF LESS than 1 day how many ... hrs. or ... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry, business or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Idaho
10. NAME OF FATHER: Leslie Linder
11. BIRTHPLACE OF FATHER (State or Country): Idaho
12. MAIDEN NAME OF MOTHER: Grace Anderson
13. BIRTHPLACE OF MOTHER (State or Country): Colo.
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) x M E Adams
(Address) Weiser Ida
15. Filed Sept 15 1921 W. R. Hamilton Local Registrar
By E Ott

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 12 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 10 1921, to July 12 1921, that I last saw h-er alive on July 12 1921 and that death occurred on the date stated above, at 9 P.M.

The CAUSE OF DEATH* was as follows:

acu [redacted]

Acute endocarditis.

(Duration) Yrs. mos. 6 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) C A Canaan M. D.

7-13 1921 (Address) Weiser Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Hillcrest Cemetery — DATE OF BURIAL: 7-13 1921

20. UNDERTAKER: Northam & McCann — ADDRESS: Weiser Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

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FORM V. S. No. 5-25 M. 1-19.

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CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 86
Primary Registration District No. 1010
File No. 35403
Registered No. 38

1. PLACE OF DEATH
County of Washington
City of Weiser (Or Town) St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Baby Hartong

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: January (Month) 16 (Day) 1921 (Year)

7. AGE: — Yrs. — Mos. — ds.
IF LESS than 1 day how many 1 hrs. or — min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ida

10. NAME OF FATHER: Samuel Hartong

11. BIRTHPLACE OF FATHER (State or Country): Ida

12. MAIDEN NAME OF MOTHER: Blanche Albrecht

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Earl Albrecht
(Address) Weiser Ida

15. Filed Sept 15 1921 W. R. Hamilton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 14 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 14 1921 to July 14 1921 that I last saw h[illegible] alive on July 14 1921, and that death occurred on the date stated above, at 6 A.M.
The CAUSE OF DEATH* was as follows:

Premature

(Duration) Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) W. H. Marshall M. D.
July 14 1921 (Address) Weiser

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Hillcrest Cemetery — DATE OF BURIAL: 7-17 1921
20. UNDERTAKER: Northam & McCann — ADDRESS: Weiser Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

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FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 86
Primary Registration District No. 1010
File No. 35404
Registered No. 37

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SEP 17 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Washington
City of Weiser (If outside limits, give township) St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Frank S. Miller
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Dec 13 1885 (Month) (Day) (Year)

7. AGE: 35 Yrs. 6 Mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Real Estate Broker
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ida

10. NAME OF FATHER: John S Miller

11. BIRTHPLACE OF FATHER (State or Country): Indiana

12. MAIDEN NAME OF MOTHER: Mary S Donart

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Horace A. Donart
(Address) Mesa Idaho

15. Filed Aug 1st 1921 W. R. Hamilton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July 8th 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 10th 1921, to July 8th 1921, that I last saw h[illegible] alive on July 7th 1921, and that death occurred on the date stated above, at 2300 M.
The CAUSE OF DEATH* was as follows:
Typhoid Fever
(Duration) ..... Yrs. ..... mos. 30 ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) W. R. Hamilton M. D.
7/10 1921 (Address) Weiser Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Soldiers Cemetery — DATE OF BURIAL: 7-11 1921
20. UNDERTAKER: Northcraft McCann — ADDRESS: Weiser

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

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FORM V. S. No. 5-25 M. 1-19.

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BUREAU OF VITAL STATISTICS
STATE OF IDAHO

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 86
Primary Registration District No. 2012
File No. 35405
Registered No. 40

1. PLACE OF DEATH
County of Washington
City of Weiser
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Gene Minnie Rowland

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: Wht
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.):

6. DATE OF BIRTH: May (Month) 25 (Day) 1921 (Year)

7. AGE: — Yrs. 1 Mos. 19 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Wilbur Rowland

11. BIRTHPLACE OF FATHER (State or Country): Nebr.

12. MAIDEN NAME OF MOTHER: Jessie Ellen Abbott

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wilbert Rowland
(Address) Eatons

15. Filed Aug 1st 1921 — W. R. Hamilton, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 14 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 14th 1921, to July 14th 1921
that I last saw her alive on " 14th 1921
and that death occurred on the date stated above, at 5 P.M.
The CAUSE OF DEATH* was as follows:
Coalw Enlenbs
(Duration) Yrs. mos. 2 ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) W. R. Hamilton M. D.
7/18/1921 (Address) Weiser Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Hillcrest Cemetery — DATE OF BURIAL: 7/15 1921

20. UNDERTAKER: Northam & Conn — ADDRESS: Weiser, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED SEP 17 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 86
Primary Registration District No. 212
File No. 35406
Registered No. 41

1. PLACE OF DEATH
County of Washington
City of Weiser
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Robert Fifield
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widower

6. DATE OF BIRTH: Apr (Month) 24 (Day) 1866 (Year)

7. AGE: 55 Yrs. 3 Mos. 17 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Chas Byron Fifield

11. BIRTHPLACE OF FATHER (State or Country): Vermont

12. MAIDEN NAME OF MOTHER: Lucy Hardy

13. BIRTHPLACE OF MOTHER (State or Country): Maine

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Rex Fifield
(Address): Weiser Idaho

15. Filed Sept 16 1921 W. R. Hamilton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 13 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19 .... to ..... 19 ....
that I last saw h[illegible] alive on July 13 1921,
and that death occurred on the date stated above, at 4.30 P.M.
The CAUSE OF DEATH* was as follows: Heart disease) died Before Medical Aid Could Be Called.
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Jas. J. McCann Coroner M. D.
7-15 1921 (Address) Weiser Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Weston, Ida. | DATE OF BURIAL ..... 19 ....

20. UNDERTAKER: Northam McCann | ADDRESS: Weiser, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

Form V. S. No. 2-D M. 1-20.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
OCT 31 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
Registration District No. 2119
County of Franklin
Primary Registration District No. 27
City of Preston (St.)
File No. 35407
Registered No. 55
If death occurs away from usual residence, give facts called for under special information.
2. FULL NAME Vernal Smart
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Aug (Month) 7 (Day) 1898 (Year)

7. AGE: 23 Yrs. 2 Mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Lake ~~Bear~~ Bogie town Bear Lake Co.

10. NAME OF FATHER: Abel Smart

11. BIRTHPLACE OF FATHER (State or Country): Trinety Wiltshire Engd

12. MAIDEN NAME OF MOTHER: Emma Irvine Italy

13. BIRTHPLACE OF MOTHER (State or Country): Coalville Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Ethel Smart
(Address) Preston Idaho.

15. Filed Oct 26 1921 D A R Curtis Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct 15 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 15 1921, to Oct 15 1921 that I last saw h.l.M. alive on Oct 15 1921, and that death occurred on the date stated above, at 5:50 P.M.

The CAUSE OF DEATH* was as follows:
Accidental shooting — by rifle - shot through abdomen

(Duration) ..... Yrs. ..... mos. 9 hrs. ..... ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Laurie Bland M. D. Preston Ida
10/15 1921 (Address) Preston Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Preston Idaho — DATE OF BURIAL: Oct 18 1921

20. UNDERTAKER: W A Skedmore — ADDRESS: Preston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED OCT 31 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 1004
File No. 35408
Registered No. 307

1. PLACE OF DEATH

County of Ada
City of Boise (If outside limits of city or village, write the name of township.) 510 E. Bannock St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Clarence Marion Rouse

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	White	Single

6. DATE OF BIRTH: October 24 1921 (Month) (Day) (Year)

7. AGE: ... Yrs. ... Mos. 1 ds. IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Boise Ida

10. NAME OF FATHER: Clarence G. Rouse

11. BIRTHPLACE OF FATHER (State or Country): Mich

12. MAIDEN NAME OF MOTHER: Mary McLaughlin

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Clarence G. Rouse
(Address) Hammett Ida.

15. Filed Oct 27 1921 R. H. Pratt Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct 25 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 23 1921, to Oct 25 1921 that I last saw h... alive on Oct 25 1921 and that death occurred on the date stated above, at ... M.

The CAUSE OF DEATH* was as follows:
Acute intoxication

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) J. H. Hamm M. D.
Oct 27 1921 (Address) [illegible]

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Glenns Ferry Ida — DATE OF BURIAL: Oct 28 1921

20. UNDERTAKER: Summers & Trefz — ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
OCT 31 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35409
Registered No. 908

1. PLACE OF DEATH
Registration District No. 2
Primary Registration District No. 1004
County of Ada
City of Boise (No. 410, State St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Orville John Olsen
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: March 3 (Month) (Day) 1902 (Year)

7. AGE: 19 Yrs. 7 Mos. 24 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Placerville Ida

10. NAME OF FATHER: Hans Olsen

11. BIRTHPLACE OF FATHER (State or Country): Norway

12. MAIDEN NAME OF MOTHER: Lizzie Evensen

13. BIRTHPLACE OF MOTHER (State or Country): Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Lizzie Olsen
(Address) Horse Shoe Bend

15. Filed Oct 27 1921 R. N. Pratt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct 27 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 27 1921 to ..... 19....., that I last saw h... alive on Oct 26 1921 and that death occurred on the date stated above, at 2.2 A.M.
The CAUSE OF DEATH* was as follows:
Bronchitis, Pneumonia
(Duration) ..... Yrs. ..... mos. 12 ds.
Contributory (Secondary) Lobar Pneumonia
(Duration) ..... yrs. ..... mos. 3 ds.
(Signed) W. H. Hallenan M. D.
19 21 (Address) Boise

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence Horse Shoe Bend

19. PLACE OF BURIAL OR REMOVAL: Horse Shoe Bend — DATE OF BURIAL: 10/28 1921

20. UNDERTAKER: Schreiber & Sidenfaden — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY; PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25-M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35410
Registered No. 309

RECEIVED
OCT 31 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
Registration District No. 2
Primary Registration District No. 1004
County of Ada
City of Boise (If outside limits, give township) No. 710 State St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Francis Isabell Bolt
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: June (Month) 14th (Day) 1888 (Year)

7. AGE: 33 Yrs. 4 Mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housekeeper
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mo.

10. NAME OF FATHER: E. S. Hazzard

11. BIRTHPLACE OF FATHER (State or Country): Ill.

12. MAIDEN NAME OF MOTHER: M.

13. BIRTHPLACE OF MOTHER (State or Country): Am.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jesse W Bolt
(Address) Hill City Idaho

15. Filed Oct 27 1921 W. H. Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. (Month) 27 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 10-13 1921 to 10-27 1921 that I last saw her alive on 10-27 1921, and that death occurred on the date stated above, at 1:45 P.M.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage

(Duration) Yrs. 1 mos. 2 ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D O Higgs M. D.
10-27 1921 (Address) Boise Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence Hill City Idaho

19. PLACE OF BURIAL OR REMOVAL: Hill City Idaho — DATE OF BURIAL: Oct 28 1921

20. UNDERTAKER: Schreiber & Hickenbottom — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

DISINTERMENT PERMIT

STATE OF IDAHO
DEPARTMENT OF PUBLIC HEALTH
BOISE, IDAHO

APPLICATION HAVING BEEN MADE for the disinterment of the body of Frances Isabell Bolt

now lying buried in Hill City Cemetery, in the City or Town of Hill City

County of Camas State of Idaho, who died on the 27th day of October, 1921, Aged adult years ____ months

____ days, the cause of death being Cerebral hemorrhage and not directly or indirectly by diphtheria; (membranous croup); scarlet fever; smallpox; leprosy; asiatic cholera; typhus fever; or yellow fever as shown by the certificate of death of said deceased, given by

D. P. Higgs attending Physician

THIS IS TO CERTIFY that permission is hereby given for such disinterment and removal by private
private or railway conveyance

to Cloverdale Cemetery in the City or Town of _____ County of Ada

State of Idaho to take effect upon the approval by the local board of health of the City, Town, or County of

Camas it being understood and provided that nothing herein shall be deemed as contravening or in anywise modifying or releasing the Regulations of the Department of Public Health governing the Transportation of Corpses or the requirements for a Transportation permit, and all Transportation Companies and Common Carriers will be governed accordingly; and provided further, that where the disinterment is for the purpose of reinterment in another part of the same cemetery, or in a contiguous cemetery, the removal shall not be made by any public conveyance. The disinterment and removal must be done under the personal supervision of a licensed Embalmer in good standing. If the remains are to be removed from the cemetery they (including the disinterred casket), must be enclosed in a new metallic lined outer case before removal.

Given under my hand and Seal of the Department of Public Health at Boise, Idaho,

permit issued to: this 5th day of Oct, A.D. 54.

McBratney-Alden
Boise, Idaho

W W Benson
Director, Division of Vital Statistics

The foregoing application for disinterment and removal is hereby approved by the local Board of Health of the City, Town or County of Camas State of Idaho, this 6 day of Oct 1954.

Removal completed Oct. 17, 1954
A. E. Alden

Marion J. Kerns
Health Officer

Form DPH-48019

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35411
Registered No. 310

RECEIVED
OCT 30 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Ada
City of Boise (No. 518 N 13th St.)
Registration District No. 7
Primary Registration District No. 1004
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sarah A. Cunningham
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): widowed

6. DATE OF BIRTH: January 3 (Month) (Day) 1857 (Year)

7. AGE: 64 Yrs. 9 Mos. 25 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): St Stephen New Brunswick

10. NAME OF FATHER: George T. Young.

11. BIRTHPLACE OF FATHER (State or Country): Maine

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Mayfield
(Address) Boise Idaho

15. Filed 10/29 1921
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct 28th 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 2 1921, to Oct 28 1921, that I last saw h... alive on Oct 28 1921, and that death occurred on the date stated above, 11:30 P. M.
The CAUSE OF DEATH* was as follows:
Apoplexy
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Leo Callista M. D.
19..... (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence Boise, Idaho

19. PLACE OF BURIAL OR REMOVAL: Masonic Cemetery
DATE OF BURIAL: 10/29 1921

20. UNDERTAKER: Schreiber & Sidenfaden
ADDRESS: Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
OCT 31 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35412

Registered No. 311

1. PLACE OF DEATH

County of Ada.

City of Boise (No. St. Luke's Hospital St.)

Registration District No. 2

Primary Registration District No. 1004

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Edward M. Pierce

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M.	W.	Widowed

6. DATE OF BIRTH: Sept. 29. 1859
(Month) (Day) (Year)

7. AGE: 62 Yrs. — Mos. 29 ds.
IF LESS than 1 day how many ____ hrs. or ____ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer.
(b) General nature of industry, business or establishment in which employed (or employer): Common.

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER: Connelly Pierce

11. BIRTHPLACE OF FATHER (State or Country): Ireland.

12. MAIDEN NAME OF MOTHER: Don't Knows

13. BIRTHPLACE OF MOTHER (State or Country): New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. VanCleave.
(Address) Homestead — Ore.

15. Filed Oct 29 1921 R. H. Pratt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. 28 — 1921
(Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 30 1921 to Oct 28 1921 that I last saw him alive on Oct 27 1921 and that death occurred on the date stated above, at 6:30 P.M.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) ____ Yrs. ____ mos. ____ ds.

Contributory (Secondary)

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) John Bacon M. D.

10/30/1921 (Address) Boise. Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 10/30/21

20. UNDERTAKER: W. McBratney — ADDRESS: Boise Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35414

Registered No. 313

1. PLACE OF DEATH

County of Ada

City of Boise (No. 407 Broad St.)

Registration District No. 2

Primary Registration District No. 1004

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
OCT 31 1921
BUREAU OF VITAL STATISTICS

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Amanda Baxter

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: ~~Widow~~ (Write word.)

6. DATE OF BIRTH: Aug (Month) 7 (Day) 1836 (Year)

7. AGE: 85 Yrs. 2 Mos. 22 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business or establishment in which employed (or employer): ——

9. BIRTHPLACE (State or Country): New Jersey.

10. NAME OF FATHER: Charles Laywith

11. BIRTHPLACE OF FATHER (State or Country): England.

12. MAIDEN NAME OF MOTHER: Amanda Crowcal

13. BIRTHPLACE OF MOTHER (State or Country): New Jersey.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Carrie L Baxter

(Address) .....

15. Filed Oct 31 1921 R. W. Pratt Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 29 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 27 1921, to Oct 29 1921, that I last saw h.. alive on Oct 29 1921, and that death occurred on the date stated above, at 11 A M.

The CAUSE OF DEATH* was as follows:

Senility

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Arteria sclerosis

? (Duration) 5 yrs. 0 mos. 0 ds.

(Signed) Roscoe C Ward M. D.

10/31 1921 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Masonic Cemetery — DATE OF BURIAL: Oct 31 1921

20. UNDERTAKER: Summers & Gebs. — ADDRESS: Boise Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35415

Registered No. 214

RECEIVED
OCT 31 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 2

County of Ada

Primary Registration District No. 1 w 4

City of Boise (No. 410 Linda St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Clay Clarke Case

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: July (Month) 31 (Day) 1900 (Year)

7. AGE: 21 Yrs. 3 Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Motor Mechanic
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Arkansas

10. NAME OF FATHER: R. F. Case

11. BIRTHPLACE OF FATHER (State or Country): Ark.

12. MAIDEN NAME OF MOTHER: Grace Simmons

13. BIRTHPLACE OF MOTHER (State or Country): Ark.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R. F. Case
(Address) Glenns Ferry, Ida

15. Filed Oct 31 1921 R. K. Pratt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: October (Month) 31 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from October 27 1921, to October 31 1921, that I last saw h.im alive on October 31 1921, and that death occurred on the date stated above, at 10 to 12 M.

The CAUSE OF DEATH* was as follows:
Tuberculer peritonitis

(Duration) Yrs. 6 mos. 0 ds.

Contributory (Secondary) Pulmonary tuberculosis

(Duration) 1 yrs. mos. ds.

(Signed) Roscoe L Ward M. D.

10/31/1921 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence Glenns Ferry Ida

19. PLACE OF BURIAL OR REMOVAL: Glenns Ferry Ida — DATE OF BURIAL: Nov 2 1921

20. UNDERTAKER: Schreiber & Siebenpfeiffer — ADDRESS: Boise

to Pillings

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED OCT 31 19[illegible]

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 35416
Registered No. 376

1. PLACE OF DEATH
County of Ada
City of Boise (If outside limits, give township) St. No. 1406 Grand Ave St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Audrey E. Tompkins

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Feb (Month) 25 (Day) 1913 (Year)

7. AGE: 8 Yrs. 8 Mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: A. P. Tompkins

11. BIRTHPLACE OF FATHER (State or Country): South Dakota

12. MAIDEN NAME OF MOTHER: Laura McHenry

13. BIRTHPLACE OF MOTHER (State or Country): Nebraska

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Laura M. Tompkins
(Address) 1406 Grand Ave.

15. Filed Nov 1 1921 R. H. Pratt Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: ~~Oct~~ Oct (Month) 29 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 28 1921, to Oct 29 1921, that I last saw her alive on Oct 29 1921, and that death occurred on the date stated above, at 6:00 P.M.
The CAUSE OF DEATH* was as follows:
Scarlet Fever
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) ✓
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) C. L. Sutton M. D.
10/31 1921 (Address) Overland Bldg.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery
DATE OF BURIAL: Nov 1 1921
20. UNDERTAKER: Summers & Kreps
ADDRESS: Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

RECEIVED OCT 3 - 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35417
Registered No. 306

1. PLACE OF DEATH

County of Ada — Registration District No. 7
City of Boise — Primary Registration District No. 1004
(No. 110 E. Bannock St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Hazel Bennett Burns

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
F	White	Married

6. DATE OF BIRTH: March 8 (Month) (Day) 1887 (Year)

7. AGE: 34 Yrs. 7 Mos. 16 ds. — IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mich

10. NAME OF FATHER: George G. Bennett

11. BIRTHPLACE OF FATHER (State or Country): Canada

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Richard F. Burns
(Address) 811 North 11th St.

15. Filed Oct 25 1921 — R. T. Pratt, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 24 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 18 19..., to Oct 24 1921, that I last saw her alive on Oct 24 1921, and that death occurred on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:

Cerebro Spinal Meningitis

(Duration) ... Yrs. ... mos. 7 ds.

Contributory (Secondary): Respiratory Paralysis.

(Duration) ... yrs. ... mos. 15 ~~ds.~~ mins

(Signed) T. N. Braxton M. D.

Oct 25 1921 (Address) Boise Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Morris Hill Cemetery	Oct 28 1921
20. UNDERTAKER: Summers & Turbe	ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

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FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35418

Registered No. 305

RECEIVED
OCT 31 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. .....

Primary Registration District No. .....

County of Ada

City of Boise (No. St. Lukes Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elizabeth Alexander

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (or widowed)

6. DATE OF BIRTH: — (Month) — (Day) 1874 (Year)

7. AGE: 47 Yrs. — Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Penn.

10. NAME OF FATHER: Charles Milton

11. BIRTHPLACE OF FATHER (State or Country): Ireland.

12. MAIDEN NAME OF MOTHER: Unknown.

13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) G. H. Alexander

(Address) .....

15. Filed ..... 19 .....

R. N. Pratt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 23 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 17 1921, to Oct 23 1921, that I last saw her alive on Oct 23 1921, and that death occurred on the date stated above, at 2:15 P.M.

The CAUSE OF DEATH* was as follows:

Septic Hepatitis

(Duration) ..... Yrs. ..... mos. 6 ds.

Contributory (Secondary) Respiratory failure

(Duration) ..... yrs. ..... mos. 1 ds.

(Signed) T. N. Bradfan M. D.

Oct 19 22 (Address) Boise Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Oct 26 1921

20. UNDERTAKER: Summers & Metz — ADDRESS: Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED OCT 31 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35419

1. PLACE OF DEATH
County of Ada Registration District No. 2
City of Boise Primary Registration District No. 10026
(No. 822½ Main St.)
Registered No. 304

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Effie Bell Allison

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Widowed

6. DATE OF BIRTH: October (Month) 8 (Day) 1874 (Year)

7. AGE: 47 Yrs. — Mos. 14 ds. IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired Housekeeper
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Azzy H. Wylie

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Elizabeth Perkins

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) May Allison
(Address) Boise Idaho

15. Filed Oct 25 1921 R. H. Pratt Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

~~MEDICAL~~ CERTIFICATE OF DEATH

16. DATE OF DEATH: October (Month) 22 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I ~~attended~~ have taken care of deceased ~~from~~ for twenty years 19 ... to October 22 1921, that I last saw h.er alive on October 22 19 21, and that death occurred on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:
Mother has been an invalid for the past twenty years, all physicians but mother passed away by (Duration) one week arrived mos. and ds.
he Contributory (Secondary) declared it heart Disease as cause of Death (Duration) mos. ds.

(Signed) May Allison Daughter

19 ... (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Dry Creek Cemetery	10/25 1921
20. UNDERTAKER	ADDRESS
Fetherston & Nicholson	Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35420
Registered No. 302

1. PLACE OF DEATH

County of Ada

City of Boise (No. 1414 N. 8th St.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED OCT 31 1921 BUREAU OF STATISTICS

Registration District No. 2

Primary Registration District No. 1004

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Paul George Harbeke

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Oct (Month) 25th (Day) 1918 (Year)

7. AGE: 2 Yrs. 11 Mos. 25 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Salt Lake, Utah

10. NAME OF FATHER: Louis N. Harbeke

11. BIRTHPLACE OF FATHER (State or Country): Ills.

12. MAIDEN NAME OF MOTHER: Mary Victoria Harris

13. BIRTHPLACE OF MOTHER (State or Country): Ont. Can.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) L. N. Harbeke

(Address) Boise, Idaho.

15. Filed Oct 24, 1921 R. H. Pratt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 20th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 19 1921, to Oct 20 1921, that I last saw him alive on Oct 20 1921, and that death occurred on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of Heart ?

Respiration Paralysis

(Duration) Yrs. mos. 2 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) L. V. Young M. D.

Oct 24 1921 (Address) Boise

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence: Boise, Idaho.

19. PLACE OF BURIAL OR REMOVAL: Salt Lake City, Utah. DATE OF BURIAL: 10/24 1921

20. UNDERTAKER: Schreiber & Sidenfaden ADDRESS: Boise Idaho

Dr. Young.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD

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FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35421

Registered No. 303

RECEIVED
OCT 31 1921
BUREAU OF VITAL STATISTICS

Registration District No. 2

Primary Registration District No. 1004

1. PLACE OF DEATH

County of Ada

City of Boise, (If outside limits of city or village, write the word "Outside.") No. 815 Hays St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Margaret Hanna Lyman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widow

6. DATE OF BIRTH: July 6 (Month) 1866 (Day) (Year)

7. AGE: 55 Yrs. 3 Mos. 17 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Librarian

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Minnesota

10. NAME OF FATHER: David Lyman.

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Anna J Hanna

13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Clyde E Summers

(Address) Boise Idaho

15. Filed Oct 23 1921 R. N. Pratt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 23 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1 1921, to Oct 23 1921, that I last saw her alive on Oct 23 1921 and that death occurred on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Cystitis - two months

circumscribed

(Duration) about Yrs. 2 mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) L D Brown M. D.

19..... (Address) 303 N. 12 St

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Oct 25 1921

20. UNDERTAKER: Summers & Hurst — ADDRESS: Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

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FORM V. S. No. 5-25 M. 1-19.

RECEIVED OCT 31 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35422
Registered No. 500

1. PLACE OF DEATH

Registration District No.
Primary Registration District No.

County of Ada
City of Boise (No. 1412, Hays, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lucile Alsop.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White (English)	

6. DATE OF BIRTH: January (Month) 14 (Day) 1914 (Year)

7. AGE: 7 Yrs. 9 Mos. 1 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ada Co. Idaho.

10. NAME OF FATHER: Ernest B. Alsop.

11. BIRTHPLACE OF FATHER (State or Country): New York.

12. MAIDEN NAME OF MOTHER: Grace Clark.

13. BIRTHPLACE OF MOTHER (State or Country): Iowa.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ernest B. Alsop
(Address) 1412 Hays Street Boise Ida.

15. Filed Oct 17 1921 R. N. Pratt, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: October (Month) 15 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 15th 1921, to Oct. 18th 1921, that I last saw her alive on Oct 16th 1921, and that death occurred on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:

died of Asphixiation failure
cause unknown - Probable
Aution poisoning Ptomaine - Bubonic
Typhoid - Not yet completed (Duration) Yrs. mos. ds.

Contributory (Secondary) ill only 2 days (Duration) yrs. mos. ds.

(Signed) C. M. Taylor M. D.
10/17, 1921 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 10/18 1921

20. UNDERTAKER: Schneider & Lidwell — ADDRESS: Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Ada RECEIVED

City of Boise OCT 31 1921

Registration District No.

Primary Registration District No.

(No. 210 South 7th St.)

File No. 35423

Registered No. 297

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Baby Shikumura

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Yellow

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Oct. (Month) 12 (Day) 1921 (Year)

7. AGE: ....Yrs. ....Mos. 1 ds.

IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Boise

10. NAME OF FATHER: S. Shikumura

11. BIRTHPLACE OF FATHER (State or Country): Japan

12. MAIDEN NAME OF MOTHER: K. Yamamoto

13. BIRTHPLACE OF MOTHER (State or Country): Japan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) H. Umeda

(Address) Boise

15.

Filed .... 19....

Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. (Month) 13 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 12th 1921 to Oct. 13th 1921 that I last saw him alive on Oct. 12th 1921 and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Intracranial Hemorrhage - Congenital Debility or a Malformation (congenital)

(Duration) .... Yrs. .... mos. .... ds.

Contributory (Secondary) ....

(Duration) .... yrs. .... mos. .... ds.

(Signed) Geo. Burnham M. D.

Oct. 31 1921 (Address) Boise Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .... yrs. .... mos. .... days. In the State .... yrs. .... mos. .... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Japanese Plot | DATE OF BURIAL: Nov 1 1921

20. UNDERTAKER: Schreiber & Sidenfaden | ADDRESS: Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35424
Registered No. 398

RECEIVED
OCT 31 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Ada — Registration District No. 2
City of Boise — Primary Registration District No. 1004
(If outside city limits, give township) (No. 240, E. Jefferson St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Horatio Schwartz

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widower

6. DATE OF BIRTH: October 24 (Month) (Day) 1838 (Year)

7. AGE: 83 Yrs. 11 Mos. 19 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ill

10. NAME OF FATHER: Edward Schwartz

11. BIRTHPLACE OF FATHER (State or Country): Penn

12. MAIDEN NAME OF MOTHER: Sarah Pyle

13. BIRTHPLACE OF MOTHER (State or Country): Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R. A. Schwartz
(Address) Boise Idaho

15. Filed Oct 15 1921 — H. H. Foat, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 13 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 1 1921 to Oct. 13 1921, that I last saw h.... alive on Oct. 12 1921, and that death occurred on the date stated above, at 10 A.M.
The CAUSE OF DEATH* was as follows:
Senility
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) C. O. Knigsbury M.D.
10/23 1921 (Address) 401 Idaho Bldg

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Oct 16 1921

20. UNDERTAKER: Summers & Krebs — ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
OCT 31 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No.....

Primary Registration District No.....

County of Ada.

City of Boise. (No. 628, Ford St.)

File No. 35425

Registered No. 299

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary McNish Bradley Hartmann

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Do not know.

6. DATE OF BIRTH: March (Month) 6 (Day) 1862 (Year)

7. AGE: 59 Yrs. 7 Mos. 7 ds.

IF LESS than 1 day how many.....hrs. or.....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wisconsin

10. NAME OF FATHER: Alexander McNish

11. BIRTHPLACE OF FATHER (State or Country): Scotland

12. MAIDEN NAME OF MOTHER: Elizabeth McNish

13. BIRTHPLACE OF MOTHER (State or Country): Don't know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Scott Bradley (illegible)

(Address) Boise, Idaho.

15. Filed Oct 17 1921 R. V. Pratt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 13 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 30 1921, to Oct 13 1921, that I last saw her alive on Oct 13 1921, and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Valvular Heart disease

(Duration) 10 Yrs. mos. ds.

Contributory (Secondary) Heart Block.

(Duration) yrs. mos. 7 ds.

(Signed) T. N. Braxton M. D.

Oct 13 1921 (Address) Corpire B. Boise Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 10/17 1921

20. UNDERTAKER: Schreiber & Sidenstein — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35426
Registered No. 296

RECEIVED OCT 31 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 2
Primary Registration District No. 1004

County of Ada
City of Boise (No. 710 State St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs Leota Hankammer

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Married

6. DATE OF BIRTH: Dec (Month) 21 (Day) 1883 (Year)

7. AGE: 38 Yrs. 9 Mos. 21 ds. IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Calif

10. NAME OF FATHER: W. H. Nelson

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Elizabeth Jane Maple

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. P. Hankammer
(Address) # 1 Kuna Ida

15. Filed Oct. 17-21 19 ... R. H. Pratt Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 12 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9/29 1921, to 10/12 1921, that I last saw h[er] alive on 10/11 1921, and that death occurred on the date stated above, at ... M.

The CAUSE OF DEATH* was as follows:

Typhoid fever

(Duration) ... Yrs. ... mos. 14 ds.

Contributory (Secondary) Intestinal hemorrhage

(Duration) ... yrs. ... mos. ... ds.

(Signed) Ralph Todd M. D.

10/12 1921 (Address) Boise

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Kuna Idaho	10/17 1921

20. UNDERTAKER	ADDRESS
Schneider & Sidenfaden	Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

RECEIVED OCT 31 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Tallman

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35427
Registered No. 292

1. PLACE OF DEATH
County of Ada
City of Boise (No. 418 W State St.)
Registration District No. 2
Primary Registration District No. 1004
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Edith I. Stanfield
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: White.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: (Month) 1873 (Day) 1 (Year)

7. AGE: 48 Yrs. 0 Mos. 0 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Isaac Trumbull

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Sarah Hale

13. BIRTHPLACE OF MOTHER (State or Country): Mass.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) L. B. Stanfield
(Address) Boise Idaho R. F. D. #1

15. Filed Oct 10 1921 R. V. Pratt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct 7 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1 1921, to Oct 7 1921, that I last saw h.. alive on Oct 7 1921 and that death occurred on the date stated above, at 7 A M.

The CAUSE OF DEATH* was as follows:
Pulmonary embolism following surgical operation for pelvic cellulitis.
(Duration) ..... Yrs. ..... mos. 1 ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) M. L. Tallman M. D.
10/10 1921 (Address) Box 10-21 Boise

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Oct 12 21

20. UNDERTAKER: Dunnigan & York — ADDRESS: Boise Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED OCT 31 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35428
Registered No. 293

1. PLACE OF DEATH
County of Ada
City of Boise (No. 621 N. 18th St. St.)
Registration District No. 9
Primary Registration District No. Ashwood
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs L. A. McCulla,
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widowed (Write the word.)

6. DATE OF BIRTH: Sept 20 — 1850 (Month) (Day) (Year)

7. AGE: 71 Yrs. 0 Mos. 19 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Va.

10. NAME OF FATHER: Elias. G. Harman.

11. BIRTHPLACE OF FATHER (State or Country): Va

12. MAIDEN NAME OF MOTHER: Mary May

13. BIRTHPLACE OF MOTHER (State or Country): Ky.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. McBratney
(Address) Boise Idaho

15. Filed Oct. 11 1921 R. H. Pratt, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. 9 (Month) (Day) 19 21 (Year)

17. I HEREBY CERTIFY, That I attended deceased from September 25 1921, to October 9 1921, that I last saw h.. alive on October 9 1921 and that death occurred on the date stated above, at 6 P.M.
The CAUSE OF DEATH* was as follows:
Capillary Bronchitis
(Duration) ..... Yrs. ..... mos. 14 ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) M. Mccoy Cauthorn M. D.
10/10/21 19 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. ~~LENGTH~~ OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery
DATE OF BURIAL: 10/11/ 19 21

20. UNDERTAKER: W. McBratney
ADDRESS: Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35429
Registered No. 294

RECEIVED
OCT 31 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Ada Registration District No.

City of Boise Primary Registration District No. 2

(No. 3707 N. 6th St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jack Oliver Pierce

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
M.	W.	Single (Write the word.)

6. DATE OF BIRTH Feb 27 1921
(Month) (Day) (Year)

7. AGE Yrs. 7 Mos. 14 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER W. A. Pierce

11. BIRTHPLACE OF FATHER (State or Country) Iowa

12. MAIDEN NAME OF MOTHER Viola Pierce

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. McBratney
(Address) Boise Ida.

15. Filed Oct 12 1921 R. H. Pratt
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 11 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 11 1921 to Oct 11 1921
that I last saw h. alive on Oct 11 1921,
and that death occurred on the date stated above, at 2 P. M.
The CAUSE OF DEATH* was as follows:
Acute anterior poliomyelitis

(Duration) Yrs. mos. 1 ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) M. K. Dallman M. D.
10/12 1921 (Address) Boise Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Morris Hill Cemetery	10/13/21 1921

20. UNDERTAKER W. McBratney ADDRESS Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-12

RECEIVED OCT 31 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35430
Registered No. 295

1. PLACE OF DEATH
County of Ada
City of Boise
Registration District No. 2
Primary Registration District No. 1004
(No. St. Lukes Hosp. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME, Peter Sederlund

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH: Nov (Month) 17 (Day) 1860 (Year)

7. AGE: 61 Yrs. Mos. ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Carpenter
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Malpa Sweden

10. NAME OF FATHER: Peter Tomason

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Anna Engelbrekt

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Laura Price
(Address) [illegible]

15. Filed October 14 1921 R H Pratt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 13 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 1 1921 to Oct 13 1921 that I last saw h~~im~~ alive on Oct 13 1921, and that death occurred on the date stated above, at 1.30 M.

The CAUSE OF DEATH* was as follows:
Pulmonary Tubercle

(Duration) 2 Yrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) Hubert F. Neal M. D.
10/13 1921 (Address) Meridian Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Meridian Cemetery	19

20. UNDERTAKER: W. D. Mathews ADDRESS: Meridian Id.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51997

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

Canyon Co.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35431

Registered No. 291

RECEIVED
OCT 31 1921
BUREAU OF VITAL STATISTICS

Registration District No. 7

Primary Registration District No. 1004

1. PLACE OF DEATH

County of Ada

City of Boise (No. 116 E. Bannock St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lester Joseph Clark

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: April 19 (Month) (Day) 1917 (Year)

7. AGE: 4 Yrs. 5 Mos. 21 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Boise Idaho

10. NAME OF FATHER: Roy E. Clark

11. BIRTHPLACE OF FATHER (State or Country): Boise Idaho

12. MAIDEN NAME OF MOTHER: Vera Tinsley

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address): Roy Clark Boise R.D.5

15. Filed Oct 10 1921

R. N. Pratt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. (Month) 16 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 5 1921, to Oct 16 1921, that I last saw h.... alive on Oct 9 1921, and that death occurred on the date stated above, at 1 A. M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... Yrs. ..... mos. 5 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. Owen Carmichael M. D.

10-16-1921 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Oct 12 1921

20. UNDERTAKER: Summers & Turk — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED 3.
OCT 31 1921
BUREAU OF VITAL STATISTICS

Ward,

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35432
Registered No. 290

1. PLACE OF DEATH
County of Ada
City of Boise (No. 410 W. State St.)
Registration District No. 2
Primary Registration District No. 1904

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John H Abbott

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: April 10 1846 (Month) (Day) (Year)

7. AGE: 75 Yrs. 5 Mos. 29 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: Abbott

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jesse Abbott
(Address) R. F. D. # 2, Boise, Ida.

15. Filed Oct 10 1921 R. H. Pratt Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct 9 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 30 1921, to Oct. 9 1921, that I last saw him alive on Oct 8 1921, and that death occurred on the date stated above, at 2 00 A.M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) 0 Yrs. 0 mos. 2 ds.

Contributory (Secondary): 7 Broken ribs

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Roscoe C Ward M. D.

10/10 1921 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Hopkin Cemetery — DATE OF BURIAL: Oct. 11 1921

20. UNDERTAKER: Summers & Webb — ADDRESS: Boise Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35433
Registered No. 289

1. PLACE OF DEATH

County of Ada

City of Boise (No. 1302 North 12 St.)

Registration District No.

Primary Registration District No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Thomas Cowan

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

RECEIVED OCT 5 SUPERVISOR

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: April 12 1857 (Month) (Day) (Year)

7. AGE: 64 Yrs. 5 Mos. 22 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Foreman in the
(b) General nature of industry, business or establishment in which employed (or employer): Mines

9. BIRTHPLACE (State or Country): Scotland

10. NAME OF FATHER: Walter Cowan

11. BIRTHPLACE OF FATHER (State or Country): Scotland

12. MAIDEN NAME OF MOTHER: Margaret Lesslie

13. BIRTHPLACE OF MOTHER (State or Country): Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Geo. A. Allen
(Address) 1302 North 12th Street

15.
Filed 19
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. (Month) 4 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 29 1921, to Oct. 4 1921 that I last saw h.im alive on Oct 2 1921, and that death occurred on the date stated above, at 4:30 P.M.

The CAUSE OF DEATH* was as follows:

Erysipelas of face & head

(Duration) Yrs. mos. 10 ds.

Contributory (Secondary) Embolism of heart.

(Duration) yrs. mos. ds.

(Signed) Harold W Slone M. D.

10/5 1921 (Address) 410 Overland Bldg

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence Rock Springs Wy

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery | DATE OF BURIAL: 10/6 1921

20. UNDERTAKER: Schreiber & Hidenfeldt | ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

RECEIVED OCT 31 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35434

Registered No. 287

1. PLACE OF DEATH

County of Ada

City of Boise (No. 110 E. Bannock St.)

Registration District No. 2

Primary Registration District No. 1204

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Johnnie Albert Ayres

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	White	Single

6. DATE OF BIRTH: ~~January~~ (Month) 20 (Day) 1913 (Year)

7. AGE: 6 Yrs. 3 Mos. 14 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: Clarence L Ayres

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Clara M. Wolfkeil

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Clarence L Ayres
(Address) Star Idaho

15. Filed Oct 5 1921 R. H. Poad Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. (Month) 4 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 4 1921, to Oct 4 1921, that I last saw h[illegible] alive on Oct 4 1921, and that death occurred on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

Nephritis

(Duration) Yrs. 3 mos. ds.

Contributory (Secondary) Septicaemia

(Duration) yrs. 3 mos. ds.

(Signed) J N Ramey M. D.

10/5 1921 (Address) Boise

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Star Cemetery	Oct 6 1921
20. UNDERTAKER	ADDRESS
Summers & Trefz	Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
OCT 31 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 35435
Registered No. 285

1. PLACE OF DEATH
County of Ada
City of Boise (No. 110 E. Bannock St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Granville Hardin

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Nov. (Month) 2 (Day) 1885 (Year)

7. AGE: 35 Yrs. 10 Mos. 25 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Electrician
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio.

10. NAME OF FATHER: Tom Hardin

11. BIRTHPLACE OF FATHER (State or Country): Ohio.

12. MAIDEN NAME OF MOTHER: Sa Lowery

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) P. A. Winget
(Address) Sapulpa Okla.

15. Filed Oct 3 1921 R H. Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. (Month) 29 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 24 - 1921, to Sept 29 1921
that I last saw h[illegible] alive on Sept 28 1921
and that death occurred on the date stated above, at 7 10a M.
The CAUSE OF DEATH* was as follows:

Electric burns.

..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Suppression of Urine.
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J S Spurgeon M. D.
Oct 3 1921 (Address) Boise, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lima Ohio — DATE OF BURIAL: Oct 7 1921
20. UNDERTAKER: Summers & Hirt — ADDRESS: Boise Ida

P. A. Winget. Sapulpa. Okla.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35436
Registered No. 284

RECEIVED
OCT 31 1921
BUREAU OF

1. PLACE OF DEATH

Registration District No. 2
Primary Registration District No. 1004

County of Ada
City of Boise (No. 409 Washington St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Baby Levine

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Oct. (Month) 2 (Day) 1921 (Year)

7. AGE: ....Yrs. ....Mos. ....ds.
IF LESS than 1 day how many 6 hrs. or ....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Boise

10. NAME OF FATHER: Erick Levine

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Alice Sundberg

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Erick Levine
(Address) Star Idaho

15. Filed Oct 3 - 1921 — R. H. Pratt, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: October (Month) 2 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 2 1921, to Oct 2 1921
that I last saw h.r alive on Oct 2 1921
and that death occurred on the date stated above, at 6 P.M.
The CAUSE OF DEATH* was as follows:
Premature birth; Prem
Expulsion uterine

(Duration) ....Yrs. ....mos. 1 ds.

Contributory (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) [illegible] M.D.
1921 (Address) 400 Idaho Bldg

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs. ....mos. ....days. In the State ....yrs. ....mos. ....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 10/3 1921

20. UNDERTAKER: Lemhurber & Hidenfadden — ADDRESS: Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

Gregory

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35437

Registered No. 284

RECEIVED
OCT 31 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 7

Primary Registration District No. 1004

County of Ada

City of Boise (No. 110 E. Bannock St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sarah Margaret Atkinson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F	White	Widow

6. DATE OF BIRTH: Jan 4 (Month) (Day) 1849 (Year)

7. AGE: 72 Yrs. 8 Mos. 26 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Penn

10. NAME OF FATHER: James Kirkwood

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Rinker

13. BIRTHPLACE OF MOTHER (State or Country): Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) James F. Atkinson
(Address) Boise Idaho

15. Filed Oct 3 1921

R. H. Pratt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. (Month) 30 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 19 19 7, to Death, 19..., that I last saw h.. alive on Sept. 30, 1921, and that death occurred on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:

Pulmonary Odema

about (Duration) Yrs. 1 mos. ds.

Contributory (Secondary) Broken Compensation of Valvular Heart Lesion (Duration) yrs. mos. ds.

(Signed) R. H. Gregory M. D.

19... (Address) Boise, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Oct 2 1921

20. UNDERTAKER: Summers & Krebs — ADDRESS: Boise Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35438
Registered No. 281

RECEIVED OCT 31 1921

1. PLACE OF DEATH
County of Ada
City of Boise
(No. 2016 N. 17 St.)
Registration District No.
Primary Registration District No.
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Dorothy Eleanor Towne
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: May 31 (Month) 1918 (Day) (Year)

7. AGE: 3 Yrs. 3 Mos. 28 ds.
IF LESS than 1 day how many..... hrs. or.....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Emmett Idaho

10. NAME OF FATHER: David Towne

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Stella Helvern

13. BIRTHPLACE OF MOTHER (State or Country): Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) David Towne
(Address) Boise Idaho

15. Filed Oct 1 1921 R. H. Pratt Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. (Month) 30 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 29 1921, to Sept 30 1921, that I last saw h.r alive on Sept 30 1921, and that death occurred on the date stated above, at 12:20 P.M.

The CAUSE OF DEATH* was as follows:
Edema of lungs following Convulsions - Probably Epidemic Encephalitis
(Duration) —Yrs. —mos. 1 ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) J. M. Taylor M. D.
Oct 1 1921 (Address) Boise, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Oct 3 1921

20. UNDERTAKER: Summers & Trues — ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

RECEIVED OCT 31 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Ada — Registration District No. 4

City of Boise — Primary Registration District No. 1004

(No. 410 Fort St.)

File No. 35439

Registered No. 280

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Richard Adolph Bock

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH: April (Month) 29 (Day) 1865 (Year)

7. AGE: 56 Yrs. ... Mos. ... ds. — IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Merchant
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: William Bock

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Augusta Zehrfuss

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Richard Bock Jr.
(Address) Boise Ida.

15. Filed Oct 1 1921 — A. H. Pratt, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 27 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 25 1921, to Sept 27 1921 that I last saw h— alive on Sept 27 1921 and that death occurred on the date stated above, at ... M.

The CAUSE OF DEATH* was as follows:

Peritonitis

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) Chas V Gennaway M. D.

19... (Address) Boise

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery | DATE OF BURIAL: 10/2 1921

20. UNDERTAKER: Schreiber & Lieuallen | ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED OCT 31 1921 BUREAU OF VITAL

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
Registration District No.
County of Ada
Primary Registration District No.
City of Boise (No. 410 State St.)
File No. 35440
Registered No. 269

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME E. E. Williams

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.):

6. DATE OF BIRTH: (Month) (Day) 1864 (Year)

7. AGE: 57 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Fruit Raiser
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Indiana

10. NAME OF FATHER: Morgan Williams

11. BIRTHPLACE OF FATHER (State or Country): Ind.

12. MAIDEN NAME OF MOTHER: Henrietta Hawkins

13. BIRTHPLACE OF MOTHER (State or Country): Ind.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A Schneider
(Address) Boise Ida

15. Filed Sept 23 1921 — R. H. Pratt, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: September (Month) 17 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1 1921, to Sept 16 1921, that I last saw h[illegible] alive on Sept 16 1921, and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Lee Calvert M. D.

19 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 9/23 1921

20. UNDERTAKER: Schneider & Redmond — ADDRESS: Boise

Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
OCT 31 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 8

County of Ada

Primary Registration District No. 2008

City of (No.) 4 Miles N W of Boise

File No. 35441

Registered No. 74

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Henry Lewis Wiseman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: (Month) (Day) 1857 (Year)

7. AGE: 64 Yrs. 0 Mos. 0 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Virginia

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Claude Wiseman

(Address) Holcomb Ada

15. Filed Oct 3 1921

R. H. Coats
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 29 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I ~~attended~~ saw deceased ~~from~~ Sept 29 1921 to ..... 19..... that I last saw him alive on ..... 19..... dead Sept 29 1921, and that death occurred on the date stated above, at 1 P. M.

The CAUSE OF DEATH* was as follows: Valvular heart trouble

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Clyde E. Summers Coroner & ex-officio M. D.

10/1 1921 (Address) Boise Ida, Ada County

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery | DATE OF BURIAL: Oct 3 1921

20. UNDERTAKER: Summers & Turbo | ADDRESS: Boise Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
OCT 31 1921
VITAL STATISTICS
BUREAU OF

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35442
Registered No. 67

1. PLACE OF DEATH

Registration District No. 8

County of Ada

Primary Registration District No. [redacted] 8

City of near Boise (No. 3 miles West of [redacted] (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jennie Brownfield

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widow

6. DATE OF BIRTH: April 5 (Month) (Day) 1856 (Year)

7. AGE: 65 Yrs. 5 Mos. 27 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: Harrison Phillips

11. BIRTHPLACE OF FATHER (State or Country): Mo

12. MAIDEN NAME OF MOTHER: Mary Cutler

13. BIRTHPLACE OF MOTHER (State or Country): Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. J. L. Shaffer
(Address) Star

15. Filed Oct 3 1921 R. H. Pratt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 2 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 1920, to Oct 2 1921, that I last saw her alive on Sept 26 1921, and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:
Carcinoma Uteri

(Duration) 2 Yrs. 6 mos. ds.

Contributory (Secondary) Pulmonary Edema

(Duration) yrs. mos. 1 ds.

(Signed) T. M. Braxton M. D.

Oct 3 1921 (Address) Boise Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Oct 4 1921

20. UNDERTAKER: Summers & Kreft — ADDRESS: Boise Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-A—25 M. 1-19.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED
OCT 31 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Ada — Registration District No. 8

City of Meridian — Primary Registration District No. 2008

If death occurs away from usual residence, give facts called for under special information. — No. Near Meridian St.)

File No. 35443

Registered No. 68

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME. Marie J Lockard

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word.): Single

6. DATE OF BIRTH: Sept. (Month) 12. (Day) 1907 (Year)

7. AGE: 17 Yrs. 1 Mos. 1 ds. — IF LESS than 1 day how many.....hrs. or.....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: School Girl
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Silver City Idaho

10. NAME OF FATHER: Chas Lockard

11. BIRTHPLACE OF FATHER (State or Country): Nebraska, Falls City

12. MAIDEN NAME OF MOTHER: Lenora Whitehead

13. BIRTHPLACE OF MOTHER (State or Country): Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chas T. Lockwood
(Address) Meridian Idaho

15. Filed Oct 14 1921 — R. V. Pratt, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 13 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 29 — 1921, to Oct. 14 1921, that I last saw h[illegible] alive on Oct. 12 — 1921, and that death occurred on the date stated above, at 8:45 A.M.

The CAUSE OF DEATH* was as follows:
Amebic infection

(Duration) Yrs. mos. ds.

Contributory (Secondary) Phelbitis

(Duration) yrs. mos. 10 ds.

(Signed) W L Treagier M. D.

19..... (Address) 515 Overland Bldg Boise, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill — DATE OF BURIAL 19..

20. UNDERTAKER: I O Brinton Meridian — ADDRESS

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-25 M. 1-19.

RECEIVED OCT 31 19 BUREAU OF VITAL STATISTICS STATE OF IDAHO

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35444

Registered No. 69

1. PLACE OF DEATH

County of Ada

Registration District No. 8

Primary Registration District No. 2008

City of ..... (No. Barber St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Ann Huckabee

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Oct (Month) 18 (Day) 21 (Year)

7. AGE: ——— Yrs. ——— Mos. ——— ds.

IF LESS than 1 day how many 1 hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: R E Huckabee

11. BIRTHPLACE OF FATHER (State or Country): Texas

12. MAIDEN NAME OF MOTHER: Edna Larsen

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Clyde E Summers

(Address) Boise Idaho

15. Filed Oct 19 1921 R. H. Pratt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 18 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 18 1921 to Oct 18 1921 that I last saw h. alive on Oct 18 1921, and that death occurred on the date stated above, at ——— M.

The CAUSE OF DEATH* was as follows:

Still Born — after accident Hemorhage — at Practically full term (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D Wood Fuller M. D.

10/18 1921 (Address) Emp. Bldg

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Oct 18 1921

20. UNDERTAKER: Summers & Tite — ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35445

Registered No. 70

1. PLACE OF DEATH

County of Ada

Registration District No. 8

Primary Registration District No. 2008

City of ... (No. ... St.)

RECEIVED
OCT 31 1921
BUREAU OF VITAL STATISTICS

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Arvid R. Wells.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
M.	White.	Married (Write word.)

6. DATE OF BIRTH: Feb. (Month) ... (Day) 1854 (Year)

7. AGE: 67 Yrs. ... Mos. ... ds.

IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer.
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Wisconsin

10. NAME OF FATHER: Walter. Wells

11. BIRTHPLACE OF FATHER (State or Country): England.

12. MAIDEN NAME OF MOTHER: Jane Robinson

13. BIRTHPLACE OF MOTHER (State or Country): Unknown.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) L. S. Wells
(Address) Ring Hill Idaho

15. Filed Oct 25 1921 R H Pratt
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 24 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I ~~attended~~ saw deceased ~~from~~ Oct. 23 1921 to ... 19..., ~~that I last saw him alive on ... 19...,~~ and that death ~~occurred on the date stated above,~~ at ... M.

The CAUSE OF DEATH* was as follows:
Accidently drowned in Boise River.
Body was found Oct-23-1921
(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary) ...
(Duration) ... yrs. ... mos. ... ds.

(Signed) Clyde E Summers Coroner Ada County
10/24 1921 (Address) Boise Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death? ...
Former or usual residence ...

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Morris Hill Cemetery	Oct 25 1921
20. UNDERTAKER	ADDRESS
Summers & Trebo	Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
OCT 31 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 8

Primary Registration District No. 2008.

File No. 3546

Registered No. 71

County of Ada

City of Boise (No. U.S.P.H.S. Hospital #52 St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Fred Rosenthal

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: single (Write the word.)

6. DATE OF BIRTH: XX (Month) XX (Day) 1888 (Year)

7. AGE: 33 Yrs. X Mos. X ds.

IF LESS than 1 day, how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer): X X

9. BIRTHPLACE (State or Country): Russia

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W.H.Allen,

(Address) Boise, Idaho

15. Filed Oct - 26 1921 R. T. Pratt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. 24, 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 26,1920 to Oct.24,1921, that I last saw him alive on Oct.24,1921, and that death occurred on the date stated above, at 7:30 A. M.

The CAUSE OF DEATH* was as follows:

Tuberculosis, chronic, pulmonary

Unknown (Duration) Yrs. mos. ds.

Contributory (Secondary) none

XX (Duration) yrs. mos. ds.

(Signed) W.H.Allen Surgeon in Charge (R) M. D.

(Address) USPHS Hospital #52, Boise, Idaho

Oct. 25 1921

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 1 yrs. 4 mos. 28 days. In the State Unknown yrs. mos. days

Where was disease contracted if not at place of death? Unknown

Former or usual residence Unknown

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery Boise, Idaho

DATE OF BURIAL: 10/26/21

20. UNDERTAKER: Wm. Bratney

ADDRESS: Boise Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
OCT 31 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Ada — Registration District No. 8

City of ____ — Primary Registration District No. 2nd 8

(No. 6½ mi S W of Boise St.)

File No. 35447

Registered No. 72

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Milton S Duff.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
M.	White.	Widower

6. DATE OF BIRTH

____ (Month) ____ (Day) 1845 (Year)

7. AGE

76 Yrs. ____ Mos. ____ ds.

IF LESS than 1 day how many ____ hrs. or ____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer): ____

9. BIRTHPLACE (State or Country) Ohio.

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (State or Country) Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W T Kingsbury

(Address) Boise Idaho

15.

Filed 10/29 1921 — R. V. Pratt, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 29 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1, 1920, to Oct 29 1921, that I last saw h~~im~~. alive on Oct 29 1921, and that death occurred on the date stated above, at 3 A M.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) ____ Yrs. ____ mos. ____ ds.

Contributory (Secondary) ____

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) C W Kingsbury M. D.

Oct 29 1921 (Address) 404 Idaho Bldg

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days

Where was disease contracted if not at place of death? ____

Former or usual residence ____

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Star Cemetery	Oct 30 1921

20. UNDERTAKER	ADDRESS
Summers & Cobb	Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35448

Registered No. 73

RECEIVED
OCT 31 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Ada Registration District No. 8

City of Boise Primary Registration District No. 2008

(No. Idyguild St. Boise)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James. R. Irwin.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M.	W.	Single

6. DATE OF BIRTH 1834

(Month) (Day) 1 (Year)

7. AGE 87 Yrs. — Mos. — ds.

IF LESS than 1 day how many ____ hrs. or ____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Rancher and Miner

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Canada.

10. NAME OF FATHER David Irwin.

11. BIRTHPLACE OF FATHER (State or Country) Ireland.

12. MAIDEN NAME OF MOTHER Arnett.

13. BIRTHPLACE OF MOTHER (State or Country) Ireland.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. McBratney

(Address) Boise, Idaho.

15. Filed Oct 29 1921 R. H. Pratt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. 28- 1921

(Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 14th 1921, to Oct. 28th 1921, that I last saw him alive on Oct. 28 1921, and that death occurred on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

Senility

(Duration) ____ Yrs. ____ mos. ____ ds.

Contributory (Secondary) Had a severe fall on Oct. 14th 1921 - not up again.

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) C. M. Taylor M. D.

10/29/21 (Address) Boise, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Morris Hill Cemetery	10/29/1921
20. UNDERTAKER W. McBratney	ADDRESS Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED OCT 31 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Bannock — Registration District No. 84

City of Central — Primary Registration District No. 2161 — St.)

File No. 35449

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Milo W. Rosdahl

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	white	single

6. DATE OF BIRTH: July 12, 1911 (Month) (Day) 1 (Year)

7. AGE: 10 Yrs. Mos. ds. — IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: school boy
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Central Idaho

10. NAME OF FATHER: C.W. Rosdahl

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Anna Anderson

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Father
(Address):

15. Filed 10-1-21 19 — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: September ~~XXXXX~~ 20, 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9-20-21 19 to 19, that I last saw h im alive on 19, and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

broken neck, seventh cervical verterbra

(Duration) Yrs. mos. ds.

Contributory (Secondary): Accident

(Duration) yrs. mos. ds.

(Signed) Walter L. Rosdahl M. D.

10-1 19 21 (Address) Bancroft

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL 19

20. UNDERTAKER | ADDRESS

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

35450

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 43

Registered No. 3649

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

Registration District No. 28

County of Bannock

Primary Registration District No. 2161

City of Pocatello (No. 328 No Lincoln St.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
OCT 31 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME Lawrence Vernon Watson

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH: May (Month) 7 (Day) 1917 (Year)

7. AGE: 4 Yrs. 3 Mos. 26 ds.

IF LESS than 1 day how many..... hrs. or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Pocatello

10. NAME OF FATHER: Lawrence L. Watson

11. BIRTHPLACE OF FATHER (State or Country): Pocatello Idaho

12. MAIDEN NAME OF MOTHER: Ida Mary Baugh

13. BIRTHPLACE OF MOTHER (State or Country): Merna Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Lawrence L. Watson

(Address) Pocatello

15. Filed 9/3 1921

J R Young
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE. 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. (Month) 2nd (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 2nd 1921, to Sept 2nd 1921 that I last saw him alive on Sept 2nd 1921, and that death occurred on the date stated above, at 9 P.M.

The CAUSE OF DEATH* was as follows:

Diphtheria

(Duration) do not know Yrs. mos. ds.

Contributory (Secondary) none

(Duration) yrs. mos. ds.

(Signed) [signature] M. D.

9/3 1921 (Address) Pocatello Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
N. P. Cemetery	9/4 1921

20. UNDERTAKER W. H. Parker ADDRESS Pocatello Ida

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

35451

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
OCT 3 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Bannock Registration District No. 216 File No. 43

City of Pocatello Primary Registration District No. 4 (Ward) 455 N. 4th St. Registered No. 3659

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Frances M. Panas

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: Greek

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: April 7 (Month) (Day) 1921 (Year)

7. AGE: Yrs. 4 Mos. 25 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Mike Panas

11. BIRTHPLACE OF FATHER (State or Country): Greece

12. MAIDEN NAME OF MOTHER: Georgia G. Kum

13. BIRTHPLACE OF MOTHER (State or Country): Panas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mike Panas
(Address) Pocatello Idaho

15. Filed 9/3 1921 J. W. Young Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept 2 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from dying when I Parker Sept 2 1921 that I last saw her alive on Sept 2 1921, and that death occurred on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:
Gastro enteritis

(Duration) ..... Yrs. ..... mos. few ds.
Contributory (Secondary) —
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) N. F. Howard M. D.
9 2 1921 (Address) Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain View — DATE OF BURIAL: Sept 3 1921

20. UNDERTAKER: Schumacher Bros — ADDRESS: City

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH 35452

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 43
Registered No. 3607

RECEIVED
OCT 28 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Bannock
City of Pocatello
(No. 228 W Maine Hotel St.)
Registration District No. 28
Primary Registration District No. 2161
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Oleo T Bybee

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Female	White	Married (the word.)

6. DATE OF BIRTH: June 4* 1902 (Month) (Day) (Year)

7. AGE: 19 Yrs. 7 Mos. 27 ds. IF LESS than 1 day how many..... hrs. or..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Blackfoot Ida

10. NAME OF FATHER: C. L. Swensen

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: Gertrude L. McDonald

13. BIRTHPLACE OF MOTHER (State or Country): Minnesota

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. L. Swensen
(Address) Rexburg Ida

15. Filed 9/6 1921 J. P. Young Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept 3 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 3 1921, to Sept 3 1921, that I last saw h[illegible] alive on Sept 3 1921, and that death occurred on the date stated above, at 8 a M.

The CAUSE OF DEATH* was as follows:

Gun Shot wound
Suicidal

(Duration) ..... Yrs. ..... mos. 4 hrs ds.

Contributory (Secondary) None

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. H. Sayer M. D.

Apr 16 1921 (Address) Pocatello Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Pocatello Cemetery — DATE OF BURIAL: 9/6 1921

20. UNDERTAKER: W. H. Wacker — ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

35453

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 28
Primary Registration District No. 2161
File No. 45
Registered No. 3452

RECEIVED
OCT 3 1921
BUREAU OF VITAL

1. PLACE OF DEATH
County of Bannock
City of Pocatello (No. 536 E Clark St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary D. Pane

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widowed

6. DATE OF BIRTH: July 11th 1863
(Month) (Day) (Year)

7. AGE: 55 Yrs. 1 Mos. 26 ds.
IF LESS than 1 day how many..... hrs. or..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business or establishment in which employed (or employer): Housewife

9. BIRTHPLACE (State or Country): Virginia

10. NAME OF FATHER: John Eagon

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) D. Pane, Miss
(Address) 536 E. Clark

15.
Filed 9/8 1921
J. R. Young
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept 7 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 4 1921, to Sept 7 1921, that I last saw h.er. alive on Sept 7 1921, and that death occurred on the date stated above, at P.M.

The CAUSE OF DEATH* was as follows:
Carcinoma Left breast

(Duration) 3 Yrs. mos. ds.
Contributory (Secondary): Septicemia
(Duration) yrs. mos. 10 ds.

(Signed) [signature] M. D.
9-8 1921 (Address) Pocatello

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain View — DATE OF BURIAL: Sept 9 1921

20. UNDERTAKER: Lehmann & Rice — ADDRESS: Pocatello Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

35454

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED OCT 2

Registration District No. 28
Primary Registration District No. 2161
File No. 43
Registered No. 3653

1. PLACE OF DEATH
County of Bannock
City of Pocatello (If not in incorporated limits, give township) BURIAL No. 745 N. 12th St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Minnie Coombs.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married

6. DATE OF BIRTH: Sept 1 (Month) (Day) 1873 (Year)

7. AGE: 46 Yrs. — Mos. 9 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mass.

10. NAME OF FATHER: William Dolan

11. BIRTHPLACE OF FATHER (State or Country): Mass.

12. MAIDEN NAME OF MOTHER: Not Known

13. BIRTHPLACE OF MOTHER (State or Country): Mass.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Edward Coombs.
(Address) 745 N. 12th St.

15. Filed Sept 9th 1921 — J. P. Young, Local Registrar

SYMS-YORK CO. PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept 9 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 1 1921, to Sept 9 1921, that I last saw her alive on Sept 8 1921, and that death occurred on the date stated above, at 12 20 M.

The CAUSE OF DEATH* was as follows:

Appendicitis

(Duration) Yrs. 1 mos. 14 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. P. Young M. D.

Sept 9 1921 (Address) Pocatello

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 2 yrs. mos. days. In the State 2 yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence Illinois

19. PLACE OF BURIAL OR REMOVAL: Mt View Cem. — DATE OF BURIAL: Sept 10 1921

20. UNDERTAKER: H. L. McClean — ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED OCT 19 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 28

County of Bannock

Primary Registration District No. 2161

File No. 43 35455

City of Pocatello (No. General Hospital)

Registered No. 3654

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Betty Marie Bachelor

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Never married)

6. DATE OF BIRTH: Sept 5 1921 (Month) (Day) (Year)

7. AGE: — Yrs. — Mos. 3 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: none.

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Pocatello Idaho.

10. NAME OF FATHER: Harry D. Bachelor

11. BIRTHPLACE OF FATHER (State or Country): Idaho.

12. MAIDEN NAME OF MOTHER: Hazel Corrigan

13. BIRTHPLACE OF MOTHER (State or Country): Texas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Harry D. Bachelor

(Address) 211 Fargo. Apts.

15. Filed Sept 9 1921

J. H. Young
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 8 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9-9 1921, to 9-8 1921 that I last saw h.. alive on 9-8 1921 and that death occurred on the date stated above, at 8:30 P.M.

The CAUSE OF DEATH* was as follows:

Atelectasis and patent foramen ovale

(Duration) Yrs. ..... mos. 3 ds.

Contributory (Secondary)

(Duration) yrs. ..... mos. ..... ds.

(Signed) F. E. Travis M. D.

9/9 1921 (Address) Pocatello Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? Live in Pocatello

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mt View Cem. Pocatello — DATE OF BURIAL: Sept 9 1921

20. UNDERTAKER: H. L. McHan — ADDRESS: Pocatello Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

35456

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 43

Registered No. 3455

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Bannock

City of Pocatello

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 28

Primary Registration District No. 2161

(No. ... St.)

RECEIVED
OCT 31 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME Manuel Hernandez

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Mexican

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Mar (Month) 28 (Day) 1921 (Year)

7. AGE: ... Yrs. 5 Mos. ... ds. 12

IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business or establishment in which employed (or employer): ...

9. BIRTHPLACE (State or Country): Pocatello Ida

10. NAME OF FATHER: Manuel Hernandez

11. BIRTHPLACE OF FATHER (State or Country): Mexico

12. MAIDEN NAME OF MOTHER: Carmen Contreras

13. BIRTHPLACE OF MOTHER (State or Country): Mexico

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jose Luna

(Address) Pocatello Ida

15. Filed 9/10 1921

J. R. Young
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 9 (Day) ... 19 ... (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 6 1921, to Sept 10 1921, that I last saw him alive on Sept 10 1921, and that death occurred on the date stated above, at 9 P.M.

The CAUSE OF DEATH* was as follows:

Diarrhoea
Enteritis

(Duration) ... Yrs. ... mos. 4 ds.

Contributory (Secondary) ...

(Duration) ... yrs. ... mos. ... ds.

(Signed) J. R. Young M. D.

Sept 10 1921 (Address) Pocatello Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. 1 days. In the State ... yrs. ... mos. 1 days

Where was disease contracted if not at place of death? Pocatello Ida

Former or usual residence 210 So 3rd. city

19. PLACE OF BURIAL OR REMOVAL: Pocatello | DATE OF BURIAL: 9/11 1921

20. UNDERTAKER: Makin | ADDRESS: Pocatello

FORM V. S. No. 5-25 M. 1-19.

RECEIVED OCT 31 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

35457

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 28
Primary Registration District No. 2161
File No. 45
Registered No. 3616

1. PLACE OF DEATH
County of Bannock
City of Pocatello (If outside limits, give township) No. 604 South Grant St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Paul Joseph Williams

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Infant (Write the word.)

6. DATE OF BIRTH: August (Month) 23 (Day) 1921 (Year)

7. AGE: ___ Yrs. ___ Mos. 15 ds. IF LESS than 1 day how many ___ hrs. or ___ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Pocatello Idaho

10. NAME OF FATHER: Franklin K Williams

11. BIRTHPLACE OF FATHER (State or Country): Montana

12. MAIDEN NAME OF MOTHER: Emily Collins

13. BIRTHPLACE OF MOTHER (State or Country): Boston Mass

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) F. K. Williams
(Address) Pocatello

15. Filed 9/10 1921 J. H. Young Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: September (Month) 9 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 8 1921, to Sept 9 1921, that I last saw h. im alive on Sept 9 1921, and that death occurred on the date stated above, at 3.15 P M.

The CAUSE OF DEATH* was as follows:

I Acute enteritis

(Duration) ___ Yrs. ___ mos. 2 ds.

Contributory (Secondary)

(Duration) ___ yrs. ___ mos. ___ ds.

(Signed) A. M. Newton M. D.

Sept 10 1921 (Address) Pocatello Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ___ yrs. ___ mos. ___ days. In the State ___ yrs. ___ mos. ___ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain View Cem — DATE OF BURIAL: Sept 10 1921

20. UNDERTAKER: Schumacher & Hall — ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

35458

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 2161
File No. 43
Registered No. 3457

1. PLACE OF DEATH

County of Bannock
City of Pocatello (No. 1124 N. Hayes St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Cynthia Haygood

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

RECEIVED OCT 8 BUR

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widow (Write Word)

6. DATE OF BIRTH: Sept 7. 1829 (Month) (Day) (Year)

7. AGE: 92 Yrs. — Mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House Keeper
(b) General nature of industry, business or establishment in which employed (or employer): lived with daughter

9. BIRTHPLACE (State or Country): Alabama

10. NAME OF FATHER: Knight

11. BIRTHPLACE OF FATHER (State or Country): Alabama

12. MAIDEN NAME OF MOTHER: Not Known

13. BIRTHPLACE OF MOTHER (State or Country): Alabama

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John T. Connell
(Address) 1124 N. Hayes, Pocatello Ida.

15. Filed 9/10 1921 J. R. Young Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept 10 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from November 1920, to Sept. 10 1921, that I last saw her alive on Sept. 9th 1921, and that death occurred on the date stated above, at 4:30 A.M.

The CAUSE OF DEATH* was as follows:
Cancer of face and breast
Senility

(Duration) 3 Yrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) Chas. A. Sprague M. D.
9/10 1921 (Address) Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 16 yrs. mos. days. In the State 16 yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence Alabama

19. PLACE OF BURIAL OR REMOVAL: Mt View Pocatello — DATE OF BURIAL: Sept 11 1921

20. UNDERTAKER: H. L. McHan — ADDRESS: Pocatello Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

35460

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
OCT 31 1921
BUREAU OF VITAL STATISTICS

Registration District No. 28
Primary Registration District No. 2461
File No. 43
Registered No. 3659

1. PLACE OF DEATH
County of Bannock
City of Pocatello (No. 805 So. 10th ave. St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Simon D Weatherman
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): widower

6. DATE OF BIRTH: Jan (Month) 19. (Day) 1839 (Year)

7. AGE: 88 Yrs. 7 Mos. 21 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Stockman and
(b) General nature of industry, business or establishment in which employed (or employer): Probate Judge at Albion Ida.

9. BIRTHPLACE (State or Country): Indiana.

10. NAME OF FATHER: James Weatherman

11. BIRTHPLACE OF FATHER (State or Country): Indiana

12. MAIDEN NAME OF MOTHER: Lucy Pitts

13. BIRTHPLACE OF MOTHER (State or Country): Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs W. A. Bassett
(Address) 805 So. 10 Ave.

15. Filed Sept 13 1921 J. P. Young. Local Registrar

SYMS-YORK CO. PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 11 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 23 1921 to Sept 11 1921 that I last saw him alive on Sept 10 1921 and that death occurred on the date stated above, at 3:20 P. M.

The CAUSE OF DEATH* was as follows:
Endarteritis in right leg with gangrene of foot.

(Duration) ..... Yrs. ..... mos. 20 ds.
Contributory (Secondary) Myocarditis.
(Duration) ..... yrs. 6 mos. ..... ds.

(Signed) A M Newton M. D.
Sept 14 1921 (Address) Pocatello Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 22 yrs. ..... mos. ..... days. In the State 45 yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence Albion Idaho.

19. PLACE OF BURIAL OR REMOVAL: Mt View Cem. DATE OF BURIAL: Sept 14 1921

20. UNDERTAKER: H. L. McClain ADDRESS: Pocatello Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

35461 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 28
Primary Registration District No. 2461
File No. 43
Registered No. 3660

1. PLACE OF DEATH
County of Bannock
City of Pocatello (No. 242 - So 9th St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Rose Mary Garvin
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Child (Write the word.)

6. DATE OF BIRTH: December 9 1920 (Month) (Day) (Year)

7. AGE: Yrs. 9 Mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Salt Lake City, Ut.

10. NAME OF FATHER: Martin H Garvin

11. BIRTHPLACE OF FATHER (State or Country): Wisconsin

12. MAIDEN NAME OF MOTHER: Ellen O'Rilley

13. BIRTHPLACE OF MOTHER (State or Country): Iowa.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Martin H Garvin
(Address) 242 - So 9th

15. Filed 9/12 1921 J R Young Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: September 12 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9 - 11 1921, to 9 - 12 1921, that I last saw h[er] alive on 9 - 11 1921, and that death occurred on the date stated above, at 7 P. M.
The CAUSE OF DEATH* was as follows:

Bronchio - pneumonia

(Duration) ..... Yrs. ..... mos. 2 ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) [illegible] M. D.
9/12 1921 (Address) Pocatello

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain View Cem — DATE OF BURIAL: Sept 13 1921

20. UNDERTAKER: Schumacher & Hall — ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

35462

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 28
Primary Registration District No. 2161
File No. 33
Registered No. 3661

1. PLACE OF DEATH
County of Bannock
City of Pocatello
(No.) General Hospital
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Herbert Harris
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): married

6. DATE OF BIRTH: May 3rd 1870
(Month) (Day) (Year)

7. AGE: 51 Yrs. 6 Mos. 9 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Janitor
(b) General nature of industry, business or establishment in which employed (or employer): Public school

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: John Richard Harris

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Emma C. Meeking

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Thomas E. Harris
(Address) Logan Utah

15. Filed 9/13 1921
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: September 12 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 8 1921, to Sept 12 1921
that I last saw him alive on Sept 12 1921
and that death occurred on the date stated above, at 2:30 A.M.

The CAUSE OF DEATH* was as follows:
Compound comminuted fractures both forearms, fracture skull accident
(Duration) ... Yrs. ... mos. 5 ds.
Contributory (Secondary) Pulmonary Thrombosis
(Duration) ... yrs. ... mos. 1/4 ds.

(Signed) W. F. Howard M. D.
9/2 1921 (Address) Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain View — DATE OF BURIAL: Sept 14 1921

20. UNDERTAKER: Schumacher Hall — ADDRESS: City

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED OCT 9 1921

CERTIFICATE OF DEATH

35463

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Bannock Registration District No. 28
City of Pocatello Primary Registration District No. 2141
(No. Room 1 Bro. Hospital St.)
File No. 43
Registered No. 3662

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME: Bert R. Phillips

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Nov (Month) 18 (Day) 1919 (Year)

7. AGE: 21 Yrs. 24 Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Wm Phillips

11. BIRTHPLACE OF FATHER (State or Country): Soldier Idaho

12. MAIDEN NAME OF MOTHER: Hazel Worden

13. BIRTHPLACE OF MOTHER (State or Country): Black Foot

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A. D. Russell
(Address) 457 N. Main

15. Filed 9/13 1921 J. H. Young, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 12 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 6 1921, to Sept. 12 1921 that I last saw h. alive on Sept 12 1921, and that death occurred on the date stated above, at 12:55 M.

The CAUSE OF DEATH* was as follows:
Diarrhea Enteritis Colitis

(Duration) Yrs. — mos. 7 ds.

Contributory (Secondary): Convulsions

(Duration) yrs. mos. ds.

(Signed) J. W. Young M. D.

Sept 12 1921 (Address) Pocatello Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. 5 days. In the State yrs. — mos. — days
Where was disease contracted if not at place of death? 1330 No Main
Former or usual residence Pocatello Ida

19. PLACE OF BURIAL OR REMOVAL: M W of Iowa Cemetery | DATE OF BURIAL: 9/14 1921

20. UNDERTAKER: J. M. Walker | ADDRESS: Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

35464

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED OCT 3 1921 BUR

1. PLACE OF DEATH

Registration District No. 28

Primary Registration District No. 2161

File No. 43

County of Bannock

City or Town (N) St. Anthony Hospital St.

Registered No. 3663

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Daijiro Uemura

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Japanese

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: 1879 (Month) (Day) 1 (Year)

7. AGE: 42 Yrs. Mos. ds. — IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Waiter in
(b) General nature of industry, business or establishment in which employed (or employer): Restaurant

9. BIRTHPLACE (State or Country): Japan

10. NAME OF FATHER: unknown

11. BIRTHPLACE OF FATHER (State or Country): unknown

12. MAIDEN NAME OF MOTHER: unknown

13. BIRTHPLACE OF MOTHER (State or Country): unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) T. Akiyama
(Address) 153 E Center

15. Filed 9/13 1921 J. H. Hanna Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 12 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 1 1921, to Sept 12 1921, that I last saw h~~im~~ alive on Sept 12 1921, and that death occurred on the date stated above, at 9 9 M.

The CAUSE OF DEATH* was as follows:
Cholangitis and Cholelithiasis

(Duration) 1 Yrs. 2 mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) A. M. Newton M. D.

Sept 12 1921 (Address) Kunz Bldg

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain View — DATE OF BURIAL: Sept 14 1921

20. UNDERTAKER: Peterman Trace — ADDRESS: City

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
OCT 31 1921
BUREAU OF VITAL STATISTICS
STATE OF IDAHO

35466
28

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bannock — Registration District No. 7141 — File No. 44

City of Pocatello — (Ward) — (Street) 211 Clarkson — Registered No. 3641

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Albert Echevarria

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	Spanish	Single

6. DATE OF BIRTH — Expect date unknown — 1893
(Month) (Day) (Year)

7. AGE — 28 Yrs. Mos. ds. — Near as Known — IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work — Sheep
(b) General nature of industry, business or establishment in which employed (or employer) — Herder

9. BIRTHPLACE (State or Country) — Spain

10. NAME OF FATHER — Albert Echevarria

11. BIRTHPLACE OF FATHER (State or Country) — Spain

12. MAIDEN NAME OF MOTHER — unknown

13. BIRTHPLACE OF MOTHER (State or Country) — unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Peter S. Laboyd
(Address) 231 N. 3rd

15. Filed 9/22 1921 — J. H. Sharp — Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH — Sept 21 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 15 1921, to Sept 21 1921, that I last saw h[illegible] alive on Sept 21 1921, and that death occurred on the date stated above, at 11P M.

The CAUSE OF DEATH* was as follows:

Streptococcic meningitis

(Duration) Yrs. mos. 3 ds.

Contributory (Secondary) Fracture of upper maxilla

(Duration) yrs. mos. 7 ds.

(Signed) Asa Newton M. D.

Sept 22 1921 (Address) Pocatello, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL — Mountain View — DATE OF BURIAL — Sept 24 1921

20. UNDERTAKER — Edwards Hall — ADDRESS — City

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

RECEIVED OCT

CERTIFICATE OF DEATH

35467

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 44

Registered No. 3644

1. PLACE OF DEATH

County of Bannock

City of Pocatello (No. 408 S. 3rd St.)

Registration District No. 28

Primary Registration District No. 2141

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs Bertie Hays

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widow

6. DATE OF BIRTH: January (Month) 30 (Day) 1861 (Year)

7. AGE: 60 Yrs. 7 Mos. 25 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Lincoln Idaho

10. NAME OF FATHER:

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER: Frances Duff

13. BIRTHPLACE OF MOTHER (State or Country): St. Charles Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Geo Newhill

(Address) 408 S. 3rd

15. Filed 9/24 1921

J. H. Young
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 22 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1 1921, to Sept 24 1921, that I last saw her alive on Sept 22 1921, and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows: Carcinoma of Sigmoid

(Duration) 1 Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. J. Raof M. D.

Sept 24 1921 (Address) Pocatello

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Sterling Greene DATE OF BURIAL 9/27 1921

20. UNDERTAKER T. T. Tracker ADDRESS Pocatello

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

35468

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
OCT 31 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Bannock Registration District No. 28
City of Pocatello Primary Registration District No. 6141
No. 1 Paul St. (St.)
File No. 44
Registered No. 3467
If death occurs away from usual residence, give facts called for under special information.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mrs Elizabeth Barr

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: May 3 1882 (Month) (Day) (Year)

7. AGE: 39 Yrs. 4 Mos. 25 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Clark Nebr.

10. NAME OF FATHER: Geo Taylor.

11. BIRTHPLACE OF FATHER (State or Country): Penn

12. MAIDEN NAME OF MOTHER: Lottie Henderson.

13. BIRTHPLACE OF MOTHER (State or Country): Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Walter Barr
(Address) Pocatello

15. Filed 9/29 1921 — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept 28th 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1st 1921, to Sept 28 1921, that I last saw h. on alive on Sept 27 1921, and that death occurred on the date stated above, at 4-10 A.M.

The CAUSE OF DEATH* was as follows:

Sept 28 1921 Hypertension - Appendicitis
Hypertrophied Congestion Liver
Myocarditis - Intestinal Stasis

(Duration) — Yrs. — mos. 4 ds.

Contributory (Secondary) Myocarditis

(Duration) — yrs. — mos. 4 ds.

(Signed) Hamner C. Irwin M. D.

Sept 28 1921 (Address) Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Medicine Bow Wyo — DATE OF BURIAL: 9/29 1921

20. UNDERTAKER: W. Tracker — ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

28 35469 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No.
Primary Registration District No. 2161
File No. 94
Registered No. 3668

1. PLACE OF DEATH
County of Bannock RECEIVED
City of Pocatello OCT 31 1921 (No. 1444 Bos Alabama St.)
If death occurs away from usual residence, give facts called for under special information.
BUREAU OF VITAL STATISTICS
2. FULL NAME Bert Bazil Shreves

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Married
6. DATE OF BIRTH: Dec (Month) 1 (Day) 1881 (Year)
7. AGE: 39 Yrs. 9 Mos. 28 ds. IF LESS than 1 day how many hrs. or min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Night Baggage agent
(b) General nature of industry, business or establishment in which employed (or employer): O.D.L.
9. BIRTHPLACE (State or Country): Kansas
10. NAME OF FATHER: John Tipton Shreves
11. BIRTHPLACE OF FATHER (State or Country): Illinois
12. MAIDEN NAME OF MOTHER: Marietta Munier
13. BIRTHPLACE OF MOTHER (State or Country): Mich
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. G. L. Shreves
(Address) Pocatello
15. Filed 9/29 1921 J. H. Young Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 28 (Day) 21 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Sept 9th 1921 to Sept 28 1921 that I last saw him alive on Sept 28 1921 and that death occurred on the date stated above, at 8a M.
The CAUSE OF DEATH* was as follows:
Carcinoma of the liver.
(Duration) 1 Yrs. mos. ds.
Contributory (Secondary) carcinoma of stomach
(Duration) yrs. 3 mos. ds.
(Signed) Chas Lyman M. D.
9/29 1921 (Address) Pocatello Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Inkard Mausoleum | DATE OF BURIAL: 9/29 1921
20. UNDERTAKER: Walker | ADDRESS: Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STUB-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-12 M. 6-15-17.

RECEIVED
OCT 31 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35470
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Bear Lake ... Registration District No. 53
City of Montpelier ... Primary Registration District No. 7136
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Raymon Astle

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH. April (Month) 27 (Day) 1907 (Year)
7. AGE: 14 Yrs. 4 Mos. 24 ds. IF LESS than 1 day how many .... hrs. or .... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: At School
(b) General nature of industry, business, or establishment in which employed (or employer) .....
9. BIRTHPLACE (State or Country): Idaho
10. NAME OF FATHER: J. C. Astle
11. BIRTHPLACE OF FATHER (State or Country): Idaho
12. MAIDEN NAME OF MOTHER: Matilda J. Danks
13. BIRTHPLACE OF MOTHER (State or Country): Pennsylvania
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. C. Astle
(Address) Montpelier, Idaho

15. Filed 10-1- 1921 — A. R. Young, Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 21 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191.... to ..... 191...
that I last saw h.... alive on ..... 191....
and that death occurred on the date stated above, at 8 A. M.

The CAUSE OF DEATH* was as follows:
Boy was trying to catch loose horse, horse kicked him and force of kick, broke his neck causing instant death
(Duration) ... Yrs. ... mos. ... ds.
Contributory (Secondary) .....
(Duration) ... Yrs. ... mos. ... ds.

(Signed) F. M. Williams M. D.
Sept 21 1921 (Address) Montpelier Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Montpelier, Idaho — DATE OF BURIAL: Sept. 23. 1921

20. UNDERTAKER: F. M. Williams — ADDRESS: Montpelier Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED OCT 31 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35471
Registered No.

1. PLACE OF DEATH
County of Bear Lake
City of Montpelier (If outside limits, give township.) St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 62
Primary Registration District No. 2136

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary E Gordon

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	white	Infant

6. DATE OF BIRTH: 9 (Month) 13 (Day) 21 (Year)

7. AGE: ....Yrs. Mos. 4 ds.
IF LESS than 1 day how many....hrs. or....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Montpelier

10. NAME OF FATHER Robt E. Gordon

11. BIRTHPLACE OF FATHER (State or Country) Texas

12. MAIDEN NAME OF MOTHER Lizzie Hunt

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Robt E. Gordon
(Address) Montpelier Ida

15. Filed 10-1-1921 N. W. King Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 9 (Month) 17 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9-13 1921 to 9-17 1921 that I last saw h.. alive on 9-16 1921, and that death occurred on the date stated above, at 8 P.M.
The CAUSE OF DEATH* was as follows:
Premature infant
....(Duration) ....Yrs....mos....ds.
Contributory (Secondary)
....(Duration) ....Yrs....mos....ds.
(Signed) L. P. Gardner M. D.
9/17 1921 (Address) Montpelier, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mont. Ida — DATE OF BURIAL: 9-17-1921

20. UNDERTAKER: J. M. Williams — ADDRESS: Montpelier

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-12 M. 6-15-1 RECEIVED OCT 31 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35472
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Bear Lake Registration District No. 37
City of Montpelier Registration District No. 736
If death occurs away from usual residence, give facts called for under special information. (No. ....., ... St.)

2. FULL NAME Noel P. Thornton

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Infant

6. DATE OF BIRTH. July (Month) 11 (Day) 1918 (Year)

7. AGE: 3 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many .... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Wyoming

10. NAME OF FATHER: Wm L. Thornton

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Maggie E Christensen

13. BIRTHPLACE OF MOTHER (State or Country): Wyoming

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Leslie Thornton
(Address) Grover Wyoming

15. Filed 16-1 1921 ..... Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug. 16th 1921. (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 13 1921. to Aug. 16 1921, that I last saw him alive on Aug 16 1921. and that death occurred on the date stated above, at 1 P. M.

The CAUSE OF DEATH* was as follows:
Acute Brights Dis.
.....
.....
(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) Emma Smithley M. D.
8.17. 1921. (Address) Montpelier Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the ,State....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Grover Wyoming — DATE OF BURIAL: Aug. 18, 1921.

20. UNDERTAKER: J. M. Williams — ADDRESS: Montpelier Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-12 M, 6-15-17.

CERTIFICATE OF DEATH

RECEIVED
OCT 31 1921
BUREAU OF VITAL STATISTICS

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35473
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Bear Lake Registration District No. 32
City of Montpelier Primary Registration District No. 213
If death occurs away from usual residence, give facts called for under special information. (Not in ..... St.)

2. FULL NAME Thomas Alexander

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: Canadian Indian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. ..... (Month) ..... (Day) ..... (Year)

7. AGE: About 17 or 18 yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many .... hrs. or .... min.?'

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Canada

10. NAME OF FATHER: —

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) F. M. Williams
(Address) Montpelier

15. Filed 10-1- 1921 ..... Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 31 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191.... to ..... 191.. that I last saw ~~him~~ alive on ..... 191.... and that death occurred on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:
Accidently drowned while Bathing in Bear River at R. R. Bridge near Pegram Idaho
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) F. M. Williams ~~M. D.~~
July 31. 1921. (Address) Montpelier Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Montpelier Idaho. DATE OF BURIAL: Aug. 2, 1921

20. UNDERTAKER: F. M. Williams ADDRESS: Montpelier Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-12 M. 6-15-17.

RECEIVED
OCT 21 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35474
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Bear Lake Registration District No. 32
City of Dingle Primary Registration District No. 2136
If death occurs away from usual residence, give facts called for under special information.
(No. ....., ... St.)

2. FULL NAME Dingle Gate

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH. Dec (Month) 7 (Day) 1 (Year)
7. AGE: 16 Yrs. 7 Mos. 17 ds. IF LESS than 1 day how many .... hrs. or .....min.?'
8. OCCUPATION
(a) Trade, profession or particular kind of work: At School
(b) General nature of industry, business, or establishment in which employed (or employer) .....
9. BIRTHPLACE (State or Country): Idaho
10. NAME OF FATHER: Chas C. Gate
11. BIRTHPLACE OF FATHER (State or Country): Idaho
12. MAIDEN NAME OF MOTHER: Emma May Bird
13. BIRTHPLACE OF MOTHER (State or Country): Utah
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Charles Le Gate
(Address) Dingle Idaho
15. Filed 10-1-1921 W. H. Young Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 24 (Day) 1921 (Year)
17. I HEREBY CERTIFY, That I attended deceased from July 17th 1921 to July 22nd 1921
that I last saw her alive on July 22nd 1921
and that death occurred on the date stated above, at 8:30 A.M.
The CAUSE OF DEATH* was as follows:
General Septicemia
(Duration) ..... Yrs. 2 weeks ds.
Contributory (Secondary) .....
(Duration) ..... Yrs. ..... mos. ..... ds.
(Signed) E. F. Gibson M. D.
July 26 1921 (Address) Swan Falls Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Dingle Idaho DATE OF BURIAL: July 26 1921
20. UNDERTAKER: F. M. Williams ADDRESS: Montpelier Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35476
Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

RECEIVED
OCT 31 1921
BUREAU OF VITAL STATISTICS

Registration District No. 52
Primary Registration District No. 736

1. PLACE OF DEATH
County of Bear Lake
City of Montpelier
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Linden O. Bagley

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH. Feb. 7 1904 (Month) (Day) (Year)
7. AGE 17 Yrs. 7 Mos. 14 ds. IF LESS than 1 day how many .... hrs. or .....min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Farm Hand
(b) General nature of industry, business, or establishment in which employed (or employer) .....
9. BIRTHPLACE (State or Country): Idaho
10. NAME OF FATHER: Enoch Bagley
11. BIRTHPLACE OF FATHER (State or Country): England.
12. MAIDEN NAME OF MOTHER: Eva Sarah Phelps.
13. BIRTHPLACE OF MOTHER (State or Country): Idaho.
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Enoch Bagley
(Address) Montpelier Idaho
15. Filed 10-1-1921 W. W. Rees Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 21 1921 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from Sept 10 1921 to Sept 21 1921
that I last saw he alive on Sept 21 1921
and that death occurred on the date stated above, at 4:9 M.
The CAUSE OF DEATH* was as follows:
Appendicitis
.....
.....
.....
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Acute Appendicitis
(Duration) ..... Yrs. ..... mos. ..... ds.
(Signed) Levi C. Cubley M. D.
Sept 26 1921 (Address) Montpelier
*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Montpelier Idaho — DATE OF BURIAL: Sept. 24 1921
20. UNDERTAKER: F. M. Williams — ADDRESS: Montpelier, Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35477
Registered No. .....

RECEIVED
OCT 31 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Bear Lake Registration District No. 57
City of Montpelier Primary Registration District No. 2136
If death occurs away from usual residence, give facts called for under special information. (No. ..... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Reuben Smith Findlay

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Nov (Month) 8 (Day) 1858 (Year)

7. AGE: 62 Yrs. 10 Mos. 18 ds.
IF LESS than 1 day how many .... hrs. or .....min.?'

8. OCCUPATION
(a) Trade, profession or particular kind of work: Barber
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Utah.

10. NAME OF FATHER: Hugh Findlay

11. BIRTHPLACE OF FATHER (State or Country): Scotland.

12. MAIDEN NAME OF MOTHER: Mary E. Smith

13. BIRTHPLACE OF MOTHER (State or Country): England.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. J. S. Findlay
(Address) Woodruff, Utah

15.
Filed 10-1 1921 N. P. Peterson
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 26 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 21 1921 to Sept 26 1921
that I last saw h[illegible] alive on 12 A 1921
and that death occurred on the date stated above, at 8 A. M.

The CAUSE OF DEATH* was as follows:
Apoplexy
.....(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Senile
.....(Duration) ..... Yrs. ..... mos. ..... ds.
(Signed) Evan V. Eardley M. D.
Sept 26 1921 (Address) Montpelier

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Randolph Utah. DATE OF BURIAL: Sept 28, 1921

20. UNDERTAKER: F. M. Williams ADDRESS: Montpelier Idaho

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

RECEIVED
OCT 31 1921
BUREAU OF VITAL STATISTICS

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35478
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Bear Lake ... Registration District No. 5-2
City of Montpelier ... Primary Registration District No. 2136
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Anna C. Staley

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married
6. DATE OF BIRTH. Sept (Month) 1 (Day) 1875 (Year)
7. AGE: 46 Yrs. — Mos. 25 ds. IF LESS than 1 day how many .... hrs. or .... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Ohio
10. NAME OF FATHER: Michael Burney
11. BIRTHPLACE OF FATHER (State or Country): Ireland
12. MAIDEN NAME OF MOTHER: (Not known)
13. BIRTHPLACE OF MOTHER (State or Country): Ireland.
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. G. Staley
(Address) Montpelier Idaho
Sept 27 1921
15. Filed 10-1- 1921 — W. H. Kling, Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. (Month) 26 (Day) 1921 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Jan. 1918 to Sept 26 1921 that I last saw h[er] alive on Sept 26 1921 and that death occurred on the date stated above, at 4 P. M.
The CAUSE OF DEATH* was as follows:
Spinal Tuberculosis
(Duration) 5 Yrs. — mos. — ds.
Contributory (Secondary)
(Duration) — Yrs. — mos. — ds.
(Signed) C. F. Sievers M. D.
(Address) Montpelier Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the ,State....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Montpelier Idaho — DATE OF BURIAL: Sept. 29, 1921
20. UNDERTAKER: J. M. Williams — ADDRESS: Montpelier Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16

RECEIVED
OCT 31 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH.

35479

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 13
Registered No. .....

1. PLACE OF DEATH
County of Bear Lake Registration District No 53
City of Paris (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Russell Gooding Dunford

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH. Sept (Month) 18th (Day) 1920 (Year)
7. AGE: Yrs. 11 Mos. 21 ds. IF LESS than 1 day how many ..... hrs. or ..... min.
8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....
9. BIRTHPLACE (State or Country) Idaho
10. NAME OF FATHER Teller Dunford
11. BIRTHPLACE OF FATHER (State or Country) Bear Lake Co.
12. MAIDEN NAME OF MOTHER Thelma Fuller
13. BIRTHPLACE OF MOTHER (State or Country) Bear L
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Teller Dunford
(Address) Paris Idaho
15. Filed Sept 14 1921 Mrs. J. L. Kinman Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Sept (Month) 12 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 9 1921, to Sept 11 1921, that I last saw h... alive on Sept 11 1921, and that death occured on the date stated above, at 5a. M.

The CAUSE OF DEATH* was as follows:
Intussusception (Acute Obstruction Bowels)

(Duration) ..... Yrs. ..... mos. 3 ds.
Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) C. O. Moore M. D.
Sept 14 1921 (Address) Paris Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Bloomington — DATE OF BURIAL: Sept 14 1921
20. UNDERTAKER: Bishop & Co. Hart — ADDRESS: Bloomington

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

EVANS - YORK CO., PTRS. & BDRS. 24654

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED OCT 1924 BUREAU OF STATISTICS

CERTIFICATE OF DEATH.

35480

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 5-3

Primary Registration District No.

File No. 15

Registered No.

1. PLACE OF DEATH.

County of Bear Lake

City of Paris (If outside limits of city or village give township) St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lavilla Bird

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Dec. (Month) 20 (Day) 1902 (Year)

7. AGE: 18 Yrs. Mos. 1 Ds. 16

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Clerk
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: John Bird

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Ettie Nate

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) John Bird
(Address) Paris Idaho

15. Filed Nov 2 1924 Mrs. J. S. Thomas Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 5 (Day) 1924 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 3 1924, to Feb 5 1924, that I last saw h(er) alive on Feb 5 1924, and that death occured on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:
Epidemic Cerebro Spinal Meningitis
complicated with Inflammation Lung
right (Moderate)
(Duration) Yrs. mos. 3 ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) C. O. Moore M. D.
2/7 1924 (Address) Paris, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Paris Idaho — DATE OF BURIAL: Feb 8 1924

20. UNDERTAKER: Bishop Low — ADDRESS: Paris Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.

STUB - YORK CO., PTRS. & STNRS. 24854

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
OCT 31 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35481

Registered No. 41

1. PLACE OF DEATH

County of Benewah Registration District No. 92

Primary Registration District No. 2049

City of St Maries St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George Thurston

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	

6. DATE OF BIRTH

..... (Month) ..... (Day) 1881 (Year)

7. AGE

39 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Penn.

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Coroner

(Address) St Maries

15.

Filed Sept. 27 1921 H E Eckert
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept. 24 (Month) ..... (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....,

that I last saw h..... alive on ..... 19.....,

and that death occurred on the date stated above, at 12:00 M.

The CAUSE OF DEATH* was as follows:

accidentally shot himself while cleaning shot Gun.

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H L Alcorn Coroner

9/24/1921 (Address) St Maries Benewah Co. Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Forest Run Penn.	Nov 2 1921
20. UNDERTAKER	**ADDRESS**
H E Eckert	St Maries

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35482
Registered No. 42

1. PLACE OF DEATH

Registration District No. 32
Primary Registration District No. 2049

County of Benewah
City of St Maries (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Maxine Stratton

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

RECEIVED OCT 3 - 1921 BUREAU OF STATISTICS

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
female	white	single

6. DATE OF BIRTH: Dec. (Month) 18 (Day) 1917 (Year)

7. AGE: 3 Yrs. 9 Mos. 7 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: X
(b) General nature of industry, business or establishment in which employed (or employer): X

9. BIRTHPLACE (State or Country): St Maries Ida

10. NAME OF FATHER: Norman Stratton

11. BIRTHPLACE OF FATHER (State or Country): Wisconsin

12. MAIDEN NAME OF MOTHER: Rose Lounsbury

13. BIRTHPLACE OF MOTHER (State or Country): Michigan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Norman Stratton.
(Address) St Maries Idaho

15. Filed Sept. 27 1921 — Hattie X — Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 9 (Month) 22 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 21 1921, to Sept 22 1921, that I last saw her alive on Sept 24 1921, and that death occurred on the date stated above, at 9 M.

The CAUSE OF DEATH* was as follows:

Whooping Cough and Pneumonia

(Duration) ..... Yrs. ..... mos. 10 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Owen D. Platt M. D.

Sept 25 1921 (Address) St Maries. Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Woodlawn	9/27 1921

20. UNDERTAKER	ADDRESS
Mitchell & Messager	St Maries

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35483
Registered No. 40

1. PLACE OF DEATH

County of Benewah Registration District No. 22

City of Rennsdell Primary Registration District No. 2049

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED OCT 31 1921 BUREAU OF VITAL STATISTICS

2. FULL NAME Camute E. Eide

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH

..... (Month) ..... (Day) 1 ..... (Year)

7. AGE: About 40 years

..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Carpenter

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15. Filed Sept 24 1921 H Eaton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. 24 & 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from — 19..., to — 19..., that I last saw h— alive on — 19..., and that death occurred on the date stated above, at 8:20 A. M.

The CAUSE OF DEATH* was as follows:

was struck by Boom when it Swung. Throwing him from the car and killing him instantly

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H Malcom Coroner M. D.

9/24 1921 (Address) St Maries, Ida.

*State the **Disease Causing Death**; or in deaths from **Violent Causes**, state (1) **Means of Injury**; and (2) whether **Accidental, Suicidal or Homicidal.**

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Forest City Iowa	..... 19.....
20. UNDERTAKER	**ADDRESS**
H E Hunt Co	St Maries

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED OCT 24 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35484

Registered No. 39

1. PLACE OF DEATH

Registration District No. 32

Primary Registration District No. 2049

County of Bonneville

City of Ririe (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Leslie Leach Knight

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: June 30 (Month) (Day) 1921 (Year)

7. AGE: — Yrs. 2 Mos. 8 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: X

(b) General nature of industry, business or establishment in which employed (or employer): X

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: Earnest Knight

11. BIRTHPLACE OF FATHER (State or Country): Wisconsin

12. MAIDEN NAME OF MOTHER: Lenna Snyder

13. BIRTHPLACE OF MOTHER (State or Country): Mich.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Earnest Knight

(Address) Ririe Idaho

15. Filed Sept 7 1921 H Eklund Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. 7 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 28 1921, to Aug 20 1921, that I last saw h[illegible] alive on Aug 20 1921, and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Marasmus

(Duration) Yrs. 2 mos. 8 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

9/7 1921 (Signed) Delbert Wall M. D.

(Address) St Maries

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rainbow creek — DATE OF BURIAL ..... 19.....

20. UNDERTAKER: H Eklund Co — ADDRESS St Maries

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Benewah

City of St Maries

If death occurs away from usual residence, give facts called for under special information.

BUREAU OF STATISTICS

Registration District No. 32

Primary Registration District No. 2049

(No. ..... St.)

File No. 35485

Registered No. 38

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Orson Fowler Van Cise

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH: July (Month) 18 (Day) 1849 (Year)

7. AGE: 72 Yrs. 1 Mos. 16 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Minister

(b) General nature of industry, business or establishment in which employed (or employer): Retired

9. BIRTHPLACE (State or Country): Washington Co. Penn.

10. NAME OF FATHER: Dr. Edwin Van Cise

11. BIRTHPLACE OF FATHER (State or Country): Washington Co. Penn

12. MAIDEN NAME OF MOTHER: Maria Pearson

13. BIRTHPLACE OF MOTHER (State or Country): Washington Co. Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Monona Van Cise

(Address) St Maries Idaho

15. Filed Sept 4 1921

H E Brush
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: September (Month) 3 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1921 to Sept 3 1921 that I last saw him alive on Sept 2 1921 and that death occurred on the date stated above, at 1 P. M.

The CAUSE OF DEATH* was as follows:

Anemia, Idiopathic

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Age

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. Kinnebrew M. D.

9/3 1921 (Address) St Maries Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Spokane Wash — DATE OF BURIAL: Sept 5 1921

20. UNDERTAKER: Smith & Co — ADDRESS: Spokane

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED OCT 31 19 BUREAU OF STATISTICS

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121

Primary Registration District No. 2194

File No. 35486

Registered No. 122

1. PLACE OF DEATH.

County of Bingham

City of Shelley (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Louise Freeman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Dec (Month) 22 (Day) 1912 (Year)

7. AGE: 8 Yrs. 10 Mos. 6 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer): School girl

9. BIRTHPLACE (State or Country): Basalt Idaho

10. NAME OF FATHER: Loran Farr Freeman

11. BIRTHPLACE OF FATHER (State or Country): Oregon

12. MAIDEN NAME OF MOTHER: Edna Emma Croft

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Loren Freeman

(Address) Basalt Ida.

15. Filed Sept 2 1921 Wm Walter E. Fabor Local Registrar

SYMS - YORK CO. PTRS. & BOBS. 24854

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 1 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 8-16 1921, to 9-1 1921, that I last saw her alive on 9-1 1921, and that death occured on the date stated above, at 6 A. M.

The CAUSE OF DEATH* was as follows:

Typhoid fever

Complications with

Pneumonia & Meningitis

(Duration) Yrs. mos. 18 ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Edward Gentles M. D.

9-1-1921 (Address) Shelley.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Basalt Cemetery — DATE OF BURIAL: 9-2-1921

20. UNDERTAKER: Home Employed — ADDRESS

Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

RECEIVED OCT 31 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 121
County of Bingham Primary Registration District No. 2194
City of Blackfoot (If not in city or village give township) St.)
If death occurs away from usual residence, give facts called for under special information.

File No. 35487
Registered No. 123
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Harley Laren Jensen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	W	Single

6. DATE OF BIRTH: Dec. (Month) 14 (Day) 1920 (Year)

7. AGE: yrs. 8 mos. 19 ds. IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, professsion, or particular kind of work: Infant
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: James M. Jensen

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: Anna Findlay

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) James M. Jensen
(Address) Blackfoot R.F.D. 1

15. Filed Sept. 3 1921 Mrs Nalie E. Peters Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 2 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 1 1921, to Sept 2 1921, that I last saw him alive on Sept 2 1921, and that death occurred on the date stated above, at 3:40 p. M.

The CAUSE OF DEATH* was as follows:
Pneumonia and Capillary Bronchitis

(Duration) yrs. mos. 2 ds.
Contributory (Secondary) Meningitis-Spinal
(Duration) yrs. 2 mos. — ds.
(Signed) [illegible] M. D.
Sept 3 1921 (Address) Blackfoot

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. 8 mos. 19 ds. In the State yrs. 8 mos. 19 ds.
Where was Disease contracted, if not at place of death? At home
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Groveland Cem. DATE OF BURIAL: 191

20. UNDERTAKER ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16872

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH — RECEIVED OCT 31 1921 BUREAU OF VITAL STATISTICS

Registration District No. 191
Primary Registration District No. 1007
File No. 35489
Registered No. 125

County of Bingham
City of Blackfoot (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William Leon Young

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH: November 15 1895 (Month) (Day) (Year)

7. AGE: 25 Yrs. 9 Mos. 28 ds. — IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Day Laborer
(b) General nature of industry, business or establishment in which employed (or employer): J. C. Maguire Paving Co

9. BIRTHPLACE (State or Country): Mt. Pleasant Utah

10. NAME OF FATHER: William H Young

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Mary Beanes

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Idanah Jones Young
(Address) Blackfoot Ida

15. Filed Sept 22 1921 — Mrs Helen E. Petrie, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept 13 21 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on 1921
and that death occurred on the date stated above, at 4 P. M.
The CAUSE OF DEATH was as follows:
Accidently crushed to death at J C Maguire Paving Plant while in performance of duty
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Coroner's Jury Verdict
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Ed L Egli Coroner M. D.
Sept 14 1921 (Address) Blackfoot Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain Cemetery — DATE OF BURIAL: Sept 16 1921

20. UNDERTAKER: Ed L Egli — ADDRESS: Blackfoot Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35490
Registered No. 736

1. PLACE OF DEATH
County of Bingham
City of Blackfoot
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 121
Registration District No. 2194
(No. STATE St.)

2. FULL NAME Samuel Pleasant Hudson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH: March (Month) 15 (Day) 1870 (Year)

7. AGE: 51 Yrs. 6 Mos. ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Tenn.

10. NAME OF FATHER: B. Walker Hudson

11. BIRTHPLACE OF FATHER (State or Country): Tenn

12. MAIDEN NAME OF MOTHER: Alice Dickey

13. BIRTHPLACE OF MOTHER (State or Country): Tenn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John W. Hudson.
(Address) Blackfoot, Ida. Box 592.

15. Filed Sept 17 1921 Mrs Nadeen E. Tuttle Local Registrar

SYMS-YORK CO. PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 15 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1919, to Sept 15 1921
that I last saw him alive on Sept 15 1921,
and that death occurred on the date stated above, at 7 P—M.
The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) 2 Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) R. Jameson M. D.
Sept 15 1921 (Address) Blackfoot. Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 9 yrs. mos. days. In the State 7 yrs. mos. days
Where was disease contracted if not at place of death? Here
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rockland Idaho — DATE OF BURIAL: 9-17-1921

20. UNDERTAKER: E. Peck — ADDRESS: Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 3549

Registered No. 127

RECEIVED
OCT 31 1921
BUREAU OF VITAL STATISTICS

Registration District No. 127

Primary Registration District No. 2194

1. PLACE OF DEATH

County of Bingham

City of Shelley (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ernest Marchant.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: 11 (Month) 26 (Day) 1920 (Year)

7. AGE: Yrs. Mos. 9 ds. 16

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Shelley Idaho

10. NAME OF FATHER: Harvey A. Marchant.

11. BIRTHPLACE OF FATHER (State or Country): Provo Utah

12. MAIDEN NAME OF MOTHER: Susan E. Thomas.

13. BIRTHPLACE OF MOTHER (State or Country): Oxford Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Harvey A Marchant
(Address) R-7- Idaho Falls

15. Filed Sept-18 1921 Mrs Nalee Tolle
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 9 (Month) 17 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9-16- 1921 to 9-17- 1921 that I last saw h[illegible] alive on 9-16- 1921 and that death occurred on the date stated above, at 12 10 A.M.

The CAUSE OF DEATH* was as follows:
Catarrhal Enteritis

(Duration) all his life* Yrs. mos. ds.

Contributory (Secondary) Toxemia Metabolism all his life

(Duration) yrs. mos. ds.

(Signed) Edwin Leuter M. D.

9/17/1921 (Address) Shelley

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Shelley Cemetery — DATE OF BURIAL: 9/18/1921

20. UNDERTAKER: None employed. — ADDRESS: —

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

Registration District No. 131

Primary Registration District No. 2194

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35492
Registered No. 128

RECEIVED
OCT 31 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Bingham
City of Blackfoot (No. State Hospital, St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Robert Beckenato

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: March (Month) 1 (Day) 858 (Year)

7. AGE: 63 Yrs. 6 Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: unknown

11. BIRTHPLACE OF FATHER (State or Country): unknown

12. MAIDEN NAME OF MOTHER: unknown

13. BIRTHPLACE OF MOTHER (State or Country): unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Hosp. Record R. J. Eaton M.D.
(Address) Blackfoot Idaho

15. Filed Sept 15 1921 Mrs Nellie E. Paine
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. (Month) 17 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 22 1921 to Sept 17 1921 that I last saw him alive on Sept 17 1921, and that death occurred on the date stated above, at 8:45 A.M.

The CAUSE OF DEATH* was as follows:
Exhaustion of
ileo-colitis
(Duration) Yrs. mos. 10 ds.
Contributory (Secondary) Senile dementia
(Duration) yrs. 6 mos. ds.

(Signed) R. J. Eaton M. D.
Sept 18 1921 (Address) Blackfoot Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 0 yrs. 7 mos. 26 days. In the State unknown yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence Rexburg Idaho

19. PLACE OF BURIAL OR REMOVAL: Rexburg Ida. | DATE OF BURIAL: Oct 19 21

20. UNDERTAKER: E. L. Eglin | ADDRESS: Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
OCT 31 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 127
Primary Registration District No. 1007
File No. 35493
Registered No. 127

1. PLACE OF DEATH
County of Bingham
City of Blackfoot (No. South Pine St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Adeline Boyle
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: September (Month) 25 (Day) 1873 (Year)

7. AGE: 47 Yrs. 9 Mos. 23 ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Shellsburg Wisconsin

10. NAME OF FATHER: Daniel Brady

11. BIRTHPLACE OF FATHER (State or Country): New Jersey.

12. MAIDEN NAME OF MOTHER: Sarah Oneil

13. BIRTHPLACE OF MOTHER (State or Country): Wisconsin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) James M Boyle
(Address) Blackfoot Idaho

15. Filed Sept 19 1921 Mrs Nellie E. Patrick
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: September (Month) 18 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 12 1921 to Sept 18 1921 that I last saw h.e.r. alive on Sept 18 1921 and that death occurred on the date stated above, at 10 M.

The CAUSE OF DEATH* was as follows:
Tuberculosis of Lung.

(Duration) ... Yrs. ... mos. 14 ds.
Contributory (Secondary): Pleurisy
(Duration) ... yrs. ... mos. ... ds.

(Signed) H. J. Simmons M. D.
9/19 1921 (Address) Blackfoot Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Grove City Cemetery — DATE OF BURIAL ... 19...
20. UNDERTAKER: Ed L Egli — ADDRESS Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED OCT 5 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35494
Registered No. 130

1. PLACE OF DEATH
Registration District No. 1
Primary Registration District No. 1007
County of Bingham
City of Blackfoot (If outside city limits, give township) 358 East Bridge St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Daniel Leonard Oneal
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Feb (Month) 17 (Day) 1883 (Year)

7. AGE: 38 Yrs. 7 Mos. 6 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Wholesale Battery
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kansas

10. NAME OF FATHER: Ballard Preston Oneal

11. BIRTHPLACE OF FATHER (State or Country): Va

12. MAIDEN NAME OF MOTHER: Lillie Rhoden

13. BIRTHPLACE OF MOTHER (State or Country): Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Maud ONeal
(Address) Blackfoot Idaho

15. Filed Sept 24 1921 Mrs Nellie E. Fuller Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 23 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 20 1921 to Sept 23 1921 that I last saw h.m. alive on Sept 23 1921 and that death occurred on the date stated above, at 11 30 M.
The CAUSE OF DEATH* was as follows:

Cancer of Rectum

(Duration) Two Yrs. — mos. — ds.
Contributory (Secondary) —
(Duration) — yrs. — mos. — ds.

(Signed) F. W. Mulkey M. D.
9/23 1921 (Address) Blackfoot, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Gem City Cemetery DATE OF BURIAL: Sept 25 1921

20. UNDERTAKER: E. J. Clark ADDRESS: Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
OCT 31 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 2194
File No. 35495
Registered No. 131

1. PLACE OF DEATH
County of Bingham
City of Shelley Idaho (St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lloyd Blake Cox
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Baby (Write the word.)

6. DATE OF BIRTH: Oct 9 1917 (Month) (Day) (Year)

7. AGE: 3 Yrs. 11 Mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Charles R. Cox

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Hannah Dora Blake

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) .....
(Address) Charles R. Cox

15. Filed Sept 29 1921 Mc Nulen E. Co
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 9 (Month) 27 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9-26 1921, to 9-26 1921 that I last saw him alive on 9-26 1921, and that death occurred on the date stated above, at 9 P M.
The CAUSE OF DEATH* was as follows:
Dysentery
..... (Duration) ..... Yrs. ..... mos. 14 ds.
Contributory (Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Edwin Cutler M. D.
9-29 1921 (Address) Shelley, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Shelley cemetery — DATE OF BURIAL ..... 19.....

20. UNDERTAKER: None — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35496
Registered No. 152

RECEIVED
OCT 31 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
Registration District No. 127
Primary Registration District No. 2194
County of Bingham
City of Blackfoot (or Insane Asylum, State Hospital, St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME L P Hiatt
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): widowed

6. DATE OF BIRTH: ? (Month) ? (Day) 1845 (Year)

7. AGE: 76 Yrs. ? Mos. ? ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: unknown

11. BIRTHPLACE OF FATHER (State or Country): unknown

12. MAIDEN NAME OF MOTHER: unknown

13. BIRTHPLACE OF MOTHER (State or Country): unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R.G. Eaton M. D. Hosp. Records
(Address) Blackfoot. Idaho

15. Filed Sept. 29 1921 Mrs Nellie E. Pierce
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. (Month) 28 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 29 1921, to Sept. 28 1921, that I last saw him alive on Sept. 27 1921, and that death occurred on the date stated above, at 9:15 A.M.
The CAUSE OF DEATH* was as follows:
Exhaustion of Senile Dementia
(Duration) Yrs. 1 mos. ds.
Contributory (Secondary) Senile Dementia
(Duration) 1 yrs. mos. ds.
(Signed) C. V. Hoover M. D.
Sept 29 1921 (Address) Blackfoot Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. 1 mos. ... days. In the State 21 yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence Boise Idaho

19. PLACE OF BURIAL OR REMOVAL: Asylum Cem. | DATE OF BURIAL ... 19...

20. UNDERTAKER | ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
OCT 31
BUREAU OF STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35497

Registered No.

1. PLACE OF DEATH

Registration District No.

Primary Registration District No.

County of Bonner

City of Laclede (No. Laclede, Ida. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Gustava Kull

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6. DATE OF BIRTH: July 16, 1840 (Month) (Day) (Year)

7. AGE: 81 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Canada

10. NAME OF FATHER: Jno Kull

11. BIRTHPLACE OF FATHER (State or Country): Canada

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) D Kull
(Address) Laclede, Ida.

15. Filed Sept 21 1921 F. W. Didier Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept 21, 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 21 1921, to Sept 21 1921, that I last saw h[illegible] alive on Sept 21 1921, and that death occurred on the date stated above, at 10:20 A.M.
The CAUSE OF DEATH* was as follows:
Uraemic Poisoning

(Duration) ** Yrs. ** mos. 1/2 ds.
Contributory (Secondary) Nephritis
(Duration) 5 yrs. ** mos. ** ds.

(Signed) F. W. Didier M. D.
Sept 1921, (Address) Laclede, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL
Laclede, Ida. Sept 23 1921.

20. UNDERTAKER, ADDRESS
B. H. Snyder Sandpoint, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
OCT 31 19
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35498
Registered No.

1. PLACE OF DEATH

Registration District No. 75
Primary Registration District No. 2155
County of Bonneville
City of Idaho Falls (If outside city limits so state) (No. 731 So. Euclid St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Bessie Almeda Allen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Sept. (Month) 11 (Day) 1912 (Year)

7. AGE: 9 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: School Girl
(b) General nature of industry, business or establishment in which employed (or employer): At Home

9. BIRTHPLACE (State or Country): Ida.

10. NAME OF FATHER: A. N. Allen

11. BIRTHPLACE OF FATHER (State or Country): Colo.

12. MAIDEN NAME OF MOTHER: Helen Knapp

13. BIRTHPLACE OF MOTHER (State or Country): Kans

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A. N. Allen
(Address) Idaho Falls, Ida.

15. Filed Oct 8 1921 Floyd C. Wendle Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. (Month) 6, (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ~~Aug~~ Sept 24 1921, to Sept 6 1921, that I last saw her alive on Sept 6 1921, and that death occurred on the date stated above, at 10:40 P.M.

The CAUSE OF DEATH* was as follows:

Infantile Paralysis

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) C. P. St. Clair Lyons M. D.
Sept 7 1921 (Address) Idaho Falls, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Rose Ida DATE OF BURIAL Sept. 8, 1921

20. UNDERTAKER B. H. Smith ADDRESS Idaho Falls, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35499
Registered No.

Registration District No. 75
Primary Registration District No. 2155

1. PLACE OF DEATH
County of Bonner
City of Sand Point (No. [illegible] St.) City Hospital
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Pete Berg

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Unknown
(Month) (Day) (Year)

7. AGE: About 45 yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Lumberman.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Norway.

10. NAME OF FATHER: Berg.

11. BIRTHPLACE OF FATHER (State or Country): Norway.

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) [signature]
(Address) Sand Point, Ida.

15. Filed Oct 8 1921 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept 5 1921.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 3 1921, to Sept 5 1921, that I last saw h[illegible] alive on Sept 5 1921, and that death occurred on the date stated above, at 9 20 M.

The CAUSE OF DEATH* was as follows:
Crushed Pelvis

(Duration) Yrs. mos. ds.
Contributory (Secondary): Probably Rail Road Locomotive
(Duration) yrs. mos. ds.

(Signed) O F Sayr M. D.
Sept 1921. (Address) Sand Point, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Sand Point Ida. DATE OF BURIAL: Sept 14 1921.

20. UNDERTAKER: [signature] ADDRESS: Sand Point

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No [illegible]

CERTI[illegible]F DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 75

Primary Registration District No. 2155

File No. 35501

Registered No.

1. PLACE OF DE[illegible]

County of Bonner

City or Sand Point (No. City Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME W. Clancy

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Male	White	(write the word)

6. DATE OF BIRTH Unknown 1
(Month) (Day) (Year)

7. AGE 45 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Cook
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Unknown

10. NAME OF FATHER — Clancy

11. BIRTHPLACE OF FATHER (State or Country) Unknown

12. MAIDEN NAME OF MOTHER ..

13. BIRTHPLACE OF MOTHER .. (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) [signature]
(Address) Sand Point Idaho

15. Filed Oct 8 1921 Floyd B Wendle
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. 16, 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June, 1921, to Sept-16 1921, that I last saw h[illegible] alive on Sept-16 1921, and that death occurred on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

Senility

(Duration) Yrs. mos. ds.

Contributory (Secondary) Arterio Sclerosis

(Duration) yrs. mos. ds.

(Signed) Floyd B Wendle M. D.

Sept 19 21. (Address) Sand Point, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Sand Point Ida. DATE OF BURIAL Sept 17, 1921

20. UNDERTAKER [signature] ADDRESS Sand Point Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

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MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

RECEIVED OCT 3 1921 BUREAU OF STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35502
Registered No.

1. PLACE OF DEATH

County of Bonner Registration District No. 75
City of Sand Point (No. 503 Sixth Ave. St.) Primary Registration District No. 255

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Infant Lyons

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Single

6. DATE OF BIRTH Sept 14 1921 (Month) (Day) (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Herbert Lyons

11. BIRTHPLACE OF FATHER (State or Country) Iowa

12. MAIDEN NAME OF MOTHER Angie Walker

13. BIRTHPLACE OF MOTHER (State or Country) Miss

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Herbert Lyons
(Address) Sand Point, Ida.

15. Filed Oct 5 1921 Floyd G. Wendle Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 14 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept-14 1921, to Sept-14 1921, that I last saw her alive on Sept-14 1921, and that death occurred on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:
Premature Birth
6 Month Gestation
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Floyd G Wendle M. D.
Sept. 1921 (Address) Sand Point, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Sand Point Ida DATE OF BURIAL Sept 15 1921

20. UNDERTAKER E. E. Fenton ADDRESS Sand Point Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
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FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH RECEIVED OCT 13 1921 BUREAU OF VITAL STATISTICS

Registration District No. 85 35503

County of Bonner

Primary Registration District No. 2185

File No. 249

City of Priest River (No. ..... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Louise Ramieri

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Felame

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: arried (Write the word.)

6. DATE OF BIRTH: Aug (Month) 22 (Day) 1891 (Year)

7. AGE: 30 Yrs. 1 Mos. 22 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Italy

10. NAME OF FATHER: Antonio Friro

11. BIRTHPLACE OF FATHER (State or Country): Italy

12. MAIDEN NAME OF MOTHER: Not known

13. BIRTHPLACE OF MOTHER (State or Country): Italy

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Louise Ramieri

(Address) Priest River Ida.

15. Filed Nov 1 1921

E. P. Gethoff
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 12 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 15 1921, to Oct 12 1921, that I last saw her alive on Oct 12 1921, and that death occurred on the date stated above, at 2.30P M.

The CAUSE OF DEATH* was as follows:

Bronchial Asthma

(Duration) 0 Yrs. 9 mos. - ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E. P. Gethoff M. D.

Oct 13 1921 (Address) Priest River, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Priest River — DATE OF BURIAL: Oct 15 1921

20. UNDERTAKER: Wm Davis — ADDRESS: Newport

FORM V. S. No. 5-25 M. 1-19.

RECEIVED OCT 31 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35504

Registered No. 71 —

1. PLACE OF DEATH

Registration District No. 73

Primary Registration District No. 214-5

County of Bonneville

City of Idaho Falls (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mildred Jewerin Calderwood

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Oct ..... 1 ..... (Month) (Day) (Year)

7. AGE: 4 Yrs. 9 Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None -

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Swan Valley

10. NAME OF FATHER: John Calderwood

11. BIRTHPLACE OF FATHER (State or Country): Wyom.

12. MAIDEN NAME OF MOTHER: Martha Peterson

13. BIRTHPLACE OF MOTHER (State or Country): ~~Ut~~ Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jno Calderwood

(Address) Irwin Ida

15. Filed Sept 6 1921 ..... Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 14 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug-13 1921, to Aug 14 1921, that I last saw h[er] alive on Aug 14 1921 and that death occurred on the date stated above, at 4 P.M.

The CAUSE OF DEATH*. was as follows:

Tonsulitis, Abscess & adenoid

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Hospital M. D.

Sept 6 1921 (Address) Idaho Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Irwin Ida — DATE OF BURIAL: Aug 16 1921

20. UNDERTAKER: Cliff Hayes — ADDRESS: Idaho Falls Ida

Dr Spencer.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35505

Registered No. 94

RECEIVED
OCT 31 1924
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Bonner Registration District No. 3

City of Idaho Falls (If outside city limits, give township) Primary Registration District No. 2170

(Spencer Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Florence Louise Brown

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Sept (Month) 15 (Day) 1915 (Year)

7. AGE: 6 Yrs. ... Mos. ... ds.

IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho Falls Ida.

10. NAME OF FATHER: G. Mervor Brown

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Edna Fox

13. BIRTHPLACE OF MOTHER (State or Country): Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) G. Mervor Brown

(Address) Grant Ida.

15. Filed Oct 6 1921 V. V. Spencer Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 31 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 30 1921, to Aug 31 1921, that I last saw h[er] alive on Aug 31 1921, and that death occurred on the date stated above, at 1A.M.

The CAUSE OF DEATH* was as follows:

Accident. Fracture of the Base of the Skull

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) V. V. Spencer M. D.

Oct 6 1921 (Address) Idaho Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was died contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Grant Ida. DATE OF BURIAL: Sept 2 1921

20. UNDERTAKER: Sept Hayes ADDRESS: Idaho Falls Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

Dr Spencer

Form V. S. —325 R. 1919.

RECEIVED
OCT 31 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 73

Primary Registration District No. 21 V-0

File No. 35506

Registered No. 93

County of Bonneville (No. Division)

City of Idaho Falls (Ward)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Infant Porterie

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
male	White	Single

6. DATE OF BIRTH: Sept. (Month) 6. (Day) 1921 (Year)

7. AGE: ....Yrs. ....Mos. ....ds. IF LESS than 1 day how many 7 hrs. or ....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: ns.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho Falls.

10. NAME OF FATHER: A J Porterie

11. BIRTHPLACE OF FATHER (State or Country): Neb.

12. MAIDEN NAME OF MOTHER: Ethel Parr.

13. BIRTHPLACE OF MOTHER (State or Country): Kansas.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A J Porterie
(Address) Idaho Falls Ida.

15. Filed Sept 6 1921 — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. (Month) 6. (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 6 1921 to Sept 6 1921, that I last saw h.... alive on ....1921, and that death occurred on the date stated above, at ....M.
The CAUSE OF DEATH* was as follows:

Premature birth

....(Duration) ....Yrs. ....mos. ....ds.
Contributory (Secondary)
....(Duration) ....mos. ....ds.

(Signed) [illegible] M. D.
....1921 (Address) Idaho Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs. ....mos. ....days. In the State ....yrs. ....mos. ....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Riverview — DATE OF BURIAL: Sept 7 1921

20. UNDERTAKER: C H Hayes — ADDRESS: Idaho Falls

Dr. Clin.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
OCT 31 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 73

Primary Registration District No. 21-0

File No. 35508

County of Bannock

City of Ida Falls (If outside limits, give township) (St.)

Registered No. 91

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Laura Malinda Hoffman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Aug (Month) 19 (Day) 1889 (Year)

7. AGE: 32 Yrs. 1 Mos. 13 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Aaron Alvey

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Mary M Vanlwon

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Christian F. L. Hoffman

(Address) Ida Falls

15. Filed Oct 11 1921

Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 7 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....

that I last saw h..... alive on ..... 19.....

and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Gangrenous Cholecystitis

(Duration) ..... Yrs. ..... mos. 14 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H V Ray Hatch M. D.

10/4 1921 (Address) Ida Falls, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Ida Falls — DATE OF BURIAL: 10/5 1921

20. UNDERTAKER: C. E. Dunwoody — ADDRESS: Ida Falls

H V Ray Hatch

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35509

Registered No.

RECEIVED
OCT 31 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 79

Primary Registration District No. 3156

County of Boundary

City of (N. or S. ..... E. or W. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Dora Maud Schaffner

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
F	W	Married (Write the word.)

6. DATE OF BIRTH: May (Month) 28 (Day) 1896 (Year)

7. AGE: 25 Yrs. 3 Mos. 8 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mont

10. NAME OF FATHER: John Barker

11. BIRTHPLACE OF FATHER (State or Country): Ill.

12. MAIDEN NAME OF MOTHER: Esther Drake

13. BIRTHPLACE OF MOTHER (State or Country): Kans.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ruth Barker
(Address) Bonners Ferry Ida

15. Filed Sept. 8 1921 E E Fry Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 6 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Gunshot wound of Chest. (accidental)

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E. E. Saunders M. D.
9/9 1921 (Address) Bonners Ferry Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Bonners Ferry Ida	9/9 1921
20. UNDERTAKER	ADDRESS
[illegible]	Bonners Ferry

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED OCT 31 19[illegible] BUREAU OF VITAL STATISTICS STATE OF IDAHO

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 71.
Primary Registration District No. 315-6.
File No. 35510
Registered No.

County of Boundary
City of Bonners Ferry (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William Wolfe

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	W.	Widowed

6. DATE OF BIRTH ..... 1 .....
(Month) (Day) (Year)

7. AGE about 60 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Woodsman
(b) General nature of industry, business or establishment in which employed (or employer) Wilson's Log. Camp

9. BIRTHPLACE (State or Country) Germany

10. NAME OF FATHER Wolfe

11. BIRTHPLACE OF FATHER (State or Country) Germany

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (State or Country) Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H. E. Wolfe
(Address) Seattle Wash

15. Filed Sept. 10th 1921 E E Fry
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 9 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 1 1921, to Sept. 9 1921, that I last saw h[illegible] alive on Sept. 8th 1921, and that death occurred on the date stated above, at 1A. M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) E E Fry M. D.

9/10 1921 (Address) Bonners Ferry, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Seattle Wash	19
20. UNDERTAKER	ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
OCT 31 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Butte — Registration District No. 59

City of Arco — Primary Registration District No. ____ — St.)

File No. 35511

Registered No. ____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Francis Goff

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F	W	Single

6. DATE OF BIRTH — Aug (Month) 25 (Day) 1921 (Year)

7. AGE — Yrs. 1 Mos. 15 ds. — IF LESS than 1 day how many ____ hrs. or ____ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ____
(b) General nature of industry, business or establishment in which employed (or employer) ____

9. BIRTHPLACE (State or Country) Ida

10. NAME OF FATHER Thos. L Goff.

11. BIRTHPLACE OF FATHER (State or Country) Mo

12. MAIDEN NAME OF MOTHER Francis White

13. BIRTHPLACE OF MOTHER (State or Country) Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) T. L. Goff
(Address) Arco

15. Filed 10/9 1921 — F. M. Cannon, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH — Oct (Month) 9 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 10-5 1921, to 10-9 1921, that I last saw her alive on 10-9 1921, and that death occurred on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Inanition

(Duration) ____ Yrs. ____ mos. 10 ds.

Contributory (Secondary) ____

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) F. M. Cannon M. D.

10/9 1921 (Address) Arco

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days

Where was disease contracted if not at place of death? ____

Former or usual residence ____

19. PLACE OF BURIAL OR ~~REMOVAL~~	DATE OF BURIAL
Arco	10-10 1921

20. UNDERTAKER	ADDRESS
Kendricks	Arco

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

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FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35512
Registered No.

Registration District No. 59
Primary Registration District No.

BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Butte
City of arco
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Schmohl
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F	W	Single

6. DATE OF BIRTH: 9 (Month) — 16 (Day) — 1921 (Year)

7. AGE: Yrs. Mos. 11 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Ida

10. NAME OF FATHER Chris Schmohl

11. BIRTHPLACE OF FATHER (State or Country) Germany

12. MAIDEN NAME OF MOTHER Rose Friary

13. BIRTHPLACE OF MOTHER (State or Country) Colo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chris Schmohl
(Address) arco Ida

15. Filed 9/20/21 19 F. M. Cannon
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 9 (Month) 20 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9-16-1921, to 9-20-1921 that I last saw her alive on 9-20-1921 and that death occurred on the date stated above, at 1 P. M.

The CAUSE OF DEATH* was as follows:

Insanition

(Duration) Yrs. mos. 4 ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) F. M. Cannon M. D.
9/20 19 21 (Address) arco Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
arco Ida	9/21 1921
20. UNDERTAKER	ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35513
Registered No.

RECEIVED
OCT 31 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
Registration District No. 58d
Primary Registration District No. 2138
County of Camas
City of Mamard (If outside limits, give township) No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Peter DeWitt Frostenson
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): single

6. DATE OF BIRTH: June (Month) 23d (Day) 1919 (Year)

7. AGE: 2 Yrs. 3 Mos. 7 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: M. Fritz Frostenson

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Jennie Oredson

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) M. Fritz Frostenson per LW
(Address) Mamard Idaho

15. Filed 10-10 1921 — L Wilencheck, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: September (Month) 30th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 23d 1921, to September 30 1921, that I last saw h.im alive on September 29th 1921, and that death occurred on the date stated above, at 9 a M.
The CAUSE OF DEATH* was as follows:

Ileo- Colitis

(Duration) Yrs. mos. 9 ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) L Wilencheck M. D.
10-10 1921 (Address) Fairfield Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mamard Idaho — DATE OF BURIAL: Oct 1st 1921

20. UNDERTAKER — ADDRESS

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY; PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED OCT 8 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 3

County of Canyon

Primary Registration District No. 2005

City of Caldwell (If outside limits, give township.)

(No. St.)

File No. 35514

Registered No. 102

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William Thompson Dayless

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: November 25 (Month) (Day) 1847 (Year)

7. AGE: 73 Yrs. 10 Mos. 10 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mo Gonkin Ill

10. NAME OF FATHER: R Dayless

11. BIRTHPLACE OF FATHER (State or Country): Ill

12. MAIDEN NAME OF MOTHER: Don't Know

13. BIRTHPLACE OF MOTHER (State or Country): Ill

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J D Dayless

(Address) 3638 Wabash Kansas City Mo

15. Filed Oct 6 1921

John L Meyer
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 5 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 2 1921, to Oct 5 1921, that I last saw h.. alive on Oct 5 1921, and that death occurred on the date stated above, at 10 a. M.

The CAUSE OF DEATH* was as follows:

Shock from operation
(Gastro Enterostomy)

(Duration) ..... Yrs. ..... mos. 1 ds.

Contributory (Secondary) Carcinoma of Stomach

(Duration) ..... yrs. 3 mos. ..... ds.

(Signed) J. M. Cole M. D.

10/4 1921 (Address) Caldwell Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill — DATE OF BURIAL: Oct 7 1921

20. UNDERTAKER: C. V. Peckham — ADDRESS: Caldwell Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED
OCT 31 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 2005
File No. 35515
Registered No. 101

1. PLACE OF DEATH
County of Canyon
City of Caldwell (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Helen Pearl Mumsey
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Oct. (Month) 19 (Day) 1917 (Year)

7. AGE: 3 Yrs. 11 Mos. 16 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: C. W. Mumsey

11. BIRTHPLACE OF FATHER (State or Country): Virginia

12. MAIDEN NAME OF MOTHER: Hazel Terence

13. BIRTHPLACE OF MOTHER (State or Country): Montana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. W. Mumsey
(Address) Caldwell R. (Route 2)

15. Filed Oct. 5 1921
John S. Meyer
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 5 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 4 – 1921, to Oct 5 1921, that I last saw h.e.r. alive on Oct 5 1921, and that death occurred on the date stated above, at 2 A. M.

The CAUSE OF DEATH* was as follows:
Heart Paralysis
(Duration) 1 Yrs. ..... mos. ..... ds.
Contributory (Secondary) Diphtheria
(Duration) ..... yrs. ..... mos. 3 ds.

(Signed) S. B. Dudley M. D.
10-4 1921 (Address) Caldwell Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mora Hill — DATE OF BURIAL: 10-5 1921

20. UNDERTAKER: C. V. Peckham — ADDRESS: Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
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FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED
OCT 31 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 2005
File No. 35516
Registered No. 100

1. PLACE OF DEATH

County of Canyon
City of Hunter (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Warren Wood Aldrich

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH Aug (Month) 19 (Day) 1906 (Year)

7. AGE 15 Yrs. 1 Mos. 14 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Vermont

10. NAME OF FATHER Willis W. Aldrich

11. BIRTHPLACE OF FATHER (State or Country) Vermont

12. MAIDEN NAME OF MOTHER Susan Allen

13. BIRTHPLACE OF MOTHER (State or Country) Mass.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W W Aldrich

(Address) Hunter R2

15. Filed Oct 4 1921 John A Meyer Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 3 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 3 1921, to Oct 3 1921, that I last saw h... alive on Oct 3 1921, and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Compression from fractured skull

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Lawrence Hopper M. D.

..... 19..... (Address) Homedale Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Fruzzo — **DATE OF BURIAL** 10-4 1921

20. UNDERTAKER CASE FURNITURE CO. — **ADDRESS** Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 8

Secondary Registration District No. 2085

File No. 35517

Registered No. 99

County of Canyon

City of Caldwell (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sarah Addie Westfall

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): widow

6. DATE OF BIRTH: March 19 (Month) (Day) 1856 (Year)

7. AGE: 65 Yrs. 6 Mos. 2 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: House keeping

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): California

10. NAME OF FATHER: Levy Westfall

11. BIRTHPLACE OF FATHER (State or Country): West Virginia

12. MAIDEN NAME OF MOTHER: Dorit Mercer

13. BIRTHPLACE OF MOTHER (State or Country): West Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) R. M. Westfall

(Address) Westfall, Oregon

15. Filed Sept. 21 1921 John S. Meyers Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept 20 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 10 1921, to Aug 8 1921, that I last saw her alive on Aug 8th 1921, and that death occurred on the date stated above, at 7-30 P.M.

The CAUSE OF DEATH* was as follows: Sept 20/21

Cerebral hemorrhage

(Duration) ..... Yrs. 2 mos. ..... ds.

Contributory (Secondary): Valvular heart disease

(Duration) 5 yrs. about mos. ..... ds.

(Signed) G. D. Montgomery M. D.

Sept 20 21 (Address) Caldwell

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Westfall Oregon | DATE OF BURIAL ..... 19.....

20. UNDERTAKER: E. V. Peckham | ADDRESS: Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED OCT 3 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Canyon Registration District No. 3
City of Caldwell (or Village or Township) Registration District No. 2005
File No. 35519
Registered No. 97

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Harry Lee Gillenwater

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widower

6. DATE OF BIRTH: Aug. (Month) 8 (Day) 1888 (Year)

7. AGE: 33 Yrs. 1 Mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Stockman
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Tennessee

10. NAME OF FATHER: Lucker D. Gillenwater

11. BIRTHPLACE OF FATHER (State or Country): Tennessee

12. MAIDEN NAME OF MOTHER: Ida May Gillenwater

13. BIRTHPLACE OF MOTHER (State or Country): Tennessee

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Lucker D. Gillenwater
(Address) Nampa Idaho

15. Filed Sept. 19 1921 John V. Meyer
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 18 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Suicide, Cutting throat with piece of glass at City jail
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Paul L. Evans M. D.
1921 (Address) Coroner Caldwell

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Boise Idaho
DATE OF BURIAL: 9-19 1921

20. UNDERTAKER: CASE FURNITURE CO. CASE FURNITURE CO.
ADDRESS: CALDWELL, IDAHO

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED
OCT 4 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Canyon
City of Caldwell (St.)
Registration District No. 3
Primary Registration District No. 2005
File No. 35520
Registered No. 96
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Pearl Hickerson
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6. DATE OF BIRTH: Oct (Month) 3 (Day) 1899 (Year)

7. AGE: 21 Yrs. 11 Mos. 14 ds.
IF LESS than 1 day how many..... hrs. or.....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: Geo. W. Hickerson

11. BIRTHPLACE OF FATHER (State or Country): Illinois.

12. MAIDEN NAME OF MOTHER: Nettie Marshall

13. BIRTHPLACE OF MOTHER (State or Country): Illinois.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Lena Colson
(Address) Caldwell, Ida.

15. Filed Sept. 17 1921 John U. Meyer
Local Registrar

EVANS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 17th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 8 1921, to Sept 17 1921, that I last saw h.r. alive on Sept 10 1921, and that death occurred on the date stated above, at 10 A. M.
The CAUSE OF DEATH* was as follows:
Tuberculosis of Lungs.

(Duration) 3 Yrs. mos. ds.
Contributory (Secondary) Hemdalony
(Duration) 2 yrs. mos. ds.
(Signed) C. L. Gross M. D.
Sept 17 1921 (Address) Caldwell Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Canyon Hill	Sept 18 1921
20. UNDERTAKER	ADDRESS
C. P. Peckham	Caldwell

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35521

Registered No. 93

1. **PLACE OF DEATH**

County of Canyon

City of Caldwell (No. ..... St.)

Registration District No. 3

Registration District No. 1005

If death occurs away from usual residence, give facts called for under special information.

2. **FULL NAME** Ray Arthur Young

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. **SEX**: M.

4. **COLOR OR RACE**: White

5. **SINGLE, MARRIED, WIDOWED OR DIVORCED** (Write the word.): Single

6. **DATE OF BIRTH**: Apr. 20 (Month) (Day) 1920 (Year)

7. **AGE**: 1 Yrs. 4 Mos. 27 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. **OCCUPATION**

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. **BIRTHPLACE** (State or Country): Idaho

10. **NAME OF FATHER**: Earl C. Young

11. **BIRTHPLACE OF FATHER** (State or Country): Missouri

12. **MAIDEN NAME OF MOTHER**: Irene Edith Bryant

13. **BIRTHPLACE OF MOTHER** (State or Country): Missouri

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**

(Informant) Mrs I. E. Young

(Address) 2nd & Elgin St. Caldwell Idaho

15. Filed Sept. 19 1921 John L. Meyer Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH**: Sept (Month) 17 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 7 1921, to Sept 17 1921, that I last saw h.... alive on Sept 16 1921, and that death occurred on the date stated above, at 6a M.

The CAUSE OF DEATH* was as follows:

Acute Peritonitis

(Duration) ..... Yrs. ..... mos. 11 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) L. D. Stewart M. D.

9/19 1921 (Address) Caldwell Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. **PLACE OF BURIAL OR REMOVAL**: Canyon Hill

DATE OF BURIAL: 9-19 1921

20. **UNDERTAKER**: CASE FURNITURE CO.

ADDRESS: Caldwell

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 3

Primary Registration District No. 1005

File No. 35522

Registered No. 94

County of ....

City of .... (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Edwin Lewis Hunt

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

BUREAU OF VITAL STATISTICS

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	White	Single

6. DATE OF BIRTH .... 1 .... (Month) (Day) (Year)

7. AGE 6 Yrs. .... Mos. .... ds. IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ....
(b) General nature of industry, business or establishment in which employed (or employer) ....

9. BIRTHPLACE (State or Country) Montana

10. NAME OF FATHER Elmer Lewis Hunt

11. BIRTHPLACE OF FATHER (State or Country) Mo

12. MAIDEN NAME OF MOTHER Katherine Hoffman

13. BIRTHPLACE OF MOTHER (State or Country) Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Elmer Hunt
(Address) 809 Denver - Caldwell

15. Filed Sept. 20 1921 John H. Meyers Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 16 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 15 1921 to Sept 16 1921 that I last saw h alive on Sept 15 1921 and that death occurred on the date stated above, at about 3 P.M.

The CAUSE OF DEATH* was as follows:

Myocarditis

.... (Duration) .... Yrs. .... mos. 2 ds.

Contributory (Secondary) Laryngitis

.... (Duration) .... yrs. .... mos. .... ds.

(Signed) W. H. Kelly M. D.

9-19 1921 (Address) Caldwell Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .... yrs. .... mos. .... days. In the State .... yrs. .... mos. .... days

Where was disease contracted if not at place of death? ....

Former or usual residence ....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Canyon Hill	9-20-1921

20. UNDERTAKER	ADDRESS
CASE FURNITURE CO.	Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

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FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED OCT 31 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 3

County of Canyon

Primary Registration District No. 2005

File No. 35523

City of Wilder, (No. ..... St.)

Registered No. 93

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Benjamin Howland Barker

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the words): Married

6. DATE OF BIRTH: Feb 23 1848 (Month) (Day) (Year)

7. AGE: 73 Yrs. 6 Mos. 23 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Maine.

10. NAME OF FATHER: Carr Barker

11. BIRTHPLACE OF FATHER (State or Country): Maine.

12. MAIDEN NAME OF MOTHER: Dont know

13. BIRTHPLACE OF MOTHER (State or Country): Maine.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Walter H Barker
(Address) Wilder Ida

15. Filed Sept. 17 1921 John V. Meyer Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept 16 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Hay sub Medium from Nov 1st 19 20 to Sept 16 19 21 that I last saw h..... alive on ..... 19....., and that death occurred on the date stated above, at 9-30 M.

The CAUSE OF DEATH* was as follows:
Enteritis

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) —

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. L. Newell M. D.

1921 (Address) Wilder, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Wilder Cem — DATE OF BURIAL: 9-17 1921

20. UNDERTAKER: E. V. Peckham — ADDRESS: Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35524
Registered No. 92

1. PLACE OF DEATH
County of Canyon
City of New Plymouth (If outside limits, give township.) St.)
Registration District No. 3
Primary Registration District No. 2005

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Samuel Sanderson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widower (Write the word.)

6. DATE OF BIRTH: April 16 (Month) (Day) 1846 (Year)

7. AGE: 75 Yrs. 4 Mos. 29 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Norway

10. NAME OF FATHER: Sanderson

11. BIRTHPLACE OF FATHER (State or Country): Norway

12. MAIDEN NAME OF MOTHER: Lord Knows

13. BIRTHPLACE OF MOTHER (State or Country): Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) David A. Sanderson
(Address) New Plymouth

15. Filed Sept. 16 1921 John A. Meyers Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 15 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 21" 1920, to Sept. 15" 1921, that I last saw him alive on Aug. 12" 1921, and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows: Cancer.

(Duration) 1 Yrs. 2 mos. 25 ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Dr. J. M. Kenny M. D.
19..... (Address) Caldwell Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill — DATE OF BURIAL: 9-16 1921
20. UNDERTAKER: Peckham & Co — ADDRESS: Caldwell Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

Form V. S. No. 5 20M.1-16-12

RECEIVED
OCT 31 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 2005
File No. 35525
Registered No. 91

1. PLACE OF DEATH.
County of Canyon
City of Wilder
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Joseph LeRoy Beal

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single child

6. DATE OF BIRTH: Dec (Month) 15 (Day) 1907 (Year)

7. AGE: 13 yrs. 8 mos. 28 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At home
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio.

10. NAME OF FATHER: J. H. Beal

11. BIRTHPLACE OF FATHER (State or Country): Ohio.

12. MAIDEN NAME OF MOTHER: Hattie Johnston

13. BIRTHPLACE OF MOTHER (State or Country): Ohio.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. H. Beal
(Address) Wilder Ida.

15.
Filed Sept. 14 1921
John L. Meyer
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Sept (Month) 13 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 13 1921, to Sept 13 1921, that I last saw h. m. alive on Sept 13 1921, and that death occurred on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Shock

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary): Extraction tooth

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. W. Roach M. D.

19 ..... (Address) Wilder Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Wilder Cem. DATE OF BURIAL: 9—15 1921

20. UNDERTAKER: E. V. Peckham ADDRESS: Caldwell.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35526
Registered No.

RECEIVED
OCT 31 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Canyon
City of ——— St.)
Registration District No.
Primary Registration District No. 1332
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Kennith Martin O'Hara
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: August 10 (Month) (Day) 1916 (Year)

7. AGE: 5 Yrs. 1 Mos. 28 ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: School
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho, Canyon Co.

10. NAME OF FATHER: Martin J. O'Hara

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Anna Drew McDonough

13. BIRTHPLACE OF MOTHER (State or Country): Minn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Martin J. O'Hara
(Address) Melba, Ida

15. Filed Oct 8 1921 Pearl Brooks Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: October (Month) 5 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from October 6 1921, to October 5 1921, that I last saw him alive on October 5 1921, and that death occurred on the date stated above, at 2 55 A.M.

The CAUSE OF DEATH* was as follows:
Fracture of skull; laceration of brain. Caused by over-turned motor truck. Accidental.
(Duration) ... Yrs. ... mos. 2 ds.
Contributory (Secondary)
(Duration) ... yrs. ... mos. 2 ds.

(Signed) Samuel W Swayne M. D.
Oct 8 1921 (Address) Melba, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Catholic Cemetery	10/10 1921
20. UNDERTAKER	ADDRESS
Fred K Robinson	Nampa Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED
OCT 31 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35527

Registration District No. 7

Primary Registration District No. 1006

Registered No.

1. PLACE OF DEATH

County of Canyon

City of Nampa (If outside limits of city or village, give township) (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Martha M. Hamilton

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Fem	white	Single

6. DATE OF BIRTH: Oct (Month) 26 (Day) 1895 (Year)

7. AGE: 25 Yrs. 11 Mos. 4 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: W. S. Hamilton

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Clara Brindley

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. S. Hamilton
(Address) Nampa Ida

15. Filed Oct 10 1921 Pearl Dodds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sep (Month) 30 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ____ 19__, to ____ 19__
that I last saw h__ alive on ____ 19__,
and that death occurred on the date stated above, at ____ M.
The CAUSE OF DEATH* was as follows:

Accidental Drowning

(Duration) ____ Yrs. ____ mos. ____ ds.

Contributory (Secondary)

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) C. E. Blanck M. D.
Justice of the Peace & Acting Coroner
19__ (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Kohlelawn Cem	10-2-1921
20. UNDERTAKER	ADDRESS
Enck & Robinson	Nampa Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V..S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35528
Registered No.

1. PLACE OF DEATH

County of Canyon
City of Nampa
If death occurs away from usual residence, give facts called for under special information.

RECEIVED
OCT 31 1921
BUREAU OF VITAL STATISTICS

Registration District No. 7
Primary Registration District No. 656
(No. Mercy Hospital St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Herschel Heilig

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH: 1845 (Month) (Day) 1 (Year)

7. AGE: 76 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Printer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kentucky

10. NAME OF FATHER: not known

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) L.G. Gagne
(Address) Cor 4th ave and 3dst

15. Filed Oct. 16 1921 Nampa Ida. Pearle Sadler Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sep. 30 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 3 1921 to Sep. 30 1921 that I last saw h. alive on Sep. 29 1921 and that death occurred on the date stated above, at 8 A.M.
The CAUSE OF DEATH*, was as follows:
Chronic interstitial nephritis.

(Duration) 2 Yrs. — mos. — ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) J. B. Smith M. D.
9/3, 1921 (Address) Nampa Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Kohlerlawn Cem — DATE OF BURIAL: 9/29 1921

20. UNDERTAKER: Fred K. Robinson — ADDRESS: Na

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED
OCT 31 1921
BUREAU OF VITAL

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 7

County of Canyon — Primary Registration District No. 1006

City of Nampa (No. ____, ____ St.)

File No. 35529

Registered No. ____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Della May Poff

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Female	White	Single (Write the word.)

6. DATE OF BIRTH: Dec. (Month) 10th (Day) 1910 (Year)

7. AGE: 10 Yrs. 9 Mos. 14 ds. IF LESS than 1 day how many ____ hrs. or ____ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry, business or establishment in which employed (or employer): ____

9. BIRTHPLACE (State or Country): Vermilion, Utah

10. NAME OF FATHER: D. H. Poff

11. BIRTHPLACE OF FATHER (State or Country): Virginia

12. MAIDEN NAME OF MOTHER: Emma May Potter

13. BIRTHPLACE OF MOTHER (State or Country): Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) D. H. Poff
(Address) R. F. D. No 5 Nampa

15. Filed Oct 16 1921 Pearle Dodds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: ~~Sept~~ (Month) 30 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 5 1921, to Sept 20 1921, that I last saw h.. alive on Sept 20 1921 and that death occurred on the date stated above, at 1 P. M.

The CAUSE OF DEATH* was as follows:
Heart embolus — Had recently recovered from case of Diphtheria — death sudden
(Duration) ____ Yrs. ____ mos. 15 ds.
Contributory (Secondary) Infection
(Duration) ____ yrs. [redacted] ds.

(Signed) J. H. Murray M. D.
10/1 1921 (Address) Nampa Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days
Where was disease contracted if not at place of death? ____
Former or usual residence ____

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Rohrbaugh Cem	Oct 2 1921

20. UNDERTAKER	ADDRESS
Fred H Robinson	Nampa Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

M

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED OCT 31 19

BUREAU STAT

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35530
Registered No. .....

1. PLACE OF DEATH.
County of Canyon
City of Nampa (No. ....., ... St.)
Registration District No. 7
Primary Registration District No. 1006
If death occurs away from usual residence, give facts called for under special information.
2. FULL NAME John Wall
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)
7. AGE: 67 Yrs. ..... Mos. ..... ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Common Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): England
10. NAME OF FATHER: Unknown
11. BIRTHPLACE OF FATHER (State or Country): Unknown
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (State or Country): Unknown
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Dott Rogers
(Address) Nampa Idaho
15. Filed Oct 16 1921 Pearle Dodds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 25 (Day) 1921 (Year)
17. I HEREBY CERTIFY, That I attended deceased from June 15 1920, to Sept 25 1921, that I last saw him alive on Sept 24 1921, and that death occured on the date stated above, at 4:20 a M.
The CAUSE OF DEATH* was as follows:
Senile Decay
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration ..... yrs. ..... mos. ..... ds.
(Signed) Dott Rogers M. D.
9/28 1921 (Address) Nampa Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 1 yrs. 3 mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence Owyhee Idaho

19. PLACE OF BURIAL OR REMOVAL: Catholic Cem — DATE OF BURIAL: 9-27 1921
20. UNDERTAKER: F K Robinson — ADDRESS: Nampa Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BOBB. 24653

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED
OCT 31
BUREAU OF STATISTICS

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35531
Registered No. .....

1. PLACE OF DEATH. Registration District No. 7
County of Canyon Primary Registration District No. 1886
City of Nampa (No. Idaho State Sanitarium)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Wesley Fayle

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE 20 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE
(State or Country)

10. NAME OF FATHER W. H. Fayle

11. BIRTHPLACE OF FATHER
(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Dr. O. R. Poynter
(Address) Nampa Ida.

15.
Filed Oct 10 1921 Pearle Lovell
Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Oct (Month) 9 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 4 1921, to Oct 9th 1921, that I last saw him alive on Oct 9th 1921, and that death occured on the date stated above, at 5:10 A.M.

The CAUSE OF DEATH* was as follows:
Exhaustion - Manic Depressive Insanity

(Duration) 3 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) O. R. Poynter M. D.
10/9 1921. (Address) Nampa Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs. 10 mos. 5 days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death? Lewiston Idaho
Former or usual residence Leadore Idaho

19. PLACE OF BURIAL OR REMOVAL: Dubois Ida. DATE OF BURIAL: 9/ 1921

20. UNDERTAKER: Fred R Robinson ADDRESS: Nampa Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

RECEIVED OCT 31 1921 BUREAU

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35532
Registered No.

1. PLACE OF DEATH
County of Canyon
City of Nampa ST (No. Idaho Sanitarium St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No.

2. FULL NAME Lot Pauline Hartfiel
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F	White	Single

6. DATE OF BIRTH: April 28 1907 (Month) (Day) (Year)

7. AGE: 14 Yrs. 5 Mos. 2 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Fred Hartfiel

11. BIRTHPLACE OF FATHER (State or Country): Minn

12. MAIDEN NAME OF MOTHER: Electa Webb.

13. BIRTHPLACE OF MOTHER (State or Country): Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Jessie Cunningham
(Address) Ustick Ida

15. Filed Oct 31 1921 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct 30 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 30 1921, to Oct 30 1921, that I last saw h[illegible] alive on Oct 30 1921, and that death occurred on the date stated above, at 2 P M.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) Yrs. mos. 10 ds.

Contributory (Secondary): Influenza

(Duration) yrs. mos. 8 ds.

(Signed) [redacted] M. D.

10/30 1921 (Address) Nampa Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ? yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence Nampa Ida

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Boise Idaho	Nov 2 1921

20. UNDERTAKER	ADDRESS
Summers & Kirk	Boise Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED
OCT 31 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3553
Registered No.

1. PLACE OF DEATH

County of Canyon
City of Nampa (No. ..... St.)

Registration District No. 7
Primary Registration District No. 1006

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary E. Copenhaver

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Fem	White	Widow

6. DATE OF BIRTH: June (Month) 3d (Day) 1850 (Year)

7. AGE: 71 Yrs. ..... Mos. 1 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housekeeper
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Penn.

10. NAME OF FATHER: Lewis Elmer

11. BIRTHPLACE OF FATHER (State or Country): Penn.

12. MAIDEN NAME OF MOTHER: Morrison

13. BIRTHPLACE OF MOTHER (State or Country): Penn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H. E. Copenhaver
(Address) Nampa Ida.

15. Filed Oct. 10 1921 Pearl Dodds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 4 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 10-4 1921, to 10-5 1921 that I last saw her alive on 10-4 1921 and that death occurred on the date stated above, at 12-30 P M.

The CAUSE OF DEATH* was as follows:
Paralysis Cardiac

..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Arterio-Sclerosis
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. G. Robinson M. D.
10/5 1921 (Address) Nampa Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Buchard Neb	Oct 1921
20. UNDERTAKER	ADDRESS
Fred L Robinson	Nampa Ida

BYRNS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED OCT 3 BUREAU

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35534

Registered No.

1. PLACE OF DEATH

County of Canyon

City of Nampa

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 7

Primary Registration District No. 1006

(No. Mercy Hospital St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Alfreda Marie Hansen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Fem	White	

6. DATE OF BIRTH: Sep (Month) 8 (Day) 1919 (Year)

7. AGE: 1 Yrs. 11 Mos. 17 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: (illegible)
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Wash

10. NAME OF FATHER O. Hansen

11. BIRTHPLACE OF FATHER (State or Country) Norway

12. MAIDEN NAME OF MOTHER Jeneatte Monda

13. BIRTHPLACE OF MOTHER (State or Country) Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ole Hansen
(Address) Nampa Ida

15. Filed Oct. 10 1921 Pearle Dodd
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 26 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 16 1921 to Aug 26 1921 that ~~I last~~ saw her alive on Aug 25 1921 and that death occurred on the date stated above, at — A.M.

The CAUSE OF DEATH* was as follows:

Acute gastro-enteritis
following cholera morbus
with convulsions

(Duration) ..... Yrs. ..... mos. 10 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo. R. Proctor M. D.

9/29/1921 (Address) Nampa

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Nampa Ida K. L. Cem	8/27 1921

20. UNDERTAKER	ADDRESS
Frank R Robertson	Nampa Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

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FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35536
Registered No.

1. PLACE OF DEATH

County of Canyon

City of Nampa (No. Mercy Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 7

Primary Registration District No. 1006

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lydia La Londe

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Fem	White	Single

6. DATE OF BIRTH: Dec (Month) 30 (Day) 1905 (Year)

7. AGE: 15 Yrs. 7 Mos. 15 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Ulrick La Londe

11. BIRTHPLACE OF FATHER (State or Country): Canada

12. MAIDEN NAME OF MOTHER: ———

13. BIRTHPLACE OF MOTHER (State or Country): Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) May La Londe
(Address) Nampa Ida

15. Filed Oct. 16 1921 Pearle Dodds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 15 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1921, to Aug. 15th 1921, that I last saw her alive on Aug. 15th, 1921, and that death occurred on the date stated above, at 1 P. M.

The CAUSE OF DEATH* was as follows:

Endocarditis

(Duration) 0 Yrs. 4 mos. 0 ds.

Contributory (Secondary): Infected Tonsils

(Duration) 4 yrs. 0 mos. 0 ds.

(Signed) Geo. D. McKillop M. D.

19..... (Address) Nampa, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Catholic Cem	Aug 18 1921

20. UNDERTAKER	ADDRESS
F. K. Robinson	Nampa Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SPACE RESERVED FOR BINDING

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FORM U. S. No. 5-A—25 M. 1-19.

RECEIVED OCT 31 BUREAU

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 7

Primary Registration District No. 1006

File No. 35537

Registered No.

County of Canyon

City of Nampa

(No. 306 15th ave. S St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Eliza Jane Worley

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widow (Write the word.)

6. DATE OF BIRTH: Jan. 2d (Month) 1829 (Day) 1 (Year)

7. AGE: 92 Yrs. 8 Mos. 20 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer): (Retired)

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: N. Noel

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Do not know

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Carter

(Address) Nampa Ida.

15. Filed Oct. 18 1921 Pearle Davis Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sep. (Month) 21 (Day) 19 21 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ——— 1920, to Sept 21, 1921 that I last saw her alive on Sept 20, 1921 and that death occurred on the date stated above, at 8 A. M.

The CAUSE OF DEATH* was as follows:

General paralytic stroke during the last months

(Duration) Yrs. 3 mos. ..... ds.

Contributory (Secondary) Senility

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo. R. Proctor M. D.

9/3/1921 (Address) Nampa Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Nampa Ida.

DATE OF BURIAL: 9/22 1921

20. UNDERTAKER: Fred K. Robinson

ADDRESS: Nampa Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

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FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED OCT 31 1921 BUREAU

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Canyon Registration District No. 7

City of Nampa St (No. ..... St.) Primary Registration District No. 2006

File No. 35538

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Wanda Johnson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.):

6. DATE OF BIRTH: Oct (Month) 9 (Day) 1[illegible] (Year)

7. AGE: ..... Yrs. [illegible] Mos. ..... ds.

IF LESS than 1 day how many 19 hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: V

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: A. W. Johnson

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Lida Jinkins

13. BIRTHPLACE OF MOTHER (State or Country): Nebraska

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A W Johnson

(Address) Nampa Ida

15. Filed Oct 10 1921 P. E. Arle Dodds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 10 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 9 1921, to Oct 10 1921, that I last saw her alive on Oct 10 1921, and that death occurred on the date stated above, at 1[illegible] M.

The CAUSE OF DEATH* was as follows:

Premature birth

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) O. H. Wheeler M. D.

10/10 1921 (Address) Nampa Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lakelawn Cem. DATE OF BURIAL: 10/11 1921

20. UNDERTAKER: Fred T Robinson ADDRESS: Nampa

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

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FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED
OCT 31 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 7

Primary Registration District No. 2506

File No. 35540

Registered No.

County of Canyon

City of Melba (No.) St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Francis Coleman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Dec. (Month) 21 (Day) 1911 (Year)

7. AGE: 9 Yrs. 8 Mos. 28 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: School

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ada County, Idaho.

10. NAME OF FATHER: James E. Coleman.

11. BIRTHPLACE OF FATHER (State or Country): Nebraska.

12. MAIDEN NAME OF MOTHER: Evalin Strean.

13. BIRTHPLACE OF MOTHER (State or Country): Texas.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) James E. Coleman

(Address)

15. Filed Oct. 4th 1921 Pearl Dodds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. (Month) 18 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 14 1921, to Sept 18 1921, that I last saw h.im alive on Sept 18 1921, and that death occurred on the date stated above, at 12:50 A.M.

The CAUSE OF DEATH* was as follows:

Diphtheria

(Duration) — Yrs. — mos. 10 ds.

Contributory (Secondary) Cardiac Decompensation (Duration) — yrs. — mos. 1 ds.

(Signed) Samuel A Swayne M. D.

Sept 18 1921 (Address) [redacted] Melba, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Meridian Idaho — DATE OF BURIAL: Sept 19 19 21

20. UNDERTAKER: [illegible] — ADDRESS: [illegible]

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35541

Registered No.

Registration District No. 7

Primary Registration District No. 2356

RECEIVED
OCT 31 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Canyon

City of Nampa (No. Mercy Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Barmingham

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Fem	white	

6. DATE OF BIRTH Sep (Month) 15 (Day) 1921 (Year)

7. AGE — Yrs. — Mos. — ds.

IF LESS than 1 day how many 2 hrs. or — min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work V

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER J W Barmingham

11. BIRTHPLACE OF FATHER (State or Country) Wis

12. MAIDEN NAME OF MOTHER Grace Sabin

13. BIRTHPLACE OF MOTHER (State or Country) Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. W. Barmingham

(Address) Boonsboro Idaho

15. Filed Oct 15 1921 Pearle Dodson Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sep (Month) 16 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 15, 1921, to —— 19—; that I last saw h. alive on Sept. 15, 1921, and that death occurred on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:

Premature delivery. By Cesarian Section.

(Duration) 0 Yrs. 0 mos. 0 ds.

Contributory (Secondary) Placenta previa in mother.

(Duration) 0 yrs. 0 mos. 0 ds.

(Signed) Chas. O. Kellogg M. D.

19—— (Address) Nampa Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ...yrs...mos...days. In the State ...yrs...mos...days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Kohlerlawn Cem	9/16 1921
20. UNDERTAKER Grice & Robinson	**ADDRESS** Nampa Ida

K

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

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FORM V. S. No. 5-25 M. 1-16-13

RECEIVED
OCT 3 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35542

Registered No. 15

1. PLACE OF DEATH.

County of Canyon

City of Parma (Not in Limits) St.)

Registration District No. 9

Registrar's District No. 1007

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Albert Albertson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. April (Month) 30 (Day) 1844 (Year)

7. AGE: 77 Yrs. 4 Mos. 29 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION:
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Norway.

10. NAME OF FATHER: Not known.

11. BIRTHPLACE OF FATHER (State or Country): Norway

12. MAIDEN NAME OF MOTHER: Not known.

13. BIRTHPLACE OF MOTHER (State or Country): Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) C. W. Albertson
(Address) Parma. Ida.

15. Filed 10-2 1921 Ruby Waldron Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 29 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 29 1921, to Sept 29 1921, that I last saw him alive on Sept 29 1921 and that death occured on the date stated above, at 7 P M.

The CAUSE OF DEATH* was as follows:

[redacted] (MM)
Pneumonia

(Duration) about 3 weeks Yrs. mos. ds.

Contributory (Secondary) Chronic bronchitis

(Duration about 30 yrs. — mos. — ds.

(Signed) W. E. Waldron M. D.

Sept 30 1921 (Address) Parma Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL ~~OR REMOVAL~~: Parma Idaho — DATE OF BURIAL: Oct 2 1921

20. UNDERTAKER: Peckham Fun Co — ADDRESS: Parma

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

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FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35543

Registered No. 10

1. PLACE OF DEATH

County of Caribou

City of South of Soda Springs

Registration District No. 82

Primary Registration District No. 215

(No.) St.

RECEIVED
OCT 31
BUREAU OF VITAL STATISTICS

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Laura Murray Kesler

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): married

6. DATE OF BIRTH: Mar 12 1893
(Month) (Day) (Year)

7. AGE: 28 Yrs. 7 Mos. 17 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Thomas J. Murray

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Laura Kesler

13. BIRTHPLACE OF MOTHER (State or Country): Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Edward L. Kesler
(Address) Alexandria Ida

15. Filed Oct 29 1941 Elis Kackley
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct 29 1941
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 2 1941, to Oct 29 1941, that I last saw h[illegible] alive on Oct 29 1941, and that death occurred on the date stated above, at 5a M.

The CAUSE OF DEATH* was as follows:

Carcinoma Scald arm shoulder and breast & left arm

Caused by explosion of Boiler

(Duration) Yrs. mos. 7 ds.

Contributory (Secondary): None

(Duration) yrs. mos. ds.

(Signed) Elis Kackley M. D.

19 (Address) Soda Springs Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Salt Lake Utah — DATE OF BURIAL: Oct 31 1941

20. UNDERTAKER: Schumacher & Hall — ADDRESS: Pocatello Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

RECEIVED
OCT 31 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 82
County of Custer Primary Registration District No. 2159
City of Sodo Spring (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

File No. 35544
Registered No. 11
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Jane Dalard

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	W	Not known

6. DATE OF BIRTH
Not Known (Month) 1 (Day) ..... (Year)

7. AGE
About 48 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE
(State or Country) Not Known

10. NAME OF FATHER
Not Known

11. BIRTHPLACE OF FATHER
(State or Country) Not Known

12. MAIDEN NAME OF MOTHER
Not Known

13. BIRTHPLACE OF MOTHER
(State or Country) Not Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Eric Kaeding
(Address) Soda Spring, Idaho

15.
Filed Oct 29 1921 Eric Kaeding
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Oct 29 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 22 1921, to Oct 29 1921
that I last saw h.. alive on Oct 29 1921
and that death occurred on the date stated above, at 10 P M.

The CAUSE OF DEATH* was as follows:
Organic heart disease

(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) None
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Eric Kaeding M. D.
Oct 29 1921 (Address) Soda Spring Id

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Soda Spring Idaho	Oct 31 1921
20. UNDERTAKER	ADDRESS
E. D. Whitmore	Soda Spring Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED OCT 31 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 117
Primary Registration District No.
File No. 35546
Registered No. 541

1. PLACE OF DEATH.
County of Cassia
City of Burley (No. 2196 St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Infant Ploeger

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
F	White	Single

6. DATE OF BIRTH. Sept (Month) 11 (Day) 1921 (Year)

7. AGE ... Yrs. ... Mos. ... ds. IF LESS than 1 day how many 3 hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer)...

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER J B Ploeger

11. BIRTHPLACE OF FATHER (State or Country) Kansas

12. MAIDEN NAME OF MOTHER Frances Richardson

13. BIRTHPLACE OF MOTHER (State or Country) Nebraska

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J B Ploeger
(Address) Burley Ida

15. Filed 8-12-21 191 Dr. J. C. Patterson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 11 1921, to Sept 11 1921, that I last saw h-- alive on Sept 11 1921, and that death occured on the date stated above, at 10 a. M.

The CAUSE OF DEATH* was as follows:
Premature
(Duration) ... Yrs. ... mos. 3 hrs ds.
Contributory (Secondary) ...
(Duration ... yrs. ... mos. ... ds.
(Signed) J. C. Patterson M. D.
8-11 1921 (Address) Burley, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?...
Former or usual residence ...

19. PLACE OF BURIAL OR REMOVAL Pleasant View Cemetery — DATE OF BURIAL Sept 12 1921

20. UNDERTAKER R W Watt — ADDRESS Burley Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35547
Registered No. 540

1. PLACE OF DEATH

Registration District No. 117
Primary Registration District No. 2192
County of Cassia
City of Burley (No. N. Miller St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Edward Simmons

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Oct (Month) 22 (Day) 1853 (Year)

7. AGE: 67 Yrs. 10 Mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Hotel Owner
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Spanish Fork Utah.

10. NAME OF FATHER: Orrawell Simmons.

11. BIRTHPLACE OF FATHER (State or Country): Unknown.

12. MAIDEN NAME OF MOTHER: Martha Dickson

13. BIRTHPLACE OF MOTHER (State or Country): New Brunswick Canada.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Mrs Edward Simmons
(Address): Burley Ida.

15. Filed Sept. 18 1921 Dr. J. C. Patterson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 17 (Day) — 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 3 1921, to Sept. 17 1921
that I last saw h. alive on Sept. 17 1921
and that death occurred on the date stated above, at 2330 P.M.
The CAUSE OF DEATH* was as follows:
Cancer of Rectum

(Duration) 1½ Yrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) J. C. Patterson M. D.
9-18 1921 (Address) Burley Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Payson Utah. DATE OF BURIAL: Sept. 20 1921

20. UNDERTAKER: L.B. Talcott ADDRESS: Burley Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35548

Registered No. 538

1. PLACE OF DEATH

County of Cassia Registration District No. 117

City of Burley (St.) Primary Registration District No. 2196

If death occurs away from usual residence, give facts called for under special information.

RECEIVED OCT 31 1921 BUREAU OF VITAL STATISTICS

2. FULL NAME Josephine Wright.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Aug. 17 (Month) (Day) 1915 (Year)

7. AGE: 6 Yrs. 1 Mos. 27 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: At Home.

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Los Angeles.

10. NAME OF FATHER: Lee A Wright.

11. BIRTHPLACE OF FATHER (State or Country): Soldier Kan.

12. MAIDEN NAME OF MOTHER: Ethel Rathbone.

13. BIRTHPLACE OF MOTHER (State or Country): Morris Co. Kan.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Lee A Wright

(Address) 436 N. Elba Ave Burley Ida.

15. Filed 9-15-21 19.....

Dr. J. C. Patterson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. (Month) 13 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 13 1921, to Sept. 13 1921 that I last saw h.er alive on Sept. 13 1921 and that death occurred on the date stated above, at 11:30 P.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ..... Yrs. ..... mos. 2-3 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) R. V. Pe M. D.

9/15 1921 (Address) Burley, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Burley Ida. DATE OF BURIAL: Sept. 14 1921

20. UNDERTAKER: L. P. Talleyday. ADDRESS: Burley Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

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OCT 31 1921
BUREAU OF VITAL STATISTICS

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35549
Registered No. 43

1. PLACE OF DEATH. Registration District No. 90
County of Clearwater. Primary Registration District No. 2168
City of Orofino (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Peter Lorente

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH: About X (Month) (Day) 1890 (Year)
7. AGE: 31 yrs. - mos. - ds. IF LESS than 1 day how many ..... hrs. or ..... min.
8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry business or establishment in which employed (or employer): Mining
9. BIRTHPLACE (State or Country): Italy
10. NAME OF FATHER: Unknown
11. BIRTHPLACE OF FATHER (State or Country): Unknown
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (State or Country): Unknown
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. W. Atteberry
(Address) Orofino Idaho.
15. Filed Oct 31 1921 J. M. Faul Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Sept 1st 1921 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from May 7th 1918, to Sept 1st 1921
that I last saw h[illegible] alive on August 31 1921
and that death occurred on the date stated above, at 12:25 A M.
The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis

9 (Duration) 1 yrs. mos. ds.
Contributory (Secondary) Insanity
..... (Duration) ..... yrs. mos. ds.
(Signed) John W. Givens, M. D.
9/ 1st 1921 (Address) Orofino Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.) about
At place of death 3 yrs. 7 mos. 25 ds. In the State 3 yrs. 4 mos. 12 ds.
Where was disease contracted, if not at place of death?
Former or usual residence Came from Wallace, Butte, Montana

19. PLACE OF BURIAL OR REMOVAL: Grave No 21 Fly N & I Cemetery Row # 4 The New Add.
DATE OF BURIAL: Sept 1 1921
20. UNDERTAKER: J. W. Atteberry
ADDRESS: Orofino, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

FORM V. S. No. 5-12 M. 6-15-17.

RECEIVED
OCT 31 1921
BUREAU OF STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35550
Registered No. 114

1. PLACE OF DEATH
County of Latah
City of Orofino
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 90
Primary Registration District No. 216
(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME S. H. Rodgers

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: May (Month) 20 (Day) 1842 (Year)

7. AGE: 79 Yrs. 3 Mos. 15 ds.
IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) .....
(Address) Mrs Mary E. Rodgers

15. Filed Sept 30 1921 — J. M. Irwin, Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 5 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..... to Sept 5 1921
that I last saw h... alive on Sept 5 1921
and that death occurred on the date stated above, at 3:00 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

.....(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Chronic Cystitis
.....(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) J. M. Irwin M. D.
9/5 1921 (Address) Orofino Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days, In the State....yrs....mos....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Orofino Ida — DATE OF BURIAL: Sept. 7. 1921

20. UNDERTAKER: V. A. Shaw — ADDRESS: Orofino Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3555
Registered No. 44

RECEIVED
OCT 31 1921
BUREAU OF STATISTICS

1. PLACE OF DEATH
County of Kootenai
City of Ashtabula
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 9
Primary Registration District No. 2168
No. ..., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME James W. Miller

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: ..... (Month) 1 (Day) ..... (Year)

7. AGE: 43 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many .... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ida

10. NAME OF FATHER: —

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. C. Jones
(Address) Troy Ida

15. Filed Sept 20 1921 — J. M. Tarbly, Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 13 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 12 1921 to Sept 13 1921 that I last saw h. alive on Sept 13 1921 and that death occurred on the date stated above, at 1 A.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Hemorrhage

(Duration) ..... Yrs. ..... mos. V ds.

Contributory (Secondary) Tuberculosis Pulm

(Duration) ? Yrs. ..... mos. ..... ds.

(Signed) J. M. Tarbly M. D.

9/13 1921 (Address) Troy Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs. ....mos. ....days. In the State ....yrs. ....mos. ....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Ashtabula Ida — DATE OF BURIAL: Sept. 14 1921

20. UNDERTAKER: W. A. Spence — ADDRESS: Troy

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED OCT 31 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH. Registration District No. 90
County of Clearwater — Primary Registration District No. 2168
City of Orofino, (If outside limits give township) ..... St.)
If death occurs away from usual residence, give facts called for under special information.

File No. 35552
Registered No. 46
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Rose Sherman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: About 1869 (Month) (Day) (Year)

7. AGE: About 52 yrs. mos. ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife and Ped Dar
(b) General nature of industry business or establishment in which employed (or employer): General Housework & selling goods

9. BIRTHPLACE (State or Country): Syria

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. W. Atteberry
(Address) Orofino Idaho.

15. Filed Sept 15 1921 — J. W. McFaily, Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: September (Month) 14th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 27, 1906 to Sept. 14th 1921, that I last saw her alive on Sept. 13th 1921 and that death occurred on the date stated above, at 1:20 P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia

..... (Duration) ..... yrs. ..... mos. 5 ds.
Contributory (Secondary) Insanity
..... (Duration) about 18 yrs. ..... mos. ..... ds.

(Signed) John O. Squires M. D.
Sept. 14 1921 (Address) Orofino, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 15 yrs. 2 mos. 19 ds. In the State over 19 years yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence Moscow, Idaho.

19. PLACE OF BURIAL OR REMOVAL: Grave 2 Row #5 New add. The N. S. Cemetery — DATE OF BURIAL: Sept 16 1921

20. UNDERTAKER: J. W. Atteberry — ADDRESS: Orofino, Idaho.

SYMS-YORK CO., PRINTERS & BINDERS. BOISE 17143

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-12 M. 6-15-17.

RECEIVED
OCT 31 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35553
Registered No. 47

Registration District No. 20
Primary Registration District No. 2168

1. PLACE OF DEATH
County of Clearwater
City of Kamiah (Ward, ..., St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Dan Murray

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH. Aug (Month) 24 (Day) 1877 (Year)

7. AGE 44 Yrs. 1.5 Mos. ..... ds. IF LESS than 1 day how many .... hrs. or .....min.?'

8. OCCUPATION
(a) Trade, profession or particular kind of work ....Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Iowa

10. NAME OF FATHER ~

11. BIRTHPLACE OF FATHER (State or Country) ~

12. MAIDEN NAME OF MOTHER ~

13. BIRTHPLACE OF MOTHER (State or Country) ~

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) G. W. Brown
(Address) .....

15. Filed Oct 30 1921 J. M. Frank Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 15 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 10 1921 to Sept 15 1921 that I last saw him alive on Sept 14 1921 and that death occurred on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:
Acute Polyneuritis
.....
.....
.....(Duration) ..... Yrs..... mos. ....5 ds.

Contributory (Secondary) .....
.....(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) C. W. Haswell M. D.
Oct 25 1921 (Address) Orofino Ida

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means of Injury, and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the ,State....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Lawyer Ida — DATE OF BURIAL Sept 16 1921

20. UNDERTAKER Ida Shaw — ADDRESS Grofin

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

RECEIVED SEP 31 1921 BUREAU OF VITA STATISTICS

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35554
Registered No. 48

1. PLACE OF DEATH.
County of Clearwater
City of Orofino, (No. ..... St.)
Registration District No. 90
Primary Registration District No. 2168
If death occurs away from usual residence, give facts called for under special information.
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Lois Poggo

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: About (Month) 1903 (Day) (Year)

7. AGE: 18 yrs. mos. ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Teton, Fremont County, Idaho

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. W. Attebery
(Address) Orofino, Idaho.

15. Filed Sept 30 1921 — J. M. Trail, Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: September (Month) 17th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 7th 1920 to Sept. 17th 1921, that I last saw h[er] alive on Sept. 17th 1921 and that death occurred on the date stated above, at 12:10 P. M.

The CAUSE OF DEATH* was as follows:
Gastriculcer
Unknown
(Duration) — yrs. — mos. — ds.
Contributory (Secondary) Insanity
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) John M. Stevens M. D.
Sept. 17th 1921 (Address) Orofino Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 6 yrs. 10 mos. 11 ds. In the State About 18 yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence St. Anthony, Idaho.

19. PLACE OF ~~BURIAL~~ OR REMOVAL: Sugar City, Idaho — DATE OF BURIAL: Sept 18 1921

20. UNDERTAKER: C. C. Bobo & Long — ADDRESS: Orofino Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

FORM V. S. No. 5-12 M. 6-15-17.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED OCT 31 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35555
Registered No. 49
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Gooding
City of Gooding
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 90
Primary Registration District No. 2168
Ward ....., ... St.)

2. FULL NAME Jessie Irvin Brown

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Dec. (Month) 24 (Day) 1877 (Year)

7. AGE: 42 Yrs. 7 Mos. ... ds. IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Absalom Funkhouser

11. BIRTHPLACE OF FATHER (State or Country): Indiana

12. MAIDEN NAME OF MOTHER: Rebecca Funkhouser

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Roy Brown
(Address)

15. Filed Nov. 30 1921
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. (Month) 26 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 6 1921 to Sept. 26 1921 that I last saw h[illegible] alive on Sept. 25 1921 and that death occurred on the date stated above, at 5:45 P.M.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

(Duration) ... Yrs. ? mos. ... ds.

Contributory (Secondary)

(Duration) ... Yrs. 1 mos. ... ds.

(Signed) J. M. Gourley M. D.

9/26 1921. (Address) Gooding Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Gooding Ida. DATE OF BURIAL: Sept 28 1921

20. UNDERTAKER: W. A. Shaw ADDRESS: Gooding

FORM V. S. No. 5-12 M. 6-15-17.

RECEIVED OCT 31 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35556
Registered No. .....

1. PLACE OF DEATH
County of Clearwater
City of Orofino
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 90
Primary Registration District No. 2168
No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary Elizabeth Cordell

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): widowed
6. DATE OF BIRTH. Feb. (Month) 24 (Day) 1858 (Year)
7. AGE: 63 Yrs. 7 Mos. 4 ds. IF LESS than 1 day how many .... hrs. or .... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: dressmaker
(b) General nature of industry, business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country) Wilkesboro N. Carolina
10. NAME OF FATHER James Cordell
11. BIRTHPLACE OF FATHER (State or Country) N. Carolina
12. MAIDEN NAME OF MOTHER Phillips
13. BIRTHPLACE OF MOTHER (State or Country) N. Carolina
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. E. Cordell
(Address)
15. Filed Sept 30 1921 J. M. Farley Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 28 (Day) 1921 (Year)
17. I HEREBY CERTIFY, That I attended deceased from ? 191 to ? 191
that I last saw her alive on 191
and that death occurred on the date stated above, at 7 00 M.
The CAUSE OF DEATH* was as follows:
Sudden death from
Cerebral Hemorrhage
(Duration) ? Yrs. mos. ds.
Contributory (Secondary)
(Duration) Yrs. mos. ds.
(Signed) J. M. Farley M. D.
9/28 1921 (Address) Orofino Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the State....yrs.....mos....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL, OR REMOVAL: Gilbert Ida — DATE OF BURIAL: Sept 29. 1921
20. UNDERTAKER: H A Shaw — ADDRESS: Orofino

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

Form V. S. No. 5. 12½M.7-24-11

RECEIVED OCT 31 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35557
Registered No. 51

1. PLACE OF DEATH. Registration District No. 40
County of Clearwater Primary Registration District No. 2168
City of Orofino, (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Louis Ringstead

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: ✓ (Month) ✓ (Day) 1843 (Year)

7. AGE: 78 yrs. ✓ mos. ✓ ds. IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Saw Filer
(b) General nature of industry business or establishment in which employed (or employer): Filing Saws at Saw Mill.

9. BIRTHPLACE (State or Country): Norway

10. NAME OF FATHER: ✓

11. BIRTHPLACE OF FATHER (State or Country): ✓

12. MAIDEN NAME OF MOTHER: ✓

13. BIRTHPLACE OF MOTHER (State or Country): ✓

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. A. Atteberry
(Address) Orofino Idaho,

15. Filed Sept 29 1921 J. M. Finley Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Sept. (Month) 28 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 3 1917, to Sept. 28 ~~191~~ 1921 that I last saw him alive on Sept. 28 ~~191~~ 1921 and that death occurred on the date stated above, at 12 M. o'clock Noon

The CAUSE OF DEATH* was as follows:
Cerebral Hemmorhage

..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Insanity
..... (Duration) Unknown yrs. ..... mos. ..... ds.

(Signed) John A. Owens M. D.
Sept 28 1921 (Address) Orofino, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 7 yrs. 4 mos. 25 ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, ✓
If not at place of death?
Former or usual residence Bonners Ferry Idaho

19. PLACE OF BURIAL OR REMOVAL: Orofino Idaho — DATE OF BURIAL: Sept 29 1921

20. UNDERTAKER: C. E. Bolt Mgr. Sno — ADDRESS: Orofino Ida.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 76
Primary Registration District No. 2153
File No. 35558
Registered No.

1. PLACE OF DEATH
County of Custer
City of Mackay
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Franka Jurkovich
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.
4. COLOR OR RACE: Austrian
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: 9 (Month) 30 (Day) 1921 (Year)

7. AGE: — Yrs. — Mos. 4 ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Mackay, Idaho

10. NAME OF FATHER: George Jurkovich

11. BIRTHPLACE OF FATHER (State or Country): Croatia

12. MAIDEN NAME OF MOTHER: Katie Basich

13. BIRTHPLACE OF MOTHER (State or Country): Croatia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) .....
(Address) .....

15. Filed 10/11 1921 R. Nowocki
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 10 (Month) 4 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9/30 1921, to 10/4 1921
that I last saw h.. alive on 10/2 1921
and that death occurred on the date stated above, at 11 A M.
The CAUSE OF DEATH* was as follows:

Immature Development

(Duration) — Yrs. — mos. 4 ds.
Contributory (Secondary) Premature birth
(Duration) ... yrs. ... mos. — ds.

(Signed) F. P. Richards M. D.
10/5 1921 (Address) Mackay

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL 19...

20. UNDERTAKER | ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED OCT 31 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Elmore — Registration District No. 34

City of Mtn Home (Ward, St.) — Primary Registration District No. 2025

File No. 35559

Registered No. 171

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lawrence Dixon

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	W	

6. DATE OF BIRTH: July (Month) 8 (Day) 1921 (Year)

7. AGE: Yrs. 2 Mos. 19 ds. — IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Mtn Home Ida

10. NAME OF FATHER Frank S. Dixon

11. BIRTHPLACE OF FATHER (State or Country) Kansas

12. MAIDEN NAME OF MOTHER Beatrice Smith

13. BIRTHPLACE OF MOTHER (State or Country) Nebr. Lincoln

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Frank S. Dixon

(Address) Mtn Home Ida

15. Filed 5-2-1921 — H. E. Evans, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 27 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9-23 1921 to 9-27 1921 that I last saw h[illegible] alive on 9-27 1921 and that death occurred on the date stated above, at 5.00 A.M.

The CAUSE OF DEATH* was as follows:

Acute intestinal obstruction

(Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary) Dysentery

(Duration) ..... yrs. ..... mos. 2 ds.

(Signed) D. O. P. Hamilton M. D.

9-28 1921 (Address) Mtn Home Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Mtn. Home	Sept 28 1921

20. UNDERTAKER A. W. Conover — ADDRESS Mtn. Home

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED OCT 31 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 84

Primary Registration District No. 2020

File No. 35560

County of Elmore

City of Mtn Home (Ward, St.)

Registered No. 16.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Eileen B. Saxton

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Sep. (Month) 3 (Day) 1894 (Year)

7. AGE: 27 Yrs. X Mos. 8 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Bedford Ore.

10. NAME OF FATHER: Francis H. Bowr

11. BIRTHPLACE OF FATHER (State or Country): Penn.

12. MAIDEN NAME OF MOTHER: Sara C. Coone

13. BIRTHPLACE OF MOTHER (State or Country): Columbus Nebr.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) F. A. Saxton

(Address) Prairie Idaho

15.

Filed ..... 19 .....

J. E. Evans
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sep (Month) 11 (Day) 19 21 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 5 19 21 to Sept 11 19 21

that I last saw her alive on Sept 11 19 21

and that death occurred on the date stated above, at 4.30 P. M.

The CAUSE OF DEATH* was as follows:

Septicemia (Large abscess granulated size 10"x12" about private).

(Duration) 5 Yrs. ..... mos. ..... ds.

Contributory (Secondary) Refused to take nourishment except when forced

(Duration) ..... yrs. 3 mos. ..... ds.

(Signed) O P Hamilton M. D.

9-13 19 21 (Address) Mountain Home Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mountain Home Ida — DATE OF BURIAL: Sep 13 19 21

20. UNDERTAKER: A. W. Conover — ADDRESS: Mtn. Home Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED OCT 31 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 99

Primary Registration District No. 2177

File No. 35561

County of Fremont

City of St. Anthony (No. ..... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Maria Jane Thompson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Widow

6. DATE OF BIRTH: Aug. (Month) 1st (Day) 1829 (Year)

7. AGE: 92 Yrs. 2 Mos. 17 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER: David L. Brown

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Orpha Brown

13. BIRTHPLACE OF MOTHER (State or Country): New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C.W. Thompson
(Address) St. Anthony

15. Filed Oct 10 1921 W.S. Ware Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: September (Month) 18th. (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 15th. 1921, to Sept. 17th. 1921, that I last saw her alive on Sept. 17th. 1921, and that death occurred on the date stated above, at 8.30 A.M.

The CAUSE OF DEATH* was as follows:
unknown except, old age.

..... (Duration) ..... Yrs. ..... mos. 10 ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. P. Louis M. D.
9-19 1921 (Address) St. Anthony Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Riverview Cemetery St. Anthony Ida.	9-19 1921
20. UNDERTAKER W.H. Hansen	ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35562

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

RECEIVED OCT 31 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH. Registration District No. 99

County of Fremont Primary Registration District No. 2177

City of St. Anthony (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Nellie Cherry Mitchell

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. March (Month) 26th, (Day) 1892 (Year)

7. AGE: 29 Yrs. 6 Mos. 8 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Kentucky

10. NAME OF FATHER J. C. Cherry

11. BIRTHPLACE OF FATHER (State or Country) Kentucky

12. MAIDEN NAME OF MOTHER Cleste White

13. BIRTHPLACE OF MOTHER (State or Country) Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) A. C. Cherry
(Address) Weiser Idaho

15. Filed Oct 10 1921 W Burk Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 9 (Month) 12 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 6/1 1921, to 9/12 1921, that I last saw h alive on 9/12 1921, and that death occured on the date stated above, at 11 M.

The CAUSE OF DEATH* was as follows:

Puerperal Eclampsia

(Duration) 4 Yrs. mos. 4 ds.

Contributory (Secondary) Nephritis

(Duration yrs. 1 mos. 2 ds.

(Signed) Jno R Gray M. D.

9/13 1921 (Address) St Anthony Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Elton, Kentucky — DATE OF BURIAL ..... 191...

20. UNDERTAKER W. M. Kanaga — ADDRESS St Anthony Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SDRS. 24654

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 99
Primary Registration District No. 2177
File No. 35563
Registered No.

1. PLACE OF DEATH
County of Fremont
City of St. Anthony
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Thomas Pool McFarland
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (or wd.)

6. DATE OF BIRTH: March 8 1868 (Month) (Day) (Year)

7. AGE: 53 Yrs. 6 Mos. 19 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): West Weber Utah

10. NAME OF FATHER: James McFarland

11. BIRTHPLACE OF FATHER (State or Country): Scotland

12. MAIDEN NAME OF MOTHER: Mitilda Pool

13. BIRTHPLACE OF MOTHER (State or Country): Spain

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Sophia McFarland
(Address): St Anthony Route 3

15. Filed Oct 10 1921 W B Wright
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept 17 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 4 1921, to Sept 14 1921
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
(Carcinoma)
(Duration) 3 Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) J. Frank Bathe M. D.
Sept 19 1921 (Address) St Anthony

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Parke Co
DATE OF BURIAL: Sept 19 1921

20. UNDERTAKER: Grice
ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 99
Primary Registration District No. 2177
File No. 35564
Registered No.

1. PLACE OF DEATH

County of Fremont
City of St. Anthony (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

OCT 3 BUREAU OF VITAL STATISTICS

2. FULL NAME Alice N. Chappell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: married (Write the word.)

6. DATE OF BIRTH: Unknown (Month) (Day) 1871 (Year)

7. AGE: Unknown Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: ——— Noyes

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Louise Mc Bride

13. BIRTHPLACE OF MOTHER (State or Country): New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W M Chappell
(Address) 1166 E 5S Salt Lake

15. Filed Sept 10 1921 W M Wrst Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 8 (Month) 18 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 8/18/1921, to 8/18/1921, that I last saw her alive on 8/17/1921 and that death occurred on the date stated above, at 4-55 P.M.

The CAUSE OF DEATH* was as follows:

Bronchial asthma

Duration Yrs. mos. ds.

Contributory (Secondary) none

Duration yrs. mos. ds.

(Signed) Jno Peay M. D.

8/19 1921 (Address) St Anthony Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Provo, Utah — DATE OF BURIAL: Aug 22nd 1921

20. UNDERTAKER: W M Hansen — ADDRESS: St. Anthony Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35565
Registered No.

1. PLACE OF DEATH
County of Fremont
City of St Anthony
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 99
Primary Registration District No. 2177
(No. ..... St.)

2. FULL NAME Melvin B. Hobbs.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH: Aug (Month) - 28 (Day) - 1903 (Year)

7. AGE: 18 Yrs. 11 Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Driggs - Idaho

10. NAME OF FATHER: Earnest Hobbes.

11. BIRTHPLACE OF FATHER (State or Country): London England

12. MAIDEN NAME OF MOTHER: Mrs Rosalie Bronders

13. BIRTHPLACE OF MOTHER (State or Country): Marseilles, France

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Earnest Hobbes
(Address): St Anthony - Idaho

15. Filed Sept 10 1921
W Bennett
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 28 (Day) - 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 28 1921, to Aug. 28 1921, that I last saw him alive on Aug. 28 1921 and that death occurred on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:
Ruptured Intestine and Stomach - Kicked by horse
(Duration) ..... Yrs. ..... mos. 1½ ds.
Contributory (Secondary): Peritonitis
(Duration) ..... yrs. ..... mos. ½ ds.
(Signed) J E Melton M. D.
8-29 1921 (Address) St Anthony Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: St Anthony, Idaho — DATE OF BURIAL: Aug. 28 1921

20. UNDERTAKER: Wm Hansen — ADDRESS: St Anthony Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

Form V. S. No. 5 20M.1-16-12 RECEIVED OCT 31 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

1921 84 1837

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 99
County of Fremont Primary Registration District No. 2107 File No. 35566
City of St. Anthony (No. ....., ... St.) Registered No. .....
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary F. Cook
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH: January 26 (Month) (Day) 1837 (Year)

7. AGE: 84 yrs. 4 mos. 17 ds. IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: [illegible] F Cook

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Sarah Masterson

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W B Cook
(Address) Drummond Ida

15. Filed Sept 10 1921 W Clerk Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June (Month) 12 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 16 1921, to June 12 1921, that I last saw her alive on June 7 1921, and that death occurred on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:
Myocarditis

(Duration) yrs. 2 mos. ..... ds.
Contributory (Secondary) none
(Duration) yrs. ..... mos. ..... ds.

(Signed) J E Melton M. D.
June 12 1921 (Address) St Anthony Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Wilford — DATE OF BURIAL: 6/13 1921

20. UNDERTAKER: J Rooney ADDRESS: Rigby

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & SDRS. 19760

FORM V. S. No. 5-25 M. 1-19.

RECEIVED OCT 31 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35567
Registered No.

1. PLACE OF DEATH
County of FREMONT. Registration District No. 186.
City of ASHTON. (No. , St.) Primary Registration District No. 2

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME HEBER. C. SMITH.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: MALE.
4. COLOR OR RACE: WHITE.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: MARRIED. (Write the word.)

6. DATE OF BIRTH: OCTOBER (Month) 24th (Day) 1846 (Year)

7. AGE: 74. Yrs. 11 Mos. 9 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Drayman
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): IOWA.

10. NAME OF FATHER: DANIEL SMITH?

11. BIRTHPLACE OF FATHER (State or Country): DONT KNOW.

12. MAIDEN NAME OF MOTHER: ELIZABETH BIBLE.

13. BIRTHPLACE OF MOTHER (State or Country): DONT KNOW.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) SAMUEL. L. SMITH.
(Address) LEWISTON. UTAH.

15. Filed 9-4-1924 Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 3 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 4, 1921, to Sept 3 1921, that I last saw h.. alive on Sept 3 1921, and that death occurred on the date stated above, at 12 M.
The CAUSE OF DEATH* was as follows:
Uremia

(Duration) Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

Signed E. P. Harris M. D.
Sept 3 1921 (Address) Ashton Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: PINE VIEW CEMETERY Idaho
DATE OF BURIAL: 10/5/21.

20. UNDERTAKER: LEWIS KISER.
ADDRESS: ASHTON IDAHO

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
OCT 31 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
Registration District No. 102
County of Fremont. Primary Registration District No. 6
City of Idaho. (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

File No. 35568
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Franklin Ross.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single,

6. DATE OF BIRTH: April. (Month) 15 (Day) 1908 (Year)

7. AGE: Yrs. 4 Mos. 25 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Work On Farm.
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ashton Idaho.

10. NAME OF FATHER: James , J. Ross.

11. BIRTHPLACE OF FATHER (State or Country): Utah.

12. MAIDEN NAME OF MOTHER: Chr. M. Christensen,

13. BIRTHPLACE OF MOTHER (State or Country): Denmark,

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) James J. Ross.
(Address) Ashton Idaho.

15. Filed 9-10 1921 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. (Month) 9 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 8 1921, to Sept 9 1921, that I last saw h[illegible] alive on Sept 9 1921, and that death occurred on the date stated above, at 1 P.M.
The CAUSE OF DEATH* was as follows:
Lagrip Pneumonia Fatal Edition
Contributory
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) [signature] M. D.
9/10/1921 (Address) Ashton Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Farnum Idaho — DATE OF BURIAL: 9/11 2 19.....
20. UNDERTAKER: Lewis Kiser — ADDRESS: Ashton Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 102.

County of FREMONT. Primary Registration District No. 6

City of ASHTON. (No.) (St.)

File No. 35569

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME MARY LUCINDA BAKER.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

RECEIVED
U.S. BUREAU OF VITAL STATISTICS

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: FEMALE.

4. COLOR OR RACE: WHITE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): MARRIED?

6. DATE OF BIRTH: OCTOBER (Month) 7 (Day) 1850. (Year)

7. AGE: 70 Yrs. 11 Mos. 29. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: HOUSE WIFE.

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): WISCONSIN.

10. NAME OF FATHER: HORACE WEAVER

11. BIRTHPLACE OF FATHER (State or Country): PENN.

12. MAIDEN NAME OF MOTHER: CAROLINE PARSONS

13. BIRTHPLACE OF MOTHER (State or Country): OHIO.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) CLARA. ODEKIRK

(Address) TWIN FALLS. IDAHO.

15. Filed 10-7- 1921

Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 6 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1 1921, to Oct 6 1921, that I last saw her alive on Oct 6 1921, and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage Rheumatism

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) E. P. Hayes M. D.

Oct 6 1921 (Address) Ashton Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: ASHTON IDAHO.

DATE OF BURIAL: 10/7/21.

20. UNDERTAKER: LEWIS KISER.

ADDRESS: ASHTON IDAHO

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 102

County of FREMONT.

Primary Registration District No. 6.

File No. 35570

City of ASHTON. (No. ..... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME RHODA. AN? BROWER.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

BUREAU OF VITAL STATISTICS

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: FEMALE.

4. COLOR OR RACE: WHITE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: MIDOWED. (Write the word.)

6. DATE OF BIRTH: MARCH (Month) — (Day) 1862 (Year)

7. AGE: 59 Yrs. 5 Mos. ..... ds. 29

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: HOUSE WIFE.
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): ENGLAND?

10. NAME OF FATHER: THOMAS ASHMENT.

11. BIRTHPLACE OF FATHER (State or Country): ENGLAND.

12. MAIDEN NAME OF MOTHER: AN. HUGGINS.

13. BIRTHPLACE OF MOTHER (State or Country): ENGLAND.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) MRS NEELY.

(Address) MARYSVILLE. IDAHO

15. Filed 10-6 1927

Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 5 (Day) 1927 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 25 1927 to Oct 5 1927 that I last saw her alive on Oct 5 1927, and that death occurred on the date stated above, at 4 A M.

The CAUSE OF DEATH* was as follows:

Mitral regurgitation

.....

.....

(Duration) 10 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E. P. Harris M. D.

Oct 6 1927 (Address) Ashton Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: ASHTON IDAHO

DATE OF BURIAL: 10/6/ 27.

20. UNDERTAKER: Lewis Kiser

ADDRESS: Ashton Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED
OCT 8 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35571
Registered No. .....

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

1. PLACE OF DEATH.
County of Gooding
City of Gooding
(No. ....., ... St.)
Registration District No. .....
Primary Registration District No. .....
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ray Piper Ball—

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower.

6. DATE OF BIRTH. July (Month) 4 (Day) 1883 (Year)

7. AGE: 38 Yrs. 2 Mos. 21 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer & Stockgrower
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Kansas.

10. NAME OF FATHER: E. M. Ball—

11. BIRTHPLACE OF FATHER (State or Country): Kentucky—

12. MAIDEN NAME OF MOTHER: Mathilda Piper.

13. BIRTHPLACE OF MOTHER (State or Country): Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) E. M. Ball—
(Address) Hagerman —

15. Filed Sept 26 1921
F. F. Caym M.D.
Local Registrar

SYMS - YORK CO., PTRS. & ROBS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 26 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 5 1921, to Sept 26 1921, that I last saw him alive on Sept 26 1921, and that death occured on the date stated above, at 3 A M.

The CAUSE OF DEATH* was as follows:
Gastric Ulcer—
Malnutrition.
(Duration) 3— Yrs. — mos. — ds.
Contributory (Secondary) Ruptured Appendix
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) H. E. Lamb M. D.
9/26 1921 (Address) Gooding Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Gooding Idaho — DATE OF BURIAL: 9/27 1921

20. UNDERTAKER: [illegible] — ADDRESS: Gooding Ida

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
OCT 21 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. **PLACE OF DEATH**

Registration District No. 165

County of Idaho — Primary Registration District No. 2183

City of Cottonwood (No. ..... St.)

File No. 10

Registered No. 35572

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Peter Haan

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	white	~~unmarried~~ widowed

6. DATE OF BIRTH: Oct (Month) 26 (Day) 1850 (Year)

7. AGE: 70 Yrs. 11 Mos. 20 ds. — IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Germany

10. NAME OF FATHER Nicholas Haan

11. BIRTHPLACE OF FATHER (State or Country) Germany

12. MAIDEN NAME OF MOTHER Baumgen

13. BIRTHPLACE OF MOTHER (State or Country) Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Peter Haan-Jr
(Address) Cottonwood Idaho

15. Filed Oct 7 1921 — W. F. Orr, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 9 (Month) 16 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April, 1921, to Sept 1921 that I last saw him alive on Sept 16 1921 and that death occurred on the date stated above, at 5P M.

The CAUSE OF DEATH* was as follows:
Chronic Valvular Heart Disease

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. D. Sturnick M. D.
9-16 1921 (Address) Cottonwood Ida Ho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Moscow Idaho	9-19 1921

20. UNDERTAKER Allan — ADDRESS Moscow Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING — WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35573

Registered No. .....

RECEIVED
OCT 31 1921
BUREAU OF VIT. STATISTICS

1. PLACE OF DEATH.

Registration District No. 24

Primary Registration District No. .....

County of Idaho

City of Near Kamiah (or Village of ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Louis Hollingshead.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: Wht

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH. April (Month) 1 (Day) 1835 (Year)

7. AGE: 86 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country) Ontario Canada

10. NAME OF FATHER John Hollingshead

11. BIRTHPLACE OF FATHER (State or Country) Canada

12. MAIDEN NAME OF MOTHER Do not Know

13. BIRTHPLACE OF MOTHER (State or Country) Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) W. A. Hollingshead
(Address) Kamiah Idaho

15. Filed 9/25 1921

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. (Month) 25 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1921, to Sept 1921, that I last saw him alive on July 1921, and that death occured on the date stated above, at 6 AM.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage

(Duration) ..... Yrs. ..... mos. 6 ds.

Contributory (Secondary) Hypostatic Pneumonia

(Duration) 7 yrs. ..... mos. ..... ds.

(Signed) C. C. Chapman M. D.

9/25/21 (Address) Kamiah Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL ..... 191.....

20. UNDERTAKER | ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BOOK. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35574

Registered No. 2

RECEIVED
OCT 21 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH.

Registration District No. 103

Primary Registration District No. 2181

County of Idaho

City of Grangeville St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Alfred Edmund Borgeson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Sept (Month) 16 (Day) 1921 (Year)

7. AGE ... Yrs. ... Mos. 9 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Einer W Borgeson

11. BIRTHPLACE OF FATHER (State or Country) Sweden

12. MAIDEN NAME OF MOTHER Hazel Zumwalt

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) E W Borgeson

(Address) Grangeville Idaho

15. Filed Oct 1 1921 G S Stricklen, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 25 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 16 1921, to Sept 25 1921, that I last saw him alive on Sept 16 1921, and that death occured on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Inanition from
Deformity at birth

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary) unable to take nourishment on account of deformity

(Duration) ... yrs. ... mos. ... ds.

(Signed) G S Stricklen M. D.

Sept 25 1921 (Address) Grangeville

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Prairie View — DATE OF BURIAL: Sept 26 1921

20. UNDERTAKER: none — ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SY160 - YORK CO., PTFS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35575
Registered No. 2

1. PLACE OF DEATH.

County of Idaho RECEIVED Registration District No. 103

City of Grangeville OCT 31 1921 Primary Registration District No. 2181

(No. ..... St.)

BUREAU OF VITAL

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John W Hawkey

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH. June (Month) 17 (Day) 1841 (Year)

7. AGE: 80 Yrs. 3 Mos. 5 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Russeldale Ontario

10. NAME OF FATHER: —

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rosella Moss

(Address) Spokane Wash

15. Filed Oct 1 1921 G B Stockton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 22 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1921, to Sept 22 1921, that I last saw h[illegible] alive on Sept 22 1921, and that death occured on the date stated above, at 10, P. M.

The CAUSE OF DEATH* was as follows:

Asteni Selerosis

(Duration) ? Yrs. ? mos. ? ds.

Contributory (Secondary) Valvular lesion of heart

(Duration ? yrs. ? mos. ? ds.

(Signed) G B Stockton M. D.

9/23 1921 (Address) Grangeville Ida

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Prairie View — DATE OF BURIAL: 9/24 1921

20. UNDERTAKER: E S Hancock — ADDRESS: Grangeville

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED
OCT 31 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 103

County of Idaho Primary Registration District No. 1007

City of Grangeville (If outside limits, give township.) St.)

File No. 35576

Registered No. 12

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Edwin Rufus Cawley

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. April 1st 1852 (Month) (Day) (Year)

7. AGE: 69 Yrs. 5 Mos. 16 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Bookeeper
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Sanborton New Hamshire

10. NAME OF FATHER: Daniel Cawley

11. BIRTHPLACE OF FATHER (State or Country): newhamshire

12. MAIDEN NAME OF MOTHER: nancy Morrison

13. BIRTHPLACE OF MOTHER (State or Country): newhamshire

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Ida M. Cawley
(Address) Grangeville Ida

15.
Filed Oct 1 1921 G L Stockton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
September 13 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 16 1921, to Sept 16 1921, that I last saw h— alive on ..... 191..., and that death occured on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Found dead

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Valvular heart disease

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G L Stockton M. D.

9/14 1921 (Address) Grangeville Ida

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Yreka California — DATE OF BURIAL: 1921

20. UNDERTAKER: E. S. Harcock — ADDRESS: Grangeville

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYNS - YORK CO., PTRS. & BORS. 24858

FORM V. S. No. 5-25 M. 1-[illegible]

RECEIVED
OCT 31 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 103

County of Idaho Primary Registration District No. 1001

City of Grangeville (No. ....., ... St.)

File No. 35577

Registered No. 23

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elisebeth A Breed

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): widowed

6. DATE OF BIRTH. Feb. (Month) 18th (Day) 1836 (Year)

7. AGE: 85 Yrs. 2 Mos. 22 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: P Price

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: mrs Kirby

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J B Breed
(Address) Grangeville

15. Filed Oct 1 1921 G S Stockton Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 11 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 1920 to May 1921, that I last saw h.r alive on May 8 1921, and that death occured on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:

Senile Nephritis

(Duration) 3 Yrs. — mos. — ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) B Chipman M. D.

May 21 1921 (Address) Grangeville Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Fairview — DATE OF BURIAL: May 13 1921

20. UNDERTAKER: E. S. Hancock — ADDRESS: Grangeville

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED OCT 31 19 BUREAU OF STATISTICS

Registration District No. 78
Primary Registration District No. 2176
File No. 35578
Registered No. 48

1. PLACE OF DEATH
County of Jefferson
City of Rigby (St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Nephi James Bates

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: widowed (Write the word.)

6. DATE OF BIRTH: Nov 18 1848 (Month) (Day) (Year)

7. AGE: 72 Yrs. 9 Mos. 18 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): La

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): "

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country): "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) S. Lee Bates
(Address) Rigby

15. Filed 10/10 1921 Ray H. Brake Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept 5 1921 (Month) (Day) (Year)
Sept 5

17. I HEREBY CERTIFY, That I attended deceased from Sept 1 1921 to Sept 5 1921
that I last saw h~~e~~ alive on Sept 5 1921
and that death occurred on the date stated above, at 4 P. M.
The CAUSE OF DEATH* was as follows:
Hemorrhage from
Gastric Ulcer
(Duration) Yrs. mos. 5 ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) A. M. Palmer M. D.
9/6 1921 (Address) Rigby Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Shelton — DATE OF BURIAL: Sept 8 1921

20. UNDERTAKER: Friends — ADDRESS: Rigby

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 3558

Registered No. 76

1. PLACE OF DEATH

County of Jefferson

City of Ririe (St.)

Registration District No. 98

Primary Registration District No. 2176

RECEIVED OCT 31 1921 BUREAU OF VITAL STATISTICS

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Not named

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Baby

6. DATE OF BIRTH: Aug (Month) 11 (Day) 1921 (Year)

7. AGE: ....Yrs....Mos....ds.

IF LESS than 1 day how many....hrs. or 20 min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Ted F. Wren

11. BIRTHPLACE OF FATHER (State or Country): Kansas

12. MAIDEN NAME OF MOTHER: Eltha Ricks

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ted F. Wren

(Address) Poplar Idaho

15. Filed 10/10 1921 Ray H. Fisher Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 11 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 11 1921 to Aug 11 1921 that I last saw h.r alive on Aug 11 1921 and that death occurred on the date stated above, at 4:20 P.M.

The CAUSE OF DEATH* was as follows:

Blue Baby

(Duration) ....Yrs....mos....ds.

Contributory (Secondary)

(Duration) ....yrs....mos....ds.

(Signed) Sam F. Price M. D.

Aug 12 1921 (Address) Ririe Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients or Recent Residents.)

At place of death....yrs....mos....days. In the State....yrs....mos....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Shelton — DATE OF BURIAL: Aug 12 1921

20. UNDERTAKER — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
OCT 31 1921
BUREAU OF VITAL STATISTICS

Registration District No. 48
Primary Registration District No. 2176
File No. 35582
Registered No.

1. PLACE OF DEATH

County of JEFFERSON

City of RIGBY (No. St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME WILLIAM ROBINSON

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: WHITE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: SINGLE (Write the word.)

6. DATE OF BIRTH: SEPT. (Month) 2nd. (Day) 1910 (Year)

7. AGE: 11 Yrs. 0 Mos. 24 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: SCHOOL BOY

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): CLARK IDA.

10. NAME OF FATHER: WILLIAM ROBINSON

11. BIRTHPLACE OF FATHER (State or Country): UTAH

12. MAIDEN NAME OF MOTHER: RACHEL E. CONNELL

13. BIRTHPLACE OF MOTHER (State or Country): UTAH

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John S. Connell

(Address) Rigby Ida.

15. Filed Oct. 10th 19 21 Ray H. Fisher Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 26th (Day) 19 21 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 20 1921, to Sept 26 19 21, that I last saw h[illegible] alive on Sept 21 19 21, and that death occurred on the date stated above, at [illegible] A. M. The CAUSE OF DEATH* was as follows:

Diphtheria
Resperatory Paralysis

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H A Anderson M. D.

19 ..... (Address) Rigby Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: SHELTON CEMETARY — DATE OF BURIAL: 9-26 1921

20. UNDERTAKER: D. A. Harris — ADDRESS: Rigby Ida.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARKEN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35583
Registered No.

RECEIVED
OCT 3 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
Registration District No. 98
Primary Registration District No. 2176
County of Jefferson
City of Ririe (No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Essie Opal Clifford
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Infant-Single

6. DATE OF BIRTH: Feb. (Month) 19 (Day) 1921 (Year)

7. AGE: Yrs. 6 Mos. 20 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ririe, Idaho.

10. NAME OF FATHER: Elmer E. Clifford

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Essie Summers

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Elmer E. Clifford
(Address) Ririe Idaho

15. Filed Oct 10 1921 Ray H. Finks Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. (Month) 8 (Day) 21 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 6. 1921, to Sept 8 1921, that I last saw h[illegible] alive on Sept 8 1921, and that death occurred on the date stated above, at 3 P M.

The CAUSE OF DEATH* was as follows:
Enteritis
(Duration) Yrs. mos. ds.
Contributory (Secondary) Convulsions
(Duration) Yrs. mos. ds.
(Signed) [illegible] M. D.
19 (Address) Ririe Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Ammis - Idaho
DATE OF BURIAL: 9-10 1921

20. UNDERTAKER: [illegible]
ADDRESS: Rigby - Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 98

County of JEFFERSON

Primary Registration District No. 2176

File No. 35584

City of LOUISVILLE (No. ..... St.)

Registered No. .....

RECEIVED
OCT 31 1921
BUREAU OF VITAL STATISTICS

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME DALLAS WALTER CLEMENT

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
MALE	WHITE	CHILD

6. DATE OF BIRTH: JUNE (Month) 14 (Day) 1916 (Year)

7. AGE: 5 Yrs. 3 Mos. 20 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: CHILD
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Lewisville, ~~LOUISVILLE~~ IDA.

10. NAME OF FATHER: WALTER A. CLEMENT

11. BIRTHPLACE OF FATHER (State or Country): UTAH.

12. MAIDEN NAME OF MOTHER: JENNIE NORTON

13. BIRTHPLACE OF MOTHER (State or Country): LINCOLN IDA.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Walter A. Clement
(Address) Rigby Idaho R.D. #1

15. Filed Oct 10 1921 Ray N. Fisher Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 3 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 25 1921, to Oct 3 1921, that I last saw him alive on 3 1921, and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Diphtheria

(Duration) ..... Yrs. ..... mos. 10 ds.

Contributory (Secondary) acute Myocarditis

(Duration) ..... yrs. ..... mos. 7 ds.

(Signed) D. F. Call M. D.

1921 (Address) Rigby

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence Lewisville

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
~~LOUISVILLE~~ CEMETARY	10/4/21

20. UNDERTAKER	ADDRESS
D. G. Harris	Rigby Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

RECEIVED
OCT 31 1921
BUREAU OF VITAL STATISTICS

Registration District No. 98
Primary Registration District No. 2176

File No. 35585
Registered No. 50

County of JEFFERSON
City of RIGBY (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME ROBERT SYLVESTER BENNETT

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: MALE

4. COLOR OR RACE: WHITE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: SINGLE (Write the word.)

6. DATE OF BIRTH: APRIL (Month) 7th. (Day) 1910 (Year)

7. AGE: 11 Yrs. 5 Mos. 11 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: SCHOOL BOY

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): ROBERTS IDA.

10. NAME OF FATHER: BASH L. BENNET

11. BIRTHPLACE OF FATHER (State or Country): FONTANELLE IOWA

12. MAIDEN NAME OF MOTHER: ALICE WILLIAMS

13. BIRTHPLACE OF MOTHER (State or Country): MINNESOTA

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

Informant) Bash L Bennett

(Address) RIGBY IDA.

Filed 10/10 1921 Ray H Fisher Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 18 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 18th 1921, to Sept 18 1921, that I last saw him alive on Sept 18th 1921, and that death occurred on the date stated above, at 12:55 P.M.

The CAUSE OF DEATH* was as follows:

Diphtheria

(Duration) Yrs. 1 mos. 18 ds.

Contributory (Secondary) Myocarditis. Paralysis of pharynx.

(Duration) yrs. mos. ds.

(Signed) Ray H Fisher M. D.

19 (Address) Rigby, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: LOUISVILLE IDA.

DATE OF BURIAL: 9-20 1921

20. UNDERTAKER: W. G. Harris

ADDRESS: Rigby Ida.

IDAHO-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED OCT 31 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
Registration District No. 98
Primary Registration District No. 2176
File No. 35586
County of Jefferson
City of Rigby (St.)
Registered No. 49
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Olive Louisa Walker
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): widowed
6. DATE OF BIRTH: Oct 2 1848 (Month) (Day) (Year)
7. AGE: 76 Yrs. 11 Mos. 13 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Illinois
10. NAME OF FATHER: Erastus Bingham
11. BIRTHPLACE OF FATHER (State or Country): Vermont
12. MAIDEN NAME OF MOTHER: Olive H. Freeman
13. BIRTHPLACE OF MOTHER (State or Country): Vermont
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Walker
(Address) Menan Idaho
15. Filed 10/10 1921 Ray H Fisher Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept 15 1921 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from Sept 1 1921 to Sept 15 1921 that I last saw h.r alive on Sept 1 1921 and that death occurred on the date stated above, at 4 P M.
The CAUSE OF DEATH* was as follows:
General Debility
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Ray H Fisher M. D.
9/16 1921 (Address) Rigby
*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewisville — DATE OF BURIAL: 9-18 1921
20. UNDERTAKER: D. L. Harris — ADDRESS: Rigby

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

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FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35587

Registered No.

RECEIVED OCT 1 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Jerome

Registration District No. 23

Primary Registration District No. 1017-2017

City of ..... (Name of St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sarah E. Davies

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widowed

6. DATE OF BIRTH: Nov (Month) ... (Day) 1832 (Year)

7. AGE: 89 Yrs. 11 Mos. ... ds.

IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: retired

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Penn.

10. NAME OF FATHER: William Titsworth

11. BIRTHPLACE OF FATHER (State or Country): Penn

12. MAIDEN NAME OF MOTHER: unknown

13. BIRTHPLACE OF MOTHER (State or Country): "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) X W. H. Vincent

(Address)

15. Filed Sept 27 1921 — E. D. Viper, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 27 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 13 1921, to Sept 27 1921 that I last saw h[illegible] alive on Sept 26 1921 and that death occurred on the date stated above, at 1[illegible] A. M.

The CAUSE OF DEATH* was as follows:

Fracture surgical neck femur followed by hypostatic pneumonia Cardiac Asthenia

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) Chas. F. Zeller M. D.

9/28 1921 (Address) Jerome, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Salt Lake Utah — DATE OF BURIAL ... 19...

20. UNDERTAKER: [illegible] E Elwell — ADDRESS Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35588

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Jerome

City of Jerome (No. ..... St.)

Registration District No. 23

Primary Registration District No. 1017-2017

If death occurs away from usual residence give facts called for under special information.

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SEP 27 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME Florence Holmes

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Jan. — 1 (Month) (Day) 914 (Year)

7. AGE: 7 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... None

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Twin Falls, Ida.

10. NAME OF FATHER John Holmes

11. BIRTHPLACE OF FATHER (State or Country) Utah.

12. MAIDEN NAME OF MOTHER Lydia M. Lisonbee

13. BIRTHPLACE OF MOTHER (State or Country) Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Holmes

(Address) Jerome Ida.

15. Filed Sept 27 1921 E. D. Piper Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. (Month) 27 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 6 1921, to Sept 27 1921, that I last saw h[illegible] alive on Sept 27 1921, and that death occured on the date stated above, at 8a. M.

The CAUSE OF DEATH* was as follows:

Acute Gastro Enteric Intoxication

.....(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Secondary Pneumonia

.....(Duration ..... yrs. ..... mos. 20 ds.

(Signed) Chas. E. [illegible] M. D.

19..... (Address) Jerome, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Jerome Cemetery — DATE OF BURIAL: Sept 28 1921

20. UNDERTAKER: James V. Platt — ADDRESS: Jerome Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOOK. 24658

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
OCT 31 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 30
Primary Registration District No. 13th 1051
File No. 35589
Registered No. 937

1. PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene (No. 328 13th St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Howard Nentin

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M.	W.	Married

6. DATE OF BIRTH
(Month) (Day) (Year)

7. AGE about 51 Yrs. Mos. ds.
IF LESS than 1 day, how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Ill.

10. NAME OF FATHER — Nentin

11. BIRTHPLACE OF FATHER (State or Country) —

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER (State or Country) —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Annie Nelms
(Address) 106 Church

15. Filed Oct 4 1921 D D Freeman Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Aug (Month) 31 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1 1921, to Aug 31 1921, that I last saw h[illegible] alive on Aug 30 1921, and that death occurred on the date stated above, at 7 9 M.

The CAUSE OF DEATH* was as follows:

Cancer of Stomach

(Duration) 1 Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) D D Freeman M. D.

8/31 1921 (Address) Coeur d'Alene

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Forest Cemetery | DATE OF BURIAL 9/1 1921

20. UNDERTAKER Coeur d'Alene | ADDRESS Coeur d'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED OCT 31 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Kootenai Registration District No. 30

City of Coeur d'Alene Primary Registration District No. 1051

(If outside limits of city or village, give township, and St.)

File No. 35590

Registered No. 958

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charley Jagels

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
M.	W.	single (Write the word.)

6. DATE OF BIRTH: 3 (Month) 20 (Day) 1899 (Year)

7. AGE: 22 Yrs. 5 Mos. 14 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: John H. Jagels

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Jennie Houck

13. BIRTHPLACE OF MOTHER (State or Country): Iowa.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John H Jagels
(Address) Coeur d'Alene

15. Filed Sept 4 1921 D D Brennan Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 4 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 3 1921, to Sept 4 1921 that I last saw h.. alive on Sept 4 1921, and that death occurred on the date stated above, at 2.45 P.M.

The CAUSE OF DEATH* was as follows:
Volvulus Small intestine,

(Duration) ..... Yrs. ..... mos. 4 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W K Hoedemaker M. D.

9/4 1921 (Address) Coeur d'Alene Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Forest Cem. C. D'Alene	9-6 1921

20. UNDERTAKER	ADDRESS
C. Cassedy	C D'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 30

Primary Registration District No. 1031

File No. 35591

Registered No. 739

County of Kootenai

City of Coeur d'Alene (No. 514 Sherman St., 7th St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ray Leslie Gentry

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): single

6. DATE OF BIRTH: April (Month) 28 (Day) 1917 (Year)

7. AGE: 4 Yrs. 0 Mos. 6 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Canada

10. NAME OF FATHER: Grover R. Gentry

11. BIRTHPLACE OF FATHER (State or Country): Ore.

12. MAIDEN NAME OF MOTHER: Minnie Thomas

13. BIRTHPLACE OF MOTHER (State or Country): Ind.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Minnie Gentry

(Address) Coeur d Alene Idaho

15. Filed Sept 7 1921

C. A. Brennan
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 4 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 2 1921, to Sept 11 1921, that I last saw h.. alive on Sept 4 1921 and that death occurred on the date stated above, at 4 P M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary) Influenza

(Duration) ..... yrs. ..... mos. 4 ds.

(Signed) W. H. Haeder M. D.

Sept 5 1921 (Address) Coeur d Alene Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetery — DATE OF BURIAL: Sept 5 1921

20. UNDERTAKER: C Cassedy — ADDRESS: C d A

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Kootenai

City of Rathdrum

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 30

Primary Registration District No. 1051

(No. ..... St.)

File No. 35593

Registered No. 962

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Frederick A Rath

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	W	S

6. DATE OF BIRTH

June (Month) 10 (Day) 1921 (Year)

7. AGE

Yrs. 2 Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Rathdrum Idaho

10. NAME OF FATHER Edward R Rath

11. BIRTHPLACE OF FATHER (State or Country) Ill

12. MAIDEN NAME OF MOTHER Agnes J. Pinnell

13. BIRTHPLACE OF MOTHER (State or Country) Minn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Edward R. Rath

(Address) Rathdrum Idaho

15. Filed Sept 4 1921 D D Drennan Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug (Month) 9 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 15 1921 to Aug 9 1921 that I last saw h... alive on July 20 1921 and that death occurred on the date stated above, at 3 a M.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia

(Duration) Yrs. 1 mos. ..... ds.

Contributory (Secondary) Whooping Cough

(Duration) ..... yrs. 1 mos. ..... ds.

(Signed) Frank Heyn M. D.

8/10 1921 (Address) Rathdrum, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rathdrum Idaho — DATE OF BURIAL: Aug 10 1921

20. UNDERTAKER: C. W. Stone — ADDRESS: Rathdrum Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED OCT 31 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Kootenai — Registration District No. 30

City of Belmont — Primary Registration District No. 1057 — (No. ..... St.)

File No. 35594

Registered No. 963

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Wm Bohn.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widower

6. DATE OF BIRTH: April (Month) 12, (Day) 1941 (Year)

7. AGE: 80 Yrs. 7 Mos. 3 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer.

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Germany.

10. NAME OF FATHER: John Bohn.

11. BIRTHPLACE OF FATHER (State or Country): Germany.

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) P. C. Bohn

(Address) Belmont Ida.

15. Filed Oct 4 1921 — D. D. Drennan, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. (Month) 15 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 23 1921, to Sept. 15 1921, that I last saw h... alive on Sept. 13, 1921, and that death occurred on the date stated above, at 9 M.

The CAUSE OF DEATH* was as follows:

Cancer

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D. D. Drennan M. D.

Sept 15 1921 (Address) Coeur d Alene Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Palmdrum — DATE OF BURIAL: Sept. 17 1921

20. UNDERTAKER: C. Cassedy — ADDRESS: Coeur d Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers,* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL *septicemia,*" "PUERPERAL *peritonitis,*" etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35595
Registered No. 964

1. PLACE OF DEATH

Registration District No. 30
Primary Registration District No. 1051
County of Kootenai
City of Coeur d'Alene (No.) Red Hospital St.)
If death occurs away from usual residence, give facts called for under special information.

RECEIVED
OCT 5 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME Olga Nelson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: April (Month) 23 (Day) 1882 (Year)

7. AGE: 39 Yrs. 4 Mos. 24 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Home Wife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER: Gus Grundstrom

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Mary Grundstrom

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Oslon Nelson
(Address) Coeur d'Alene Ida

15. Filed Oct 4 1921 D. D. Drenna Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 17 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 26 1921, to Sept 17 1921, that I last saw her alive on Sept 16 1921, and that death occurred on the date stated above, at 6:30 P.M.

The CAUSE OF DEATH* was as follows:

Typhoid fever

(Duration) ..... Yrs. ..... mos. 28 ds.

Contributory (Secondary) Broncho pneumonia

(Duration) ..... yrs. ..... mos. 14 ds.

(Signed) J. A. Wood M. D.

Sept 17 1921 (Address) Coeur d'Alene Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetery — DATE OF BURIAL: Sept 19 1921

20. UNDERTAKER: R. A. Downey — ADDRESS: Coeur d'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

RECEIVED OCT 21 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Id... BOARD OF HE... Bureau of Vital S...

1. PLACE OF DEATH

County of Kootenai Registration District No. 30

City of Coeur d'Alene (No. 1135, 3rd St.) Primary Registration District No. 1051

File No. 35590

Registered No. 965

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Irvin Millsaps

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (write the word.)

6. DATE OF BIRTH: Sept. (Month) 26 (Day) 1921 (Year)

7. AGE: ....Yrs....Mos....ds. IF LESS than 1 day how many 3 hrs. or ....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Chas Millsaps

11. BIRTHPLACE OF FATHER (State or Country): Penn.

12. MAIDEN NAME OF MOTHER: Belle Milne

13. BIRTHPLACE OF MOTHER (State or Country): Wash.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Chas. Millsaps

(Address) 1135 - 3rd St.

15. Filed Oct. 4 1921 L. L. Simms Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. (Month) 26 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 26 1921 to Sept. 26 1921 that I last saw h... alive on Sept. 26 1921 and that death occurred on the date stated above, at ....M.

The CAUSE OF DEATH* was as follows:

(Premature birth) 6 mo.

....(Duration) ....Yrs....mos....ds.

Contributory (Secondary) ....(Duration) ....yrs....mos....ds.

(Signed) John D. Wood M. D.

Sept 26 1921 (Address) Coeur d'Alene, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death....yrs....mos....days. In the State....yrs....mos....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Forest Cem. CDAlene — DATE OF BURIAL: 9-27 1921

20. UNDERTAKER: C. Casady — ADDRESS: CDAlene

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED OCT 8 1921 BUREAU OF STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 30

County of Kootenai

Primary Registration District No. 1057

City of ... (If not in incorporated city or village write the word "None") ... St.) Hayden Lake

File No. 35597

Registered No. 966

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Edith B. White

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Oct (Month) 2 (Day) 1863 (Year)

7. AGE: 58 Yrs. 11 Mos. 24 ds.

IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Home Maker

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: John Muzzy

11. BIRTHPLACE OF FATHER (State or Country): N. Y.

12. MAIDEN NAME OF MOTHER: Harriet McAllister

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E D White

(Address) Hayden Lake Idaho

15. Filed Oct 4 1921 D D Dreman Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 26 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 17 1921 to Sept 26 1921 that I last saw h[er] alive on Sept 25 1921 and that death occurred on the date stated above, at 6:00 A.M.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(Duration) ... Yrs. ... mos. 10 ds.

Contributory (Secondary) Arterio-Sclerosis

(Duration) some yrs. ... mos. ... ds.

(Signed) Frank Wenz M. D.

9/27 1921 (Address) Rathdrum, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State 31 yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetery — DATE OF BURIAL: Sept 29 1921

20. UNDERTAKER: W B Mooney — ADDRESS: Coeur d'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important—see instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH. 35598

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED OCT 3 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH.

Registration District No. 124

County of Kootenai

Primary Registration District No. 220 X

City of Harrison (No. ..... St.)

File No. 2

Registered No. 57

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ruby Mildred Holem

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Nov (Month) 19 (Day) 1911 (Year)

7. AGE: 9 Yrs. 9 Mos. 20 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Harrison Ida

10. NAME OF FATHER Sam Holem

11. BIRTHPLACE OF FATHER (State or Country) Sweden

12. MAIDEN NAME OF MOTHER Hannah Johanna Anderson

13. BIRTHPLACE OF MOTHER (State or Country) Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sam Holem

(Address) Harrison Ida

15. Filed 10-1 1921 J. H. Timmy Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 8 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 7 1921, to Sept 8 1921, that I last saw her alive on Sept 7 1921 and that death occured on the date stated above, at 12 A M.

The CAUSE OF DEATH* was as follows:

a Appendicitis

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. H. Timmy M. D.

9-9 1921 (Address) Harrison Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Harrison. DATE OF BURIAL: 9-9 1921

20. UNDERTAKER: Kutchin ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-12 M. 6-15-17.

OLIVE HERZBERGER

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35599
Registered No. 27

RECEIVED
OCT 21 1921
BUREAU OF VITAL STATISTICS

PLACE OF DEATH
County of Kootenai
City of Rose Lake,
(If death occurs away from usual residence, give facts called for under special information.)

Registration District No. 123
Primary Registration District No. .....
(Ward .....) St.)

2. FULL NAME Henry Herzberger

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. Dec (Month) 18 (Day) 1858 (Year)

7. AGE: 62 Yrs. 7 Mos. 11 ds.
IF LESS than 1 day how many .... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Butcher
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Rochester, New York

10. NAME OF FATHER: —

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Zimmermann

13. BIRTHPLACE OF MOTHER (State or Country): Germany.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Olive Herzberger
(Address) Rose Lake, Idaho

15. Filed Oct 27 1921 E E Hand Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 29 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1 1921 to July 29 1921
that I last saw h~~im~~ alive on July 29 1921
and that death occurred on the date stated above, at 10:30 P. M.

The CAUSE OF DEATH* was as follows:
Acute heart attack
(Duration) ..... Yrs. ..... mos. ½ hour
Contributory (Secondary) chronic myocarditis
(Duration) 3 Yrs. ..... mos. ..... ds.

(Signed) L. J. Stauffer M. D.
July 30 1921 (Address) Rose Lake, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Spokane, Wash. DATE OF BURIAL: ..... 191..

20. UNDERTAKER: E B Koerber ADDRESS: Rose Lake

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35600
Registered No. 48

RECEIVED
OCT 31 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Latah
City of Kisla (No. ..... St.)
Registration District No. 61
Primary Registration District No. 2141
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Earl Herbert Marcy
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.):

6. DATE OF BIRTH: Sept (Month) 9 (Day) 1921 (Year)

7. AGE: ..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many 3 hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Jean H Marcy

11. BIRTHPLACE OF FATHER (State or Country): Michigan

12. MAIDEN NAME OF MOTHER: Clovabell Russell

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jean H Marcy
(Address) Moscow

15. Filed Sept 10 19..... W S Hoarthers
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 9 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....
and that death occurred on the date stated above, at 7 P M.
The CAUSE OF DEATH* was as follows:

Prematur

..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. N. Clark M. D.
9/10 1921 (Address) Moscow

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL ..... 19.....

20. UNDERTAKER | ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11 RECEIVED OCT 31 BUREAU OF VITAL STATISTICS STATE OF IDAHO CERTIFICATE OF DEATH

1. PLACE OF DEATH Registration District No.

County of Latah Primary Registration District No. 2111

City of Potlatch (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William Futter

BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35601
Registered No.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Nov. (Month) 10 (Day) 1878 (Year)

7. AGE: 42 yrs. 10 mos. 8 ds. IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Anton Futter

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: unknown

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Frank Futter
(Address) Garfield Wash.

15. Filed 9/19 1921 M. H. Arithers Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Sept (Month) 16 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1919 191 , to Sept 16 1921
that I last saw h alive on Aug. 6 1921
and that death occurred on the date stated above, at 5 A.M.

The CAUSE OF DEATH* was as follows:
Nephritis interstitial with acute dilation of the heart.
(Duration) 2 yrs. 6 mos. ds.

Contributory (Secondary) Unknown
(Duration) yrs. mos. ds.

(Signed) H. Duer M. D.
Sept 18 1921 (Address) Garfield Wash

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Farmington Wash. DATE OF BURIAL: Sept 20 1921

20. UNDERTAKER: L. L. Bruning ADDRESS: Colfax Wash.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35602
Registered No. 58

RECEIVED
OCT 21 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
Country of Idaho
City of Moscow (If outside limits, give township) St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 61
Primary Registration District No. 1011

2. FULL NAME Soloman Peiffer,

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Oct 15 1853 (Month) (Day) (Year)

7. AGE: 67 Yrs. 11 Mos. 21 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farming
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Penn

10. NAME OF FATHER: Israel Peiffer

11. BIRTHPLACE OF FATHER (State or Country): Penn

12. MAIDEN NAME OF MOTHER: Mary Water

13. BIRTHPLACE OF MOTHER (State or Country): Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Mrs Sophia Peiffer
(Address):

15. Filed 9/25 1921 W H Gaithers Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept 24 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 1 1921, to Sept 24 1921, that I last saw h— alive on Sept 21 1921, and that death occurred on the date stated above, at 3-a M.

The CAUSE OF DEATH* was as follows:

Cancer of Pancreas

(Duration) Yrs. 6 mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) W A Adair M. D.

9/25 1921 (Address) Moscow

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Moscow — DATE OF BURIAL: 9/29 1921

20. UNDERTAKER: Adair Bros — ADDRESS: Moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 61
Primary Registration District No. 1011
File No. 35603
Registered No.

RECEIVED OCT 31 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Latah
City of Moscow (St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Alice J Palmer
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widowed

6. DATE OF BIRTH: Feb 22 1855 (Month) (Day) (Year)

7. AGE: 66 Yrs. 7 Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Michigan

10. NAME OF FATHER: Archie Beeman

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Eugenia Dawson

13. BIRTHPLACE OF MOTHER (State or Country): Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Dunlap
(Address) Moscow

15. Filed 9/23 1921 M T Carothers Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept 22 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1921, to Sept 22 1921, that I last saw her alive on Sept 22 1921 and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:
Chr. Interstitial Nephritis
Arterio Sclerosis

(Duration) 15 Yrs. mos. ds.
Contributory (Secondary) Aortic regurgitation
(Duration) 10 yrs. mos. ds.

(Signed) Virgil M. Gilchrist M. D.
19 (Address) Moscow, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Moscow | DATE OF BURIAL: Sept 24 1921

20. UNDERTAKER: Neil Bros. | ADDRESS: Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED OCT 31 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Latah — Registration District No. 61
City of Moscow — Primary Registration District No. 1011 — St.)
File No. 35604
Registered No. 56
If death occurs away from usual residence, give facts called for under special information.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Agnes Leona Fylden

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.):

6. DATE OF BIRTH: Nov (Month) 17 (Day) 1911 (Year)

7. AGE: 8 Yrs. 10 Mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business or establishment in which employed (or employer): Student

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Casper Fylden

11. BIRTHPLACE OF FATHER (State or Country): Minn

12. MAIDEN NAME OF MOTHER: Norma Setter

13. BIRTHPLACE OF MOTHER (State or Country): Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Casper Fylden
(Address) Moscow

15. Filed 9/24 19..... W. H. Carithers Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept 22 (Month) (Day) 19 21 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....
and that death occurred on the date stated above, at 6:30 P. M.
The CAUSE OF DEATH* was as follows:
Infantile Paralysis
..... (Duration) ..... Yrs. ..... mos. 2 ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) J. U. Clarke M. D.
9/24 1921 (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Moscow — DATE OF BURIAL: 9/24 1921

20. UNDERTAKER ..... ADDRESS .....

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED OCT 31 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Latah — Registration District No. 61
City of Moscow — Primary Registration District No. 1011
(No. ..... St.)
File No. 35605
Registered No. 55

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charles W. Salton

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widower

6. DATE OF BIRTH: Sept (Month) 28 (Day) 1[illegible] (Year)

7. AGE: 84 Yrs. 11 Mos. 24 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Not Known here

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) David Lemmon
(Address) Moscow

15. Filed 9/23 19.. — N. H. Carithers, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 22 (Day) 192[illegible] (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 8 1921, to Sept 20th 1921, that I last saw h..... alive on ..... 19.., and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Cancer of Pancreas
(Duration) ..... Yrs. 6 mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. A. Adair M. D.
19.. (Address) Moscow Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Moscow — DATE OF BURIAL: 9/24 21

20. UNDERTAKER — ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35606
Registered No. 34

1. PLACE OF DEATH

County of Latah — Registration District No. 61

City of Moscow — Primary Registration District No. 1011

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED OCT BUREAU OF STATISTICS

2. FULL NAME Leslie Walter Lyon

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	White	

6. DATE OF BIRTH: Feb (Month) 14 (Day) 1920 (Year)

7. AGE: 1 Yrs. 7 Mos. 6 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Leslie L. Lyon

11. BIRTHPLACE OF FATHER (State or Country) Oregon

12. MAIDEN NAME OF MOTHER Ida Ruth Dawson

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Leslie L. Lyon

(Address) .....

15. Filed Sept 21 1921 — M. M. Carithers, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 20 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 14 1921 to Sept 20 1921 that I last saw him alive on Sept 20 1921 and that death occurred on the date stated above, at 3:30 P.M.

The CAUSE OF DEATH* was as follows:

Involvus Infantum

(Duration) ..... Yrs. ..... mos. 6 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Virgil M. Gilchrist M. D.

9/21 1921 (Address) Moscow, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Tenesee Valley	9/22 1921

20. UNDERTAKER Glen Grice — ADDRESS Moscow

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35607
Registered No. 53

1. PLACE OF DEATH

County of Latah RECEIVED OCT 31 1921 BUREAU OF VITAL STATISTICS

Registration District No. 61

Primary Registration District No. 1011

City of Moscow (If outside city limits, give township.) (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Herbert Andrew Langley

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widower ed

6. DATE OF BIRTH: March 17 1877 (Month) (Day) (Year)

7. AGE: 43 Yrs. 6 Mos. 3 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Salesman
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: John T. Langley

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Mary E. Wentworth

13. BIRTHPLACE OF MOTHER (State or Country): Maine

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) L. E. Langley
(Address) Moscow

15. Filed Sept 21 1921 W. H. Matthews Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept 20 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 3 1921 to Sept 20 1921 that I last saw h.. alive on Sept 19 1921 and that death occurred on the date stated above, at 2:45 PM

The CAUSE OF DEATH* was as follows:

Bulbar Paralysis

(Duration) 4 Yrs. ..... mos. 2 ds.

Contributory (Secondary): Tuberculosis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. M. Hatfield M. D.

9/21 1921 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Spokane Wn. DATE OF BURIAL ..... 19.....

20. UNDERTAKER: Allen Price ADDRESS Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
OCT 31 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Latah — Registration District No. ____
City of Moscow — Primary Registration District No. 1011
(No. ____, ____ St.)
File No. 35608
Registered No. 52

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jessie E. Hatfield

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH: May (Month) 8 (Day) 1918 (Year)

7. AGE: 6 Yrs. 4 Mos. 11 ds.
IF LESS than 1 day how many ____ hrs. or ____ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry, business or establishment in which employed (or employer): ____

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Ewing Hatfield

11. BIRTHPLACE OF FATHER (State or Country): Not known here

12. MAIDEN NAME OF MOTHER: Nannie E. Brooks

13. BIRTHPLACE OF MOTHER (State or Country): Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) L. E. Brooks
(Address) Moscow

15. Filed Sept 20 1921 — W. S. Hawthorne, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 19 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 17 1921 to Sept. 19 1921 that I last saw him alive on Sept 19th 1921 and that death occurred on the date stated above, at 9:25 P.M.

The CAUSE OF DEATH* was as follows:
Fracture at base of brain

(Duration) ____ Yrs. ____ mos. ____ ds.
Contributory (Secondary) a fall from bicycle
(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) W. W. Hamilton M. D.
9/20 1921 (Address) Moscow, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days
Where was disease contracted if not at place of death? ____
Former or usual residence ____

19. PLACE OF BURIAL OR REMOVAL: Moscow — DATE OF BURIAL: 9/21 1921

20. UNDERTAKER: Glen Price — ADDRESS: Moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED OCT 31 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 1011
Primary Registration District No. 1011
File No. 35609
Registered No. 50

1. PLACE OF DEATH
County of Latah,
City of Moscow (No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Ann Mondy,
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F	Wh	Married

6. DATE OF BIRTH: Sept (Month) 15 (Day) 1854 (Year)

7. AGE: 66 Yrs. 11 Mos. 28 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Arkansas

10. NAME OF FATHER: Abraham Mathis

11. BIRTHPLACE OF FATHER (State or Country): Arkansas

12. MAIDEN NAME OF MOTHER: Nancy Kaiser

13. BIRTHPLACE OF MOTHER (State or Country): Arkansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs A Mathis
(Address) Moscow

15. Filed 9/14 1921 M H Carruthers Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 13 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from August 10 1921 to Sept- 1921 that I last saw her alive on August 20 1921 and that death occurred on the date stated above, at 9304 P. M.
The CAUSE OF DEATH* was as follows:

Paralysis.

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Arteriosclerosis.
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. L. Britnacher M. D.
9/14 1921 (Address) Moscow Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Moscow | DATE OF BURIAL: 9/14 1921

20. UNDERTAKER: Glen Price | ADDRESS: Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

Spitman

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 61

Primary Registration District No. 1011

File No. 35610

Registered No. 49

County of Latah

City of Moscow (If outside limits, give township.) St.)

RECEIVED OCT 31 1921 BUREAU OF VITAL STATISTICS

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William R. Mix.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	White	Single

6. DATE OF BIRTH March 30 1863
(Month) (Day) (Year)

7. AGE 58 Yrs. 5 Mos. 12 Ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Retired Farmer
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Missouri

10. NAME OF FATHER Frank E Mix.

11. BIRTHPLACE OF FATHER (State or Country) Ohio

12. MAIDEN NAME OF MOTHER Mary Grimes

13. BIRTHPLACE OF MOTHER (State or Country) West Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. P. Mix
(Address) Moscow Idaho

15. Filed 11/2 19 W. H. Carithers Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. 11 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1 Sep 1916, to Occasionally 19..., that I last saw him alive on July 15 1921, and that death occurred on the date stated above, at 10:30 A.M.

The CAUSE OF DEATH* was as follows:

Cerebritis

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary) Paralysis

(Duration) 5 yrs. ... mos. ... ds.

(Signed) C. P. Christensen M. D.

9/11 1921 (Address) Moscow Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL ... 19...
20. UNDERTAKER	ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35611
Registered No. 8

RECEIVED
OCT 31 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH. Registration District No. 62
County of Latah Primary Registration District No. 3142
City of Genesee (No. St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Harold Rosenau

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Oct 25 (Month) (Day) 1921 (Year)

7. AGE: ..... yrs. ..... mos. 1 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho Genesee

10. NAME OF FATHER: A E Rosenau

11. BIRTHPLACE OF FATHER (State or Country): Minn

12. MAIDEN NAME OF MOTHER: Frieda McCracken

13. BIRTHPLACE OF MOTHER (State or Country): Genesee

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A. E. Rosenau
(Address) Genesee

15. Filed Oct 31 1921 W. N. Eden Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Oct. 29 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 27 1921, to Oct 29 1921, that I last saw h alive on Oct 26 1921, and that death occurred on the date stated above, at 10a M.

The CAUSE OF DEATH* was as follows:
Premature birth
5½ mos.

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. N. Eden M. D.
10-29 1921 (Address) Genesee

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Genesee — DATE OF BURIAL: 10-30 1921

20. UNDERTAKER: A. E. Rosenau — ADDRESS: Genesee

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Latah
City of Potlatch

Registration District No. 65
Primary Registration District No. 2145
(No. ..... St.)

File No. 35613
Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Frank E Garton

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Feb 25 (Month) (Day) 1862 (Year)

7. AGE: 59 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ill

10. NAME OF FATHER: J. D. Garton

11. BIRTHPLACE OF FATHER (State or Country): Indanice

12. MAIDEN NAME OF MOTHER: Watterman

13. BIRTHPLACE OF MOTHER (State or Country): N. Y.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs J B Robinson
(Address) Potlatch, Ida.

15. Filed Sept. 12 1921
D Jno. Thompson
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sep (Month) 11 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sep 11 1921, to Sep 11 1921
that I last saw him alive on Sep 11 1921,
and that death occurred on the date stated above, at 3 A.M.
The CAUSE OF DEATH* was as follows:
Organic heart disease
(Only saw him 2 hrs before death)
(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D B Harrison M. D.
9/11/1921 (Address) Palouse Wn

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Freeze Cem — DATE OF BURIAL: Sept 12 1921

20. UNDERTAKER: L. M. Irwin — ADDRESS: Palouse Wash

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35614

Registered No. .....

RECEIVED
OCT 3 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH.

County of Lemhi

City of Salmon

Registration District No. 41

Primary Registration District No. 2116

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William Bentley

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. April 27th (Month) (Day) 1857 (Year)

7. AGE: 64 Yrs. 4 Mos. 15 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: C W Bentley

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Ester Bentley

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant): Mrs Clara West
(Address): Salmon Ida.

15. Filed 10-10- 1921 Chas Bellomy Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept 17th (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 16 1921, to Sept 17 1921, that I last saw him alive on Sept 17 1921 and that death occured on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:
Chr. Parenchym. Nephritis

Absent (Duration) 9 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Chas F Hammer M. D.

10/10 1921 (Address) Salmon

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Salmon Cemetery — DATE OF BURIAL: 9-18- 1921

20. UNDERTAKER: W M C Jacobs — ADDRESS: Salmon Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & SDRS. 24858

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35616

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Lemhi

City of Salmon

Registration District No. 41

Primary Registration District No. 216

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
OCT 31 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME Mattie Sheridan

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Divorced

6. DATE OF BIRTH. Not known (Month) (Day) 1 (Year)

7. AGE: 36 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House keeper
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): California

10. NAME OF FATHER: Not known

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Wm C Jacobs
(Address) Salmon Idaho

15. Filed 10-10- 1921 Chas Bellomy Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: October 8th 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 15- 1921, to Oct 7 1921, that I last saw her alive on Oct 7 1921, and that death occured on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis
1da first tuberculosis

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Chas F. Hammer M. D.

Oct 10 1921 (Address) Salmon

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Salmon Cemetery — DATE OF BURIAL: 10-10 1921

20. UNDERTAKER: W C Jacobs — ADDRESS: Salmon Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTPS. & BOOKS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35617
Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Lemhi
City of Ulysses (St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 41
Primary Registration District No. 2116
RECEIVED
OCT 8 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME James M. Vann

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Oct 11" (Month) (Day) 1840 (Year)

7. AGE: 81 Yrs. 11 Mos. ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Farmer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Iowa

10. NAME OF FATHER William Vann

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER Susan Moore

13. BIRTHPLACE OF MOTHER (State or Country) Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) R. E. Vann
(Address) Ulysses Idaho

15.
Filed 10-10 1921 Clio Bellamy Local Registrar
alyss

SYMS - YORK CO., PTRS. & SMRS. 24853

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 11" (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
old age, due to Valvular heart disease
(Duration) ... Yrs. ... mos. ... ds.
Contributory (Secondary) .....
(Duration ... yrs. ... mos. ... ds.
(Signed) W. C. Dobler Coroner M. D.
9-11 1921 (Address) Salmon Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Salmon Cemetery — DATE OF BURIAL: 9-13" 1921

20. UNDERTAKER: W. C. Dobler — ADDRESS: Salmon Ida

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35618

Registered No. .....

RECEIVED
OCT 31 1921
BUREAU OF VITAL STATISTICS

Registration District No. 41

Primary Registration District No. 2116

1. PLACE OF DEATH.

County of Lemhi

City of Carmen (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Rachel Wray

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. October (Month) (Day) 1866 (Year)

7. AGE: 55 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Ranch house wife
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Penn.

10. NAME OF FATHER: Blouss

11. BIRTHPLACE OF FATHER (State or Country): Not known

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Joe T. Wray
(Address) Carmen, Idaho

15. Filed 10-10- 1921 Clio Bellamy Local Registrar

SYMS - YORK CO., PTRS. & STRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: September 22" 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 21 1921, to Sept 22 1921, that I last saw her alive on Sept 21 1921, and that death occured on the date stated above, at 5 A.M.

The CAUSE OF DEATH* was as follows:
Diabetes Mel.
About 4 years
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) Chas F. Hammon M. D.
Sept 22 1921 (Address) Salmon

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Gibbonsville Ida. DATE OF BURIAL: 9-23 1921

20. UNDERTAKER: W. C. Doeble ADDRESS: Salmon Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
OCT 31 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH. Registration District No. 4
County of Lemhi Primary Registration District No. 2116
City of May Ida (If outside city limits, write TOWN or PRECINCT and name of St.)
If death occurs away from usual residence, give facts called for under special information.

File No. 35619
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Edward O'Neal

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married
6. DATE OF BIRTH. Sept 10th (Month) (Day) 1845 (Year)
7. AGE: 75 Yrs. 11 Mos. 28 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired Rancher
(b) General nature of industry, business, or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): Illinois
10. NAME OF FATHER: Not known
11. BIRTHPLACE OF FATHER (State or Country): " "
12. MAIDEN NAME OF MOTHER: " "
13. BIRTHPLACE OF MOTHER (State or Country): " "
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) C. D. Bartlett
(Address) May Idaho
15.
Filed 10-10-1921 Clio Billow Local Registrar
Dep.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept 7th (Month) (Day) 1921 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Sep. 5 - 1921, to Sep 7 1921, that I last saw him alive on Sep 7. 1921, and that death occured on the date stated above, at 2-30 P.M.
The CAUSE OF DEATH* was as follows: Cerebral Haemorrhage
..... (Duration) ✓ Yrs. ✓ mos. 3 ds.
Contributory (Secondary) .....
..... (Duration ..... yrs. ..... mos. ..... ds.
(Signed) O. Gilmore M. D.
19..... (Address) MAY Idaho

*State the DISEASE CAUSING DEATH; in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: May Cemetery DATE OF BURIAL: 7-11 1921
20. UNDERTAKER: Wm C Tacker ADDRESS: Salmon Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BKBS. 24658

FORM V. S. No. 5-25 M. 1-16-13

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH.

RECEIVED
OCT 31 1921
SEP 16 1921
BUREAU OF VITAL STATISTICS

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 41

County of Lemhi Registration District No. 2116

City of May (If not in city give township) St.)

File No. 35620

Registered No.

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME George W Meitzler

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. November 24 (Month) (Day) 1860 (Year)

7. AGE: 60 Yrs. 9 Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Bank Cashier
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Indiana

10. NAME OF FATHER: John Meitzler

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Mamie Landers

13. BIRTHPLACE OF MOTHER (State or Country): Kentuckey

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs J A Vaughn
(Address) May Idaho

15. Filed 9-10-1921 Clio Bellamy Local Registrar
By

SYMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
August 24th 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at 10 A. M.
The CAUSE OF DEATH* was as follows:

Gun Shot Wound in Head, Self inflicted.

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary)

(Duration ... yrs. ... mos. ... ds.

(Signed) William C Doeller Coroner M.D.
8-25 1921 (Address) Salmon, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Salmon Cemetery — DATE OF BURIAL: 8-26 1921

20. UNDERTAKER: Wm C Doeller — ADDRESS: Salmon Ida

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

RECEIVED
SEP 16 1921
BUREAU OF VITAL STATISTICS

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35621

Registered No. .....

1. PLACE OF DEATH.

Registration District No. #1

Primary Registration District No. 2116

County of Bonneville

City of Idaho Falls (If outside city limits, give township) St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME O. L. Igou

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Dec 29" (Month) (Day) 1865 (Year)

7. AGE: 55 Yrs. 7 Mos. 28 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Hotel Clerk
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ills

10. NAME OF FATHER: John L Igou

11. BIRTHPLACE OF FATHER (State or Country): Pa

12. MAIDEN NAME OF MOTHER: ?

13. BIRTHPLACE OF MOTHER (State or Country): ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. L. Igou
(Address) Salmon Ida

15. Filed 9-10-1921 Clio Bellamy Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug - 26" (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Accidental.
Fell from roof of building
Breaking neck, Instantly

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Coroner M. D.
8-27 1921 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Salmon Cemetery — DATE OF BURIAL: 8-30" 1921

20. UNDERTAKER: Jno C Doubler — ADDRESS: Salmon Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & ENGRS. 24658

FORM V. S. No. 5-A—25 M. 11-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35622
Registered No.

RECEIVED OCT 31 1921 BUREAU OF VIT. STATISTICS

1. PLACE OF DEATH
County of Lewis Registration District No.
Primary Registration District No.
City of Kamiah No. St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Johnathan Willis Dickson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	Indian	single

6. DATE OF BIRTH: June (Month) 14 (Day) 1921 (Year)

7. AGE: Yrs. 3 Mos. 13 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: baby
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Lapwai Idaho

10. NAME OF FATHER: James G. Dickson

11. BIRTHPLACE OF FATHER (State or Country): State of Washington

12. MAIDEN NAME OF MOTHER: Edith Corbett

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) James G. Dickson
(Address) Lites Idaho

15. Filed 9/28/21 19.... Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. (Month) 27 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 27 19 to Sept 27 19 21, that I last saw him alive on August 19, and that death occurred on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:
Acute Gastro Enteritis & Convulsions

(Duration) Yrs. mos. 7 ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) A. H. Bryan M. D.
(Address) Kamiah Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Ford Cem No 1, Kamiah Ida — DATE OF BURIAL: 9/29 1921

20. UNDERTAKER: J. J. Johnson — ADDRESS: Kamiah Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 62
Primary Registration District No. 2129
File No. 3562
Registered No. 9

1. PLACE OF DEATH.
County of Lemhi
City of Mudeo (or Village) (If outside city limits, give township) (Street and No. or R. F. D. No.) (St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Gerald Thomas Stevens

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. May 30 1901 (Month) (Day) (Year)

7. AGE: 20 Yrs. 3 Mos. 8 Ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher.
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Forest Idaho

10. NAME OF FATHER: Thomas Stevens

11. BIRTHPLACE OF FATHER (State or Country): California

12. MAIDEN NAME OF MOTHER: Hebbe Valley

13. BIRTHPLACE OF MOTHER (State or Country): Nevada.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Thos. Stevens (per RCD)
(Address) Mudeo Idaho

15. Filed 9/7 1921 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 7 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 5 1921, to Sept 7 1921, that I last saw him alive on Sept 7 1921, and that death occured on the date stated above, at 11:45 M.

The CAUSE OF DEATH* was as follows:
Infantile Paralysis
(Phrenic Paralysis Stated)
(Duration) ..... Yrs. ..... mos. 4 ds.
Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) R. E. Durrett M. D.
9/7 1921 (Address) Cowgurnet Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death?
Former or usual residence

PLACE OF BURIAL OR REMOVAL: Leesburg
DATE OF BURIAL: 9/8 1921
UNDERTAKER: [illegible]
ADDRESS: Cowgurnet

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

BYMS - YORK CO., PTRS. & BDRS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

RECEIVED
OCT 31 1921
BUREAU OF VITAL STATISTICS

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35624

Registered No. 10

Registration District No. 50

Primary Registration District No. 2129

1. PLACE OF DEATH.

County of Lewis

City of Craigmont, Idaho (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William Earl Sumpter

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. May (Month) 9 (Day) 921. (Year)

7. AGE: Yrs. 4 Mos. 3 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... infant

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Craigmont, Idaho.

10. NAME OF FATHER Earl Sumpter

11. BIRTHPLACE OF FATHER (State or Country) Washington

12. MAIDEN NAME OF MOTHER Frances Risley

13. BIRTHPLACE OF MOTHER (State or Country) Orangeville, Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Earl Sumpter

(Address) Craigmont, Idaho

15. Filed 9/13 1921 R E Dunlap Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 12 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 11 1921 to Sept 12 1921, that I last saw him alive on Sept 12 1921, and that death occured on the date stated above, at 8 A. M.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema

(Duration) ..... Yrs. ..... mos. 1/4 ds.

Contributory (Secondary) Brochopneumonia

(Duration ..... yrs. ..... mos. 3 ds.

(Signed) R E Dunlap M. D.

9/13 21 (Address) Craigmont, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: I.O.O.F. Cemetery — DATE OF BURIAL: 9/13 1921

20. UNDERTAKER: Star Hrw and Imp Co. — ADDRESS: Craigmont Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & ROBS. 24658

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED

OCT 31 1921

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 50

Primary Registration District No. 2129

File No. 35625

Registered No. 11

County Lewis

City of Craigmont, RFD. (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs. Ellen Will

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): widowed

6. DATE OF BIRTH. April (Month) 12 (Day) 1835 (Year)

7. AGE: 86 Yrs. 5 Mos. 9 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Michael Culler

11. BIRTHPLACE OF FATHER (State or Country): Maryland

12. MAIDEN NAME OF MOTHER: Mary Ann Ernsberger

13. BIRTHPLACE OF MOTHER (State or Country): Maryland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Permenter

(Address) Craigmont, RFD.

15. Filed Sept 22 191 21 P E Duncan. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 21 (Day) 191 21 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 6 191 21, to Sept 21 191 21, that I last saw her alive on Sept 11 191 21, and that death occured on the date stated above, at 10.53 P.M.

The CAUSE OF DEATH* was as follows:

pleuritis, Chronic myocarditis

(Duration) Yrs. 2 mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) P E Duncan M. D.

9/22 1921 (Address) Craigmont Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mansfield Ohio — DATE OF BURIAL: 9/30 1921

20. UNDERTAKER: W E Stoddard — ADDRESS: Craigmont Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24858

Form V. S. No. 5 20M.1-16-12

RECEIVED OCT 31 1921

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 16

Primary Registration District No. 2016

File No. 35626

Registered No. 15

1. PLACE OF DEATH.

County of Lincoln

City of Richfield (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Elizabeth Kunz

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Feb. (Month) 10 (Day) 1870 (Year)

7. AGE: 51 yrs. 7 mos. 17 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Switzerland

10. NAME OF FATHER: Gerber

11. BIRTHPLACE OF FATHER (State or Country): Switzerland

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Switzerland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Emil Kunz
(Address) Richfield Idaho

15. Filed Sept 29 1921 J. L. Furey Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Sept (Month) 27 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Strichnine Poisoning
Suicidal

(Duration) Less than 1 hour yrs. mos. ds.

Contributory (Secondary) Climateric Period (Grave)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) O F Brennan M. D.

19.... (Address) Richfield Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Preston Idaho | DATE OF BURIAL ..... 191...

20. UNDERTAKER: O F Brennan | ADDRESS: Shoshone Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

RECEIVED OCT 31 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 100

County of Madison Registration District No. 2178

City of Rexburg, (No. ....., ... St.)

File No. 35627

Registered No. 73

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Sophia N.J. Ricks

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)
Female	White	Widowed

6. DATE OF BIRTH

May (Month) 2 (Day) 1857 (Year)

7. AGE

64 yrs. 4 mos. 5 ds.

IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION

(a) Trade, profession or particular kind of work .....

(b) General nature of industry business, or establishment in which employed (or employer) housewife

9. BIRTHPLACE (State or Country) Denmark

10. NAME OF FATHER Peter Jeppeson

11. BIRTHPLACE OF FATHER (State or Country) Denmark

12. MAIDEN NAME OF MOTHER Caroline Sewardson

13. BIRTHPLACE OF MOTHER (State or Country) Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Peter J. Ricks

(Address) Rexburg, Idaho.

15. Filed Sept 9 1921 G Thorpe Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

September 7, 1921. 191.....
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9-1-1921, to 9-7-1921, that I last saw her alive on 9-6-1921, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Chronic bronchitis
(Streptococcus infection)

.....

..... (Duration) ..... yrs. ..... mos. 10 ds.

Contributory Asthma
(Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

9/9 1921 (Signed) Louis A Rich M. D.
(Address) Rexburg Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL Rexburg, Idaho

DATE OF BURIAL Sept 10 1921

20. UNDERTAKER John Phillips

ADDRESS Rexburg Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3562?
Registered No. 74

1. PLACE OF DEATH.
Registration District No. 100
Primary Registration District No. 2178
County of Madison
City of Rexburg (No.) St.)
If death occurs away from usual residence, give facts called for under special information.

RECEIVED
OCT 2
BUREAU OF VITAL STATISTICS

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William Thayne Jensen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH.
August 9th, 1921
(Month) (Day) (Year)

7. AGE
--- Yrs. 1 Mos. 1 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Child
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE
(State or Country) Idaho

10. NAME OF FATHER
Enos Jensen

11. BIRTHPLACE OF FATHER
(State or Country) Utah

12. MAIDEN NAME OF MOTHER
Una Peacock

13. BIRTHPLACE OF MOTHER
(State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Enos Jensen
(Address) Rexburg, Ida.

15.
Filed 9/10 1921
G G Epe
Local Registrar

SYMS - YORK CO., PTRS. & SORS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
9- 10 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 8-31 1921, to 9-10- 1921, that I last saw h. I M. alive on 9-10- 1921, and that death occured on the date stated above, at 10a M.

The CAUSE OF DEATH* was as follows:
Hemophilia
(Duration) 9 Yrs. mos. 20 ds.
Contributory (Secondary) Premature birth
(Duration yrs. mos. ds.
9/10 1921 (Signed) Lorin S. Rich M. D.
(Address) Rexburg Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Rexburg, Ida.	9-11 1921

20. UNDERTAKER	ADDRESS
David Young	Rexburg, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35629

Registered No. 73

RECEIVED
OCT 5 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH.

Registration District No. 100

Primary Registration District No. 2178

County of Madison

City of Hibbard (No. ....., St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary Ann Hildt Fisher

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. April (Month) 30th (Day) 1875 (Year)

7. AGE: 46 Yrs. 4 Mos. 28 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: Charles Hildt

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Gottlieben Luginsland

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Henry Fisher

(Address) Hibbard, Ida.

15. Filed Sept. 29 1921

G. L. Eide
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 9- 28 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11-1- 1919, to 9-24 1921, that I last saw h[illegible] alive on 9-24- 1921, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) 3 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Louie F. Rich M. D.

9/30 1921 (Address) Rexburg Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rexburg, Ida.

DATE OF BURIAL: Oct. 1st 1921

20. UNDERTAKER: David Young

ADDRESS: Rexburg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRNE - YORK CO., PTRS. & STNRS. 24854

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35630
Registered No. 76

1. PLACE OF DEATH

County of Madison RECEIVED
City of Resburg OCT 31 19[illegible]
(No. ..... St.)
BUREAU OF VITAL STATISTICS

Registration District No. 100
Primary Registration District No. 2178

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Frank Taylor Spaulding

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Sept. (Month) 10 (Day) 1919 (Year)

7. AGE: 2 Yrs. 0 Mos. 25 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry, business or establishment in which employed (or employer): Child

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Silas Eli Spaulding

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Marian Taylor

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Marian Spaulding
(Address) Resburg R 3 Box 41

15. Filed Oct 1 1921 G E Estep
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: October (Month) 5 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Drowning

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Gor Wacker M. D.

..... 19..... (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Burton Cemetery
DATE OF BURIAL: Oct 8, 1921

20. UNDERTAKER: John Phillips for Resburg Furn Co
ADDRESS: Resburg Ida

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35631
Registered No. 77

RECEIVED
OCT 5 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH.
County of Madison
City of Rexburg (No. ... St.)
Registration District No. 100
Primary Registration District No. 2178
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Minnie Sorensen Olsen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married
6. DATE OF BIRTH. May (Month) 9th (Day) 1868 (Year)
7. AGE: 53 Yrs. 4 Mos. 28 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....
9. BIRTHPLACE (State or Country) Denmark
10. NAME OF FATHER Jacob Sorensen
11. BIRTHPLACE OF FATHER (State or Country) Denmark
12. MAIDEN NAME OF MOTHER Elsie Nelsen
13. BIRTHPLACE OF MOTHER (State or Country) Denmark
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) James Olsen
(Address) Salem, Ida.
15. Filed Oct 8 1921 — G. L. Espe, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. (Month) 7 (Day) 1921 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Aug. 16 1921, to Sept. 13 1921, that I last saw h[illegible] alive on Sept. 13th 1921, and that death occured on the date stated above, at 11 a M.
The CAUSE OF DEATH* was as follows:
Paralysis Agitans
(Duration) 18 Yrs. ... mos. ... ds.
Contributory (Secondary) .....
(Duration ... yrs. ... mos. ... ds.
(Signed) F. B. Evans M. D.
10-8 1921 (Address) Rexburg City Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rexburg, Ida. — DATE OF BURIAL: Oct 10 1921
20. UNDERTAKER: David Young — ADDRESS: Rexburg Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOOKS. 24654

FORM V. S. No. 5-12 M. 6-15-17.

Rick

RECEIVED OCT 6 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35692
Registered No. 78

1. PLACE OF DEATH
County of Madison Registration District No. 100
City of Rexburg Primary Registration District No. 2178
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ceil G. Carlson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Sept. (Month) 23 (Day) 1911 (Year)

7. AGE: 10 Yrs. ..... Mos. 8 ds.
IF LESS than 1 day how many .... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Montana

10. NAME OF FATHER: Charles Carlson

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Grace M. Moores

13. BIRTHPLACE OF MOTHER (State or Country): Minnesota

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Charles Carlson
(Address) Rexburg

15. Filed Oct 1 1921 G G Esplin
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 10 (Month) 1 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9-1- 1921 to 9-30- 1921
that I last saw h/M. alive on 9-30- 1921
and that death occurred on the date stated above, at 6. a.m. M.

The CAUSE OF DEATH* was as follows:
Mitral Insufficiency
.....
.....
(Duration) 2 Yrs. ..... mos. ..... ds.
Contributory (Secondary) Endocarditis
(Duration) ..... Yrs. ..... mos. ..... ds.

10/4 1921 (Signed) Lorin D. Rich, M. D.
(Address) Rexburg Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rexburg — DATE OF BURIAL: Oct. 191..

20. UNDERTAKER: J Young — ADDRESS: Rexburg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 19
Primary Registration District No. 9015
File No. 35633
Registered No. 33

1. PLACE OF DEATH

County of Minidoka
City of Rupert (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED OCT 31 1921 BUREAU OF VITAL STATISTICS

2. FULL NAME Emmi Martha Borchardt

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH: June (Month) 14 (Day) 1852 (Year)

7. AGE: 68 Yrs. 9 Mos. 3 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): North Carolina

10. NAME OF FATHER: James Parker

11. BIRTHPLACE OF FATHER (State or Country): North Carolina

12. MAIDEN NAME OF MOTHER: Sabie Jones

13. BIRTHPLACE OF MOTHER (State or Country): North Carolina

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. H. Borchardt
(Address) .....

15. Filed Oct. 4 1921 Ethel Chase Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. (Month) 17 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 13 1921, to Sept 17 1921, that I last saw her alive on Sept 17 1921, and that death occurred on the date stated above, at 2 P.M.
The CAUSE OF DEATH* was as follows:
Chronic Nephritis

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) C. H. Borchardt M. D.
9-22 1921 (Address) Rupert Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rupert Cemetery — DATE OF BURIAL: ..... 19.....

20. UNDERTAKER: Calvin Keller — ADDRESS

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35635

Registered No. 645

1. PLACE OF DEATH

RECEIVED
OCT 31 1921
BUREAU OF VITAL STATISTICS

Registration District No. 75

Primary Registration District No. 1004

County of Nez Perce

City of Lapwai (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charlotte Marie White

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: f

4. COLOR OR RACE: w

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: single (Write the word.)

6. DATE OF BIRTH: Dec (Month) 9 (Day) 1917 (Year)

7. AGE: 3 Yrs. 9 Mos. 6 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Washington

10. NAME OF FATHER Chas M White

11. BIRTHPLACE OF FATHER (State or Country) Iowa

12. MAIDEN NAME OF MOTHER Emma Wicks

13. BIRTHPLACE OF MOTHER (State or Country) Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. M. White

(Address) Spalding Idaho

15.

Filed Oct 5 1921

Susan E Bruce
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 3 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from — 19..., to — 19...,

that I last saw her alive on ..... 19...,

and that death occurred on the date stated above, at 10a M.

The CAUSE OF DEATH* was as follows:

acute gastro-enteritis
not seen by physician until
after death

(Duration) ..... Yrs. ..... mos. 4 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Paul W Johnson M. D.

9/3 1921 (Address) Clarkston Wash

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Clarkston Wash	9/5 1921
20. UNDERTAKER	ADDRESS
A R Merchant	Clarkston Wash

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35636
Registered No. 696

1. PLACE OF DEATH
County of Nez Perce
City of Lewiston (If outside limits, give township.) St.)
If death occurs away from usual residence, give facts called for under special information.

RECEIVED
OCT 31 1921
BUREAU OF VITAL STATISTICS

Registration District No. 96
Primary Registration District No. 1009

2. FULL NAME William L. Hendricks

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH: Feb (Month) 22 (Day) 1861 (Year)

7. AGE: 60 Yrs. 6 Mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Carpenter
(b) General nature of industry, business or establishment in which employed (or employer): Farm

9. BIRTHPLACE (State or Country): Ind

10. NAME OF FATHER: Samuel Hendricks

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Elda S. Hendricks
(Address) Pomeroy, Wash

15. Filed Oct 5 1921 Sworn E. Brown Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 9 (Month) 3 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 1 1920, to Sept 3 1921, that I last saw h[illegible] alive on Sept 2 1921, and that death occurred on the date stated above, at 12 A.M.
The CAUSE OF DEATH* was as follows:

Acute Stomach

(Duration) 2 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. Lang McAlley M. D.
9/4 1921 (Address) Lewiston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Lewiston, Idaho. DATE OF BURIAL: 9/7 1921

20. UNDERTAKER: [illegible] ADDRESS: Lewiston, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
OCT 31 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 96

County of Nez Perce

Primary Registration District No. 1009

File No. 35637

City of Lewiston (No. ..... St.)

Registered No. 699

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sister Mary Scholastica

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F.	White	Single

6. DATE OF BIRTH

..... (Month) ..... (Day) 1 (Year)

7. AGE

40 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Dietitian

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Ireland

10. NAME OF FATHER James O'Donnell

11. BIRTHPLACE OF FATHER (State or Country) Ireland

12. MAIDEN NAME OF MOTHER Annie Carr

13. BIRTHPLACE OF MOTHER (State or Country) Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) L. B. Warner

(Address) Lewiston Idaho

15. Filed Sept 6th 1921 Oct 3 1921

Susan E. Bruce
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 5th 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1st 1921 to Sept 5th 1921 that I last saw h.. alive on Sept 4th 1921 and that death occurred on the date stated above, at 7:00 M.

The CAUSE OF DEATH* was as follows:

Acute Miliary T.B.
Tuberculosis Abdominis
(Duration) 1 Yrs ..... mos. 10 ds.

Contributory (Secondary) Tuberculosis Peritonitis
(Duration) 1 yrs. ..... mos. ..... ds.

(Signed) O. C. Tegmann M. D.

9/6 1921 (Address) Lewiston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Lewiston Idaho	Sept 7th 1921

20. UNDERTAKER .....

ADDRESS Lewiston Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH RECEIVED OCT 31 19 BUREAU OF STATISTICS

Registration District No. 96

County of Nez Perce

Primary Registration District No. 1009

City of Lewiston (No. ..... St.)

File No. 35638

Registered No. 698

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Margaret Quinlan

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widowed

6. DATE OF BIRTH: May (Month) 15 (Day) 1845 (Year)

7. AGE: 76 Yrs. 3 Mos. 20 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ireland

10. NAME OF FATHER: Barry ~~Monaghan~~

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: ~~Barry~~

13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) L B Warner

(Address) Lewiston Idaho

15. Filed Sept 5th 1921 Oct 5 1921

Susan E Bruce
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug 20 (Month) Sept (Day) 5 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 15th 1921, to Sept 5th 1921 that I last saw her alive on Sept 5th 1921, and that death occurred on the date stated above, at 1745 M.

The CAUSE OF DEATH* was as follows:

Aortic Insufficiency

(Duration) + Yrs. ..... mos. ..... ds.

Contributory (Secondary) Arteriosclerosis

(Duration) + yrs. ..... mos. ..... ds.

(Signed) O O Larson M. D.

19 ..... (Address) Lewiston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Pendleton Or — DATE OF BURIAL 19 .....

20. UNDERTAKER: [illegible] UNDERTAKING CO — ADDRESS Lewiston Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19. RECEIVED OCT 31 19 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 35639
Registered No. 699

1. PLACE OF DEATH
County of Nez Perce
City of Lewiston (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Carrie Anderson Nelson
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married

6. DATE OF BIRTH: Jan (Month) 12 (Day) 1858 (Year)

7. AGE: 63 Yrs. 7 Mos. 25 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Norway

10. NAME OF FATHER: Eric Anderson

11. BIRTHPLACE OF FATHER (State or Country): Norway

12. MAIDEN NAME OF MOTHER: Ellen Olson

13. BIRTHPLACE OF MOTHER (State or Country): Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Edgar F. Nelson
(Address) Lewiston Idaho

15. Filed Sept 8 * Oct-8 19 21
Suzan E Bruce
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 7th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 1st 1921, to Sept 7th 1921, that I last saw h.. w.. alive on Sept 7th 1921, and that death occurred on the date stated above, at 2 30 P.M.
The CAUSE OF DEATH* was as follows:

Diabetic Coma
(Duration) ..... Yrs. ..... mos. 7 ds.
Contributory (Secondary) Diabetes Mellitus
(Duration) + yrs. ..... mos. ..... ds.
(Signed) O G Leraas M. D.
19..... (Address) Lewiston Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston, Idaho
DATE OF BURIAL: 9/8 1921

20. UNDERTAKER
ADDRESS Lewiston, Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

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FORM V. S. No. 5-25 M. 1-19.

RECEIVED
OCT 31 1921
BUREAU OF STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Nez Perce — Registration District No. 96

City of Lewiston (St.) — Primary Registration District No. 1009

File No. 35640

Registered No. 700

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Katharina Kasper

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	white	married

6. DATE OF BIRTH: March 8 (Month) (Day) 1845 (Year)

7. AGE: 76 Yrs. 6 Mos. ds. — IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wisconson

10. NAME OF FATHER: Mathias Snyder

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: ———

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mathias J Kasper
(Address)

15. Filed Oct 8 1921 — Susan E Bruce, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 8 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 23, 1921, to June 27, 1921, that I last saw h[er] alive on June 27, 1921, and that death occurred on the date stated above, at ... M.
The CAUSE OF DEATH* was as follows:

Carcinoma of Jaw

(Duration) 2 Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) John N Alley M. D.
Sept 1921 (Address) Lewiston

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Uniontown Wn — DATE OF BURIAL: Sept 10 1921

20. UNDERTAKER: VASSAR UNDERTAKING CO. — ADDRESS: Lewiston Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED OCT 5 - 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

alle Johnson,

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35641

Registered No. 701

1. PLACE OF DEATH

County of Nez Perce — Registration District No. 96

City of Lewiston — Primary Registration District No. 1009

(St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME May Nella French

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F	white	

6. DATE OF BIRTH: April (Month) 20 (Day) 1887 (Year)

7. AGE: 34 Yrs. 4 Mos. 19 ds. — IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wisconsin Clark Co

10. NAME OF FATHER: W H French

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Ada M Scofield

13. BIRTHPLACE OF MOTHER (State or Country): Wisconsin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W H French.
(Address) Peck Idaho.

15. Filed Sept 10 — 1921 — Oct-8-21 — Susan E Bruce, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. (Month) 9th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 7 1921, to Sept 9 1921, that I last saw h. alive on Sept 7 1921, and that death occurred on the date stated above, at 4 P M.

The CAUSE OF DEATH* was as follows: Pneumonia (Lobar)

(Duration) ..... Yrs. ..... mos. 8 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John R Alley M. D.

19 ..... (Address) Lewiston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Lewiston, Idaho	9/10 1921

20. UNDERTAKER: NASSAR UNDERTAKING CO — ADDRESS: Lewiston Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

[redacted] No. [redacted] Statistics

OCT 3 Primary Registration District No. [redacted] File No. 3642

BUREAU OF VITAL STATISTICS [redacted] St.) Registered No. 702

If death occurred away from ... give facts ... er special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Benita Kuhn

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on ...

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single

6. DATE OF BIRTH: July (Month) 24 (Day) 1910 (Year)

7. AGE: 11 Yrs. 2 Mos. 16 ds.

IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: School girl
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: Ralph V. Kuhn

11. BIRTHPLACE OF FATHER (State or Country): Wash

12. MAIDEN NAME OF MOTHER: C. Millicent McCollough

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15. Filed Sept 11th 1921 Susan E Bruce Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. (Month) 10 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 9th 1921 to Sept. 10th 1921 that I last saw h... alive on Sept. 10 1921 and that death occurred on the date stated above, at 8 30 M.

The CAUSE OF DEATH* was as follows: Infantile Paralysis

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary) .....

(Duration) ... yrs. ... mos. ... ds.

(Signed) F. T. Harris, M. D.

Sept. 11 1921 (Address) Lewiston Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Lewiston Idaho — DATE OF BURIAL: 9/11 1921

20. UNDERTAKER: VASSAR UNDERTAKING CO. — ADDRESS: Lewiston Ida

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
OCT 31 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35643
Registered No. 703

1. PLACE OF DEATH
County of Nez Perce — Registration District No. 96
Primary Registration District No. 1004
City of Lewiston (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Fullborn Gustison

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Sept (Month) 10 (Day) 1921 (Year)

7. AGE: ... Yrs. ... Mos. ... ds.
IF LESS than 1 day how many ..... hrs. or 5 min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Ward Gustison

11. BIRTHPLACE OF FATHER (State or Country): Da

12. MAIDEN NAME OF MOTHER: Margaret M. Hutchison

13. BIRTHPLACE OF MOTHER (State or Country): Da

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C W Hutchison
(Address) Bovington, Idaho

15. Filed Sept 11 ~~Oct~~ 6th 1921
Susan E. Bruce
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 10 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 10, 1921, to Sept 10 1921, that I last saw him alive on Sept 10 1921, and that death occurred on the date stated above, at 12 noon M.

The CAUSE OF DEATH* was as follows:
Mother had albuminuria of pregnancy, causing death of child from toxemia of pregnancy, absorption from mother
(Duration) ... yrs. ... mos. ... ds.
Contributory (Secondary)
(Duration) ... yrs. ... mos. ... ds.

(Signed) Paul W Johnson M. D.
9/16 1921 (Address) Lewiston Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston Idaho
DATE OF BURIAL: 9/16 1921

20. UNDERTAKER
ADDRESS: Lewiston Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
OCT 31 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 96

Primary Registration District No. [illegible]

File No. 35645

County of Nezperce

City of Leland. (No. , St.)

Registered No. 705

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Myrtle Evans

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married.

6. DATE OF BIRTH: Dec. 19 1878 (Month) (Day) (Year)

7. AGE: 41 Yrs. 8 Mos. 26 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Dalton Washington

10. NAME OF FATHER: William A. Wright

11. BIRTHPLACE OF FATHER (State or Country): Wisconsin

12. MAIDEN NAME OF MOTHER: Ella Emrick

13. BIRTHPLACE OF MOTHER (State or Country): Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. S. Wright

(Address) Leland Ida

15. Filed Oct. 8 1921 Susan E. Bruce Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. 15 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 1 1917 to Sept. 14 1921 that I last saw h[illegible] alive on Sept. 14 1921 and that death occurred on the date stated above, at 7:20 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar

(Duration) 2 Yrs. mos. ds.

Contributory (Secondary) [illegible]

(Duration) yrs. mos. ds.

(Signed) Glen H. Kelley M. D.

Sept. 15 1921 (Address) Lewiston, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston Idaho. DATE OF BURIAL: 9/16 1921

20. UNDERTAKER: H. P. Merchant ADDRESS: Clarkston Wn.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19. N. of Spalding

RECEIVED OCT 31 1921 DIVISION OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 96

Primary Registration District No. 1009

File No. 35646

Registered No. 706

County of Nez Perce

City of North of Spalding (Limits) (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jerome Cole

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widower

6. DATE OF BIRTH: Sept (Month) 28 (Day) 1853 (Year)

7. AGE: 67 Yrs. 11 Mos. 19 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ill

10. NAME OF FATHER: — Cole

11. BIRTHPLACE OF FATHER (State or Country): Not Known

12. MAIDEN NAME OF MOTHER: Not Known

13. BIRTHPLACE OF MOTHER (State or Country): Not Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Orin A. Reid

(Address) 516 Prospect Hillyard Wn

15.

Filed Oct 8 1921

Susan E. Burns
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 17th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 7 1921, to Sept 14 1921, that I last saw him alive on Sept 14 1921, and that death occurred on the date stated above, at 11:15 P.M.

The CAUSE OF DEATH* was as follows:

Coma

(Duration) 1 Yrs. — mos. 4 ds.

Contributory (Secondary) Injury to Brain

(Duration) ..... yrs. 2 mos. ..... ds.

(Signed) L. J. Perkins M. D.

Sept 19 1921 (Address) Lewiston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston, Idaho

DATE OF BURIAL: Sept 19th 1921

20. UNDERTAKER

ADDRESS: Lewiston Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED OCT 31 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Nez Perce. State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 96.
Primary Registration District No. 1009
File No. 35647
Registered No. 707

County of Nez Perce
City of Lewiston (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James C. Piper

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: S (Write the word.)

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1 (Year)

7. AGE: 27 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Pa.

10. NAME OF FATHER: Thos Piper

11. BIRTHPLACE OF FATHER (State or Country): Pa.

12. MAIDEN NAME OF MOTHER: Hannah J. Johnson

13. BIRTHPLACE OF MOTHER (State or Country): Pa.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Thos Piper
(Address) Spokane, Wash RFD 5

15. Filed Oct 8 1921 Susan E. Bruce Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: September 18th 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 6 1921, to Sept 18 1921, that I last saw him alive on Sept 18 1921, and that death occurred on the date stated above, at 3 P M.
The CAUSE OF DEATH* was as follows:

Appendicitis acute Gangrenous Ruptured.
(Duration) Yrs. ..... mos. 1 ds.
Contributory (Secondary) Peritonitis
(Duration) yrs. ..... mos. 12 ds.

(Signed) E G Braddock M. D.
Sept 19 1921 (Address) Lewiston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Spokane, Wash — DATE OF BURIAL: ..... 19.....

20. UNDERTAKER: PASSAR UNDERTAKING — ADDRESS: Lewiston Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. Cause of death should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED OCT 3 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Broadbeck.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35648

Registered No. 705

1. PLACE OF DEATH

County of Nez Perce Registration District No. 96

City of Lewiston (If outside limits, give township) Primary Registration District No. 1009 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Donald Griesser

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Mar 8 (Month) (Day) 1917 (Year)

7. AGE: 4 Yrs. 6 Mos. 12 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Minor

(b) General nature of industry, business or establishment in which employed (or employer): at Home

9. BIRTHPLACE (State or Country): Genesee Ida

10. NAME OF FATHER: C. Griesser

11. BIRTHPLACE OF FATHER (State or Country): Neb.

12. MAIDEN NAME OF MOTHER: Anna Hasfurther

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ernest Board.

(Address) Lewiston Ida.

15. Filed Oct 8 1921 Susan E. Brun Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept 20 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 21 1921, to Sept 20 1921, that I last saw h~~im~~ alive on Sept. 19 1921, and that death occurred on the date stated above, at 2 A M.

The CAUSE OF DEATH* was as follows:

Acute Appendicitis (Ruptured)

(Duration) ..... Yrs. 1 mos. ..... ds.

Contributory (Secondary) Broncho Pneumonia

(Duration) ..... yrs. ..... mos. 10 ds.

(Signed) E. G. Broadbeck M. D.

Sept 20 1921 (Address) Lewiston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Genesee Ida — DATE OF BURIAL ..... 19.....

20. UNDERTAKER — ADDRESS Lewiston Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED
OCT 21 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 96
Primary Registration District No. 1009
File No. 35649
Registered No. 709

County of Nez Perce
City of Lewiston (No. 12 — Jrs Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Robert W. Harsche

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	Indian	

6. DATE OF BIRTH: June (Month) 5 (Day) 1920 (Year)

7. AGE: 1 Yrs. 3 Mos. 17 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Rud Harsche

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Nancy Eneas

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Rud Harsche
(Address) Pendleton Oregon

15. Filed Oct 4 1921 Vivian E. Bruce Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. (Month) 22 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 20 1921, to Sept 22 1921
that I last saw him alive on Sept 21 1921
and that death occurred on the date stated above, at 2.30 P.M.

The CAUSE OF DEATH* was as follows:
Anterior Poliomyelitis Acute

(Duration) ..... Yrs. ..... mos. 7 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E G Braddock M. D.
Sept 22 1921 (Address) Lewiston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston, Idaho
DATE OF BURIAL: 9/22 1921

20. UNDERTAKER: [illegible]
ADDRESS: Lewiston Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED OCT 31 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Nez Perce — Registration District No. 96

City of Lewiston — Primary Registration District No. 1089 (Potlatch Creek Near Potlatch Forks St.)

File No. 35650

Registered No. 710

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Thomas Shea

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Not Known (Write the word.)

6. DATE OF BIRTH: — (Month) — (Day) 1 (Year)

7. AGE: 57 Yrs. — Mos. — ds. — IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Umbrella Mender
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: not Known

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W B Williamson Coroner
(Address) Lewiston Idaho

15. Filed Oct-8 1921 Susan E. Bruce Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept- (Month) 23 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....19...., to ....19....
that I last saw h.... alive on ....19....,
and that death occurred on the date stated above, at about 9 A.M.
The CAUSE OF DEATH* was as follows:
Natural Causes as near as Could be Determined

....(Duration) ....Yrs....mos....ds.
Contributory (Secondary)
....(Duration) ....yrs....mos....ds.

(Signed) W B Williamson Coroner M.D.
....19.... (Address) Lewiston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston Ida — DATE OF BURIAL: 9/24/1921

20. UNDERTAKER: Vassar's Und Co — ADDRESS: Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED
OCT 31 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Schoff.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96

Primary Registration District No. 1009

File No. 35651

Registered No. 711

1. PLACE OF DEATH

County of Nez Perce

City of Lewiston (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Eugenia Schleicher

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female

4. COLOR OR RACE White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.) Married

6. DATE OF BIRTH Dec (Month) 4 (Day) 1855 (Year)

7. AGE 65 Yrs. 9 Mos. 23 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Mass.

10. NAME OF FATHER Dennis Poulain

11. BIRTHPLACE OF FATHER (State or Country) France

12. MAIDEN NAME OF MOTHER Agustine

13. BIRTHPLACE OF MOTHER (State or Country) France

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ella Brown.

(Address) Lewiston Ida

15.

Filed Oct 8 1921 Susan E Brown Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 27 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1 1921 to Sept 27 1921 that I last saw h in alive on Sept 27 1921, and that death occurred on the date stated above, at 4.30 P.M.

The CAUSE OF DEATH* was as follows: Cancer of bladder

..... (Duration) 2 Yrs. 8 mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C W Strahl M. D.

9-29-1921 (Address) Lewiston

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Lewiston Ida

DATE OF BURIAL 9/29 1921

20. UNDERTAKER Vassar Und. Co.

ADDRESS Lewiston

3 from Sunset,

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
OCT 31 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 95
Primary Registration District No. 1009
File No. 35652
Registered No. 712

1. PLACE OF DEATH
County of Nezperce
City of Lewiston Orchard (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ed Madding

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Jan (Month) 1 (Day) 1867 (Year) 1867

7. AGE: 54 Yrs. 9 Mos. 21 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Stockman
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Texas

10. NAME OF FATHER: Wm Madding.

11. BIRTHPLACE OF FATHER (State or Country): Arkansas

12. MAIDEN NAME OF MOTHER: Alice Kelley

13. BIRTHPLACE OF MOTHER (State or Country): Arkansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Ed Madding
(Address) Lewiston Ida.

15. Filed Oct 8 1921 Susan E Bruce Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 30 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 25, 1921 to Sept 30 1921, that I last saw him alive on Sept 30 1921, and that death occurred on the date stated above, at 6A M.
The CAUSE OF DEATH* was as follows:
Lobar pneumonia
(Duration) ..... Yrs. ..... mos. 6 ds.
Contributory (Secondary) —
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Paul W Johnson M. D.
9/30 1921 (Address) Clarkston Wash

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Clarkston Wash DATE OF BURIAL 10/3 1921

20. UNDERTAKER: A R Merchant ADDRESS Clarkston

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 27
Primary Registration District No. 2069
File No. 3053
Registered No. 31

1. PLACE OF DEATH
County of Oneida
City of Malad
(No. ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Julia Maud Palmer
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married
6. DATE OF BIRTH: Feb. 29 1892 (Month) (Day) (Year)
7. AGE: 29 Yrs. 6 Mos. 16 ds.
IF LESS than 1 day how many ... hrs. or ... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Kaysville Utah
10. NAME OF FATHER: James G Jardine
11. BIRTHPLACE OF FATHER (State or Country): Pennsylvania
12. MAIDEN NAME OF MOTHER: Eliza Rushforth
13. BIRTHPLACE OF MOTHER (State or Country): Kaysville Ut.
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. G. Palmer
(Address)
15. Filed Oct 3 1921 R T Mauer M D
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. 15 1921 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from Sept 8 1921, to Sept 15 1921
that I last saw h... alive on Sept 15 1921
and that death occurred on the date stated above, at 3 9 M.
The CAUSE OF DEATH* was as follows:
Peritonitis (following child birth)
(Duration) ... Yrs. ... mos. 16 ds.
Contributory (Secondary)
(Duration) ... yrs. ... mos. ... ds.
(Signed) R T Mauer M. D.
Sept 15 1921 (Address) Malad Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Malad Ida — DATE OF BURIAL: 9-18 1921
20. UNDERTAKER: D. E. Johnson — ADDRESS: Malad

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

R. T. MAUER, M. D.

MALAD, IDAHO

For .....

℞ Address .....

Dr. J. M Kerns Malad Idaho attended Mrs. Palmer when her baby was born — but have been unable to get a birth certificate from him for the baby — Wish you would write him

Full Name. Dr. R T Mauer

Address .....

Reg. No. ..... Date .....

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35654

RECEIVED
OCT 3
BUREAU OF STATISTICS

Registration District No. .....
Primary Registration District No. Burst
Registered No. 32

1. PLACE OF DEATH
County of Oneida
City of ..... (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Alice Irene Higginson
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (or Widowed)

6. DATE OF BIRTH: Oct (Month) 20 (Day) 1897 (Year)

7. AGE: 23 Yrs. 10 Mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Salt Lake City Ut.

10. NAME OF FATHER: John W Welland

11. BIRTHPLACE OF FATHER (State or Country): Salt Lake City Ut.

12. MAIDEN NAME OF MOTHER: Anna Evans

13. BIRTHPLACE OF MOTHER (State or Country): Salt Lake City Ut.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John W Welland
(Address) Salt Lake City Utah

15. Filed Oct 3 1921
R T Mauer M.D.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 15 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 15 1921
that I last saw her alive on Sept 15 1921
and that death occurred on the date stated above, at 12:30 P.M.
The CAUSE OF DEATH* was as follows:

Pneumonia

..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J F Alston M. D.
8-16 1921 (Address) Malad Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Salt Lake City Ut. — DATE OF BURIAL: 9-18 1921

20. UNDERTAKER: W. C. Johnson — ADDRESS: Malad

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

RECEIVED OCT 31 1921 BUREAU OF VITAL STATISTICS

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 26
Primary Registration District No. 2069
File No. 35655
Registered No. D 30

1. PLACE OF DEATH

County of Oneida
City of Malad (or Village, or Township, or Precinct, or St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sarah James Jones

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Widowed

6. DATE OF BIRTH April 19 1840
(Month) (Day) (Year)

7. AGE 81 Yrs. 4 Mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Wales.

10. NAME OF FATHER David Jones.

11. BIRTHPLACE OF FATHER (State or Country) Wales.

12. MAIDEN NAME OF MOTHER Catherine Bowen

13. BIRTHPLACE OF MOTHER (State or Country) Wales

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Esther Griffiths
(Address) Malad Ida.

15. Filed Oct 3 1921 R. M. Mauer Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. 4 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 28 1921, to Sept 4 1921, that I last saw her alive on Sept 3 1921, and that death occurred on the date stated above, at 3.45 P.M.

The CAUSE OF DEATH* was as follows:

Apoplexy

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [signature] M. D.

Sept. 19 (Address) Malad

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Cherry Creek, Idaho	Sept 7 1921

20. UNDERTAKER	ADDRESS
John M. Richards	Logan Utah

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
OCT 31 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 74
Primary Registration District No. 2151

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35656
Registered No. 2

1. PLACE OF DEATH

County of Owyhee
City of Castle Creek (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Martha Washington Foreman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female

4. COLOR OR RACE White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED Widowed (Write the word.)

6. DATE OF BIRTH December 7 1841 (Month) (Day) (Year)

7. AGE 79 Yrs. 9 Mos. 16 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.? ✓

8. OCCUPATION

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country) Indiana

10. NAME OF FATHER Wm. E. Soey

11. BIRTHPLACE OF FATHER (State or Country) Pennsylvania

12. MAIDEN NAME OF MOTHER Martha Reinhart

13. BIRTHPLACE OF MOTHER (State or Country) Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Thomas Foreman

(Address) Castle Creek

15. Filed Oct. 10 1921 W J Eckenbeck Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH September 23 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased ~~from~~ Sept. 17 1921, to day only 1921 that I last saw h.er alive on September 7 1921, and that death occurred on the date stated above, at 1 A.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
Left side

..... (Duration) ..... Yrs. ..... mos. 6 ds.

Contributory (Secondary) old age

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. J. Eckenbeck M. D.

1921 (Address) Grand View

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL ~~OR REMOVAL~~ Oreana, Idaho — **DATE OF BURIAL** Sept. 24 1921

20. UNDERTAKER ✓ — **ADDRESS** ✓

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

35658 State of Idaho

BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED OCT 31 1921 BUREAU OF VITAL STATISTICS

Registration District No. 26

Primary Registration District No. 20-2

File No. 3

Registered No. 135

1. PLACE OF DEATH.

County of Power

City of American Falls (No. Id ho St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Samuel Henry Stitt

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH.

April (Month) 15 (Day) 1861 (Year)

7. AGE

60 Yrs. 6 Mos. 22 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... None

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Ohio

10. NAME OF FATHER Samuel Stitt

11. BIRTHPLACE OF FATHER (State or Country) Penn

12. MAIDEN NAME OF MOTHER Elizibith Linsy

13. BIRTHPLACE OF MOTHER (State or Country) Not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Samuel C. Stitt

(Address) American Falls, Idaho

15.

Filed ..... 191.....

Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct (Month) 8 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191.... to ..... 191...., that I last saw him only alive on ..... 191...., and that death occured on the date stated above, at ..... M.

Saw person after death

The CAUSE OF DEATH* was as follows:

Intestinal Tuberculosis

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) W. G. Logan M. D.

9-9 1921 (Address) American Falls Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
American Falls	Sept. 29 1921
20. UNDERTAKER	ADDRESS
Arthur [illegible]	Am. Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

Write Plainly with Unfading Ink—This is a permanent record
Read Explanations on back carefully

A DEATH CERTIFICATE MUST BE FILED BEFORE BURIAL OR REMOVAL

1. PLACE OF DEATH

STATE OF IDAHO — DIVISION OF PUBLIC HEALTH

CERTIFICATE OF DEATH

Registered No. 3638

County of Power — Registration Dist. No. 25
City of American Falls — Primary Reg. Dist. No. 2072
(Home, Hospital or Institution) — Local Registrar's No. 135

If death occurred in hospital or institution give its name instead of street and number.

Length of residence in County where death occurred	Yrs.	Mos.	Days

How long in U. S. if of foreign birth?	Yrs.	Mos.	Days

2. FULL NAME Samuel Henry Stitt

(a) Residence: ____ (If non-resident give city or county and state)

PERSONAL AND STATISTICAL PARTICULARS

3. MALE FEMALE	4. White, Black, Yellow, Red	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced Husband of (or) Wife of Stella Young Stitt

6. Date of Birth (Month, day and year) April 15, 1861

7. AGE	Years	Months	Days	If less than 1 day
	60	6	22	hrs. ____ min. ____

Occupation

8. Trade, profession, or particular kind of work done: None

9. Industry or business in which work was done

10. Date deceased last worked at this occupation (month and year)

11. Total time (yrs.) spent in this occupation

12. BIRTHPLACE (City or Town, County and State, or Country): Ohio

Father

13. NAME Samuel Stitt

14. BIRTHPLACE (City or Town, County and State, or Country): Penn

Mother

15. MAIDEN NAME Elizibith Linsy

16. BIRTHPLACE (City or Town, County and State, or Country): not known

17. SIGNATURE OF INFORMANT Samuel C. Stitt

(Address) American Falls

18. BURIAL, CREMATION OR REMOVAL

Place American Falls Date Sept. 9 1921

19. UNDERTAKER Arthur Davis

(Address) American Falls, Idaho

20. FILED AND BURIAL OR REMOVAL PERMIT ISSUED

on October 31, 1921 (Date) 193 by ____ Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day and year) September 8, 1921

22. I HEREBY CERTIFY, That I attended deceased from Saw him after death only 19__, to 19__

I last saw h__ alive on ____ 19__ Death is said to have occurred on the date stated above, at ____ m.

The principal cause of death and related causes of importance in order of onset were as follows:

	Date of Onset Yr	Mo	Day
Contributory causes of importance not related to principal causes			

Where was disease first diagnosed? ____

Name of operation ____ date of ____

Condition for which performed ____

What test confirmed diagnosis? ____

Was there an autopsy? ____ Was there an inquest? ____

23. If death was due to external causes, fill in also the following:

(Check) Accident—Suicide—Homicide? Date of injury ____, 19__ Where did injury occur? ____ (Specify city or town, county and state)

Check whether injury occurred in industry__ home__ public place__

Manner of injury ____

Nature of injury ____

24. Was disease or injury in any way related to occupation of deceased? ____ If so, specify ____

(SIGNED) W. G. Logan M. D.

(Address) American Falls

STATE OF IDAHO)
COUNTY OF POWER) SS

A F F I D A V I T

I, V. G. Logan, M. D., being first duly sworn, on my oath state:

That I am the identical person who as physician and surgeon signed the Certificate of Death of Samuel Henry Stitt, who died on September 8, 1921, according to said Death Certificate;

That I was called in to make a Death Certificate to permit burial after the death of said Samuel Henry Stitt, and that, in making out said Certificate, I was guided by hearsay as to the cause of death; that I had never treated deceased for Intestinal Tuberculosis prior to his death, and had no reason for so stating said cause in said Certificate except upon hearsay and through misunderstanding of the facts concerning Mr. Stitt's death; I have never observed or treated any member of Mr. Stitt's family, including Mr. Stitt himself, for any ailment, sickness, disease, injury or other indisposition of any kind or character.

This statement is made for use in connection with the application of Henry Geroge Stitt for life insurance, and is made in order to prevent any unjust discrimination against said Henry George Stitt in the securing of such insurance by reason of said Certificate of Death first above mentioned.

V. G. Logan

Subscribed and sworn to before me this 7th day of June 1941.

(SEAL)

W. C. Loofbourrow
Notary Public

Residing at American Falls, Idaho.
My commission expires Dec. 8, 1941.

July 15, 1940

Henry George Stitt
c/o Mt. States Tel. Co.
Pocatello, Idaho

Dear Sir:

In checking our old file we find we have an incomplete correction of a certificate pertaining to the death of your father, Samuel Henry Stitt.

Doctor Logan filled out a new death certificate and also enclosed an affidavit of correction. However, since this affidavit was not properly stated, a new affidavit was sent to him but to date we have heard nothing from him.

Would it be possible for you to contact Doctor Logan and have him complete this affidavit in order that your father's death certificate may be properly corrected?

We are holding stamps in the amount of fifty cents for the certified copy.

Yours very truly

BUREAU OF VITAL STATISTICS

Mae G. Atwood, State Registrar

MGA/mp

September 28, 1939

V. G. Logan, M. D.
American Falls, Idaho

Dear Doctor Logan:

We are writing you relative to the correction of the cause of death of Samuel Henry Stitt, who died on September 8th, 1921.

The Attorney General's office has ruled that the only way to handle this case is to attach an affidavit of correction to the original certificate of death as filed by you and then issue a copy of the affidavit with the certified copy of the original death record.

We are enclosing an affidavit prepared by the office of the Attorney General to be signed by you in triplicate before a notary and returned to this office.

Very truly yours,

DIVISION OF PUBLIC HEALTH

Mae G. Atwood, Registrar
of Vital Statistics

MGA:c
Encl. 3

Mrs. Atwood Bureau of Vital Statistics

AFFIDAVIT

STATE OF IDAHO,)
COUNTY OF POWER.) ss.

I, V.G.Logan, M.D., being first duly sworn, on my oath state:

That I am the ~~same individual~~ identical person as physician & surgeon who signed the Certificate of Death of Samuel Henry Stitt, who died on September 8th, 1921, according to said Death Certificate;

That I was called in to make a Death Certificate to permit burial after the death of said Samuel Henry Stitt, and that, in making out said Certificate, I was guided by hearsay as to the cause of death; that I had never treated deceased for Intestinal Tuberculosis prior to his death, and had no reason for so stating said cause in said Certificate ~~unless by~~ except hearsay and through misunderstanding of the facts concerning Mr. Stitt's death; I have not ~~now, nor did I have at said last named date, ever~~ since observed or treated any member of Mr. Stitt's family, including Mr. Stitt himself, for ~~Intestinal Tuberculosis.~~ ailment, sickness, disease, injury or other disposition

This statement is made for use in connection with the application of Henry George Stitt for life insurance, and is made in order to prevent any unjust discrimination against said Henry George Stitt in the securing of such insurance by reason of said Certificate of Death first above mentioned.

_____

Subscribed and sworn to before me this 14th day of July, 1938.

_____
Notary Public,

AFFIDAVIT

STATE OF IDAHO,)
COUNTY OF POWER.) ss.

I, V.G.Logan, M.D., being first duly sworn, on my oath state:

That I am the same individual who signed the Certificate of Death of Samuel Henry Stitt, who died on September 8th, 1921, according to said Death Certificate;

That I was called in to make a Death Certificate to permit burial after the death of said Samuel Henry Stitt, and that in making out said Certificate, Iwas guided by hearsay as to the cause of death; that I had never treated deceased for Intestinal Tuberculosis prior to his death, and had no reason for so stating said cause in said Certificate unless by hearsay and through misunderstanding of the facts concerning Mr. Stitt's death; I have not now, nor did I have at said last named date, ever observed or treated any member of Mr. Stitt's family, including Mr. Stitt himself, for Intestinal Tuberculosis.

This statement is made for use in connection with the application of Henry George Stitt for life insurance, and is made in order to prevent any unjust discrimination against said Henry George Stitt in the securing of such insurance by reason of said Certificate of Death first above mentioned.

V. G. Logan M.D.

Subscribed and sworn to before me this 14th day of July, 1938.

Notary Public,

RESIDING AT AMERICAN FALLS, IDAHO
MY COMMISSION EXPIRES OCTOBER 22, 1939

May 27, 1939

Henry George Stitt
c/o Mt. States Telephone Co.
Pocatello, Idaho

Dear Sir:

Regarding the correction of the cause of death on the death certificate of your father, Samuel Henry Stitt, we have concluded it might be better for Dr. Logan to fill out and sign a new death certificate.

We are enclosing a blank form partially filled out but have not filled in any of the blanks of the medical certificate. If you will have Dr. Logan fill this in and sign and return to this office, we will attach the corrected copy to the old one and issue a new certified copy from the corrected certificate.

Also it might be advisable to fill in the name of the deceased's wife.

Very truly yours,

DIVISION OF PUBLIC HEALTH

Mae G. Atwood, Registrar
of Vital Statistics

c

C. A. BOTTOLFSEN, GOVERNOR
EMORY AFTON, COMMISSIONER
DEPARTMENT OF PUBLIC WELFARE
H. L. McMARTIN, M. D., DIRECTOR
DIVISION OF PUBLIC HEALTH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
DIVISION OF PUBLIC HEALTH
BOISE

BOARD OF PUBLIC WELFARE
FRANK ENSIGN, BOISE
T. S. KERR, MOSCOW
I. E. ROCKWELL, BELLEVUE
L. O. NICHOLS, BOISE
FRANK ATKINS, BUHL

May 27, 1939

Henry George Stitt
c/o Mt. States Telephone Co.
Pocatello, Idaho

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Regarding the correction of the cause of death on the death certificate of your father, Samuel Henry Stitt, we have concluded it might be better for Dr. Logan to fill out and sign a new death certificate.

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Also it might be advisable to fill in the name of the deceased's wife.

Very truly yours,

DIVISION OF PUBLIC HEALTH

Mae G. Atwood

Mae G. Atwood, Registrar
of Vital Statistics

c

FORM V. S. No. 5-25, M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 29 — 35659

Primary Registration District No. 2072

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 3

Registered No. 134

1. PLACE OF DEATH.

County of Cowr

City of American Falls, (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Winnie Warnas.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH. Aug. 20. (Month) (Day) 1873 (Year)

7. AGE: 48 Yrs. 12 Mos. ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... House wife

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Chicago Ills.

10. NAME OF FATHER Jno Miller

11. BIRTHPLACE OF FATHER (State or Country) Germany.

12. MAIDEN NAME OF MOTHER Wilhemina Stahn

13. BIRTHPLACE OF MOTHER (State or Country) Germany.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Richard Warnas

(Address) American Falls Ida

15. Filed 10 — 8 — 1921 R. J. Roth Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept 4 (Month) / (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 15 1921, to Sept 4 1921, that I last saw her alive on Sept 4 1921 and that death occured on the date stated above, at 1.15 P M.

The CAUSE OF DEATH* was as follows:

Acute dilatation of heart

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Pleuro-pneumonia

(Duration 1 yrs. 1 mos. X ds.

(Signed) C. F. Hewitt M. D.

9/5 1921 (Address) Amer. Falls Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Chicago Ills. DATE OF BURIAL: 191

20. UNDERTAKER: A W Davis ADDRESS: Am Falls.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35660
Registered No. 2

1. PLACE OF DEATH.
County of Ada
City of Boise
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 9 or 10 ch
Primary Registration District No.
(No. ..... St.)

2. FULL NAME Lottie Ann Birch

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fm
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH: Sept 16 1921 (Month) (Day) (Year)

7. AGE: ..... yrs. ..... mos. 13 ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *mins.*

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ada Co Idaho

10. NAME OF FATHER: Fred William Birch

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Hazel Otte Hagle

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Fred William Birch
(Address) Middleton Ida RFD 1

15. Filed Oct 4 1921 Dorcas Tyson Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: October 8 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 16 1921, to Oct 4 1921, that I last saw her alive on Oct 4 1921 and that death occurred on the date stated above, at 8:15 A.M.

The CAUSE OF DEATH* was as follows:
Malignant Tumor

(Duration) ..... yrs. ..... mos. 13 ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E W Hall M. D.
Oct 5 1921 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Star — DATE OF BURIAL: ..... 191...

20. UNDERTAKER: None — ADDRESS:

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35661

Registered No. 64

RECEIVED
OCT 3 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Shoshone Registration District No. 70

City of Wallace Primary Registration District No. 1011

If death occurs away from usual residence, give facts called for under special information.

No. Grandview Hospital (If not in hospital or institution, give street)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Alvita Lundgren

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: single (Write the word.)

6. DATE OF BIRTH: ..... (Month) 1 (Day) ..... (Year)

7. AGE: 20 Yrs. — Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Chief Operator telephone

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Charles Lundgren

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Mary Lang

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Thos. Guerd

(Address) Wallace

15. Filed Sept 7 1921 F L Jones Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH [redacted] Sept 4 1921 (Month) (Day) (Year)

17. I ~~HEREBY~~ CERTIFY, That I attended deceased from September 1921, to Sept 4 1921, that I last saw her alive on Sept 4 1921 and that death occurred on the date stated above, at 9:30 P.M.

The ~~CAUSE OF DEATH~~* was as follows: Acute Dilatation of Heart

..... (Duration) ..... yrs. ..... mos. 2 ds.

Contributory (Secondary) Abortion

..... (Duration) ..... yrs. ..... mos. 9 ds.

(Signed) D Mowery M.D.

9/4 1921 (Address) Wallace Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence Wallace Ida

19. PLACE OF BURIAL OR REMOVAL: Wallace Ida — DATE OF BURIAL: Sept 7 1921

20. UNDERTAKER: Ward Mud Co — ADDRESS: Wallace Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. **PLACE OF DEATH**

Registration District No. 70

County of Shoshone

Primary Registration District No. 104

File No. 35662

City of Wallace No. (If outside city limits) Residence Hospital St.

Registered No. 66

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
OCT 31 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME Alexander Wm. McRae

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	white	single

6. DATE OF BIRTH ..... (Month) ..... (Day) ..... 1 ..... (Year)

7. AGE 15 Yrs. — Mos. — ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Student
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Mullan Idaho

10. NAME OF FATHER A. P. McRae

11. BIRTHPLACE OF FATHER (State or Country) Canada

12. MAIDEN NAME OF MOTHER Hattie Carmody

13. BIRTHPLACE OF MOTHER (State or Country) California

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. A. P. McRae
(Address) Mullan Ida

15. Filed Sept 8 1921 F L Jones Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 5 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 5 1921 to Sept 5 1921 that I last saw h~~im~~ alive on Sept 5 1921 and that death occurred on the date stated above, at 1:30 P.M.

The CAUSE OF DEATH* was as follows:

Irregular case of
Pneumonia
(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) D. Mowery M. D.
9/6 1921 (Address) Wallace Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence Mullan Ida

19. PLACE OF BURIAL OR REMOVAL Wallace Ida — DATE OF BURIAL Sept 8 1921

20. UNDERTAKER Hand Mort Co — ADDRESS Wallace Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

35663

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 66
Registered No. ....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

RECEIVED
OCT 31 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Shoshone
City of Wallace
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 70
Primary Registration District No. 104
No. High St. Wallace St.

2. FULL NAME Ebba Lucille Swanson

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Aug (Month) 19 (Day) 1906 (Year)

7. AGE: 15 Yrs. 0 Mos. 18 ds.
IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: P. O. Swanson

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Ida Danielson

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) B. Worstall
(Address)

15. Filed Sept 11 191.... F. L. Jumper Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 7 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 15 1921 to Sept 7 1921 that I last saw h.. alive on Sept 7 1921 and that death occurred on the date stated above, at 10a M.

The CAUSE OF DEATH* was as follows:
Mitral regurgitation
Aortic stenosis
(Duration) .... Yrs. .... mos. .... ds.
Contributory (Secondary) Rheumatism
(Duration) .... Yrs. .... mos. .... ds.

(Signed) D. Mowery M. D.
9/9 1921 (Address) Wallace Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days, In the ,State....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Wallace Id
DATE OF BURIAL: Sept 11 1921

20. UNDERTAKER: B. Worstall
ADDRESS: Wallace

FORM V. S. No. 5-12 M. 6-15-17.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED OCT 31 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35664
Registered No. 6

1. PLACE OF DEATH
County of Shoshone Registration District No. 70
City of Wallace Primary Registration District No. 164
If death occurs away from usual residence, give facts called for under special information. (No. ... Hospital St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Leo M. Noonan

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married
6. DATE OF BIRTH. March 1st 1889 (Month) (Day) (Year)
7. AGE: 32 Yrs. 6 Mos. 12 ds. IF LESS than 1 day how many .... hrs. or .... min.?
8. OCCUPATION (a) Trade, profession or particular kind of work: Auto Driver (b) General nature of industry, business, or establishment in which employed (or employer)
9. BIRTHPLACE (State or Country): Iowa
10. NAME OF FATHER: Peter Noonan
11. BIRTHPLACE OF FATHER (State or Country): Iowa
12. MAIDEN NAME OF MOTHER: Mary —
13. BIRTHPLACE OF MOTHER (State or Country): not known
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Mrs. Leo Noonan (Address) Wallace
15. Filed Sept 15 1921 F. L. Junker Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 12 1921 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from Sept 8 1921 to Sept 12 1921 that I last saw h.. alive on Sept 12 1921 and that death occurred on the date stated above, at 6:30 P. M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) Yrs. mos. ds.

Contributory (Secondary) Alcoholism

(Duration) 2 Yrs. mos. ds.

(Signed) D. S. Mowry M. D.

9/14 1921 (Address) Wallace Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs.....mos....days. In the ,State....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Wallace Ida — DATE OF BURIAL: Sept. 15. 1921

20. UNDERTAKER: B. L. Worstell — ADDRESS: Wallace

FORM V. S. No. 5-25 M. 1-19.

RECEIVED OCT 5 1921 BUREAU OF VITAL STATISTICS STATE OF IDAHO

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 16
Primary Registration District No. 1011
File No. 35665
Registered No. 68

County of Shoshone
City of Wallace
No. 5 Providence Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Arnold Lofgren

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): single

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1 (Year)

7. AGE: 53 Yrs. ... Mos. ... ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: miner
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER: not given

11. BIRTHPLACE OF FATHER (State or Country): not given

12. MAIDEN NAME OF MOTHER: not given

13. BIRTHPLACE OF MOTHER (State or Country): not given

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jack Duncan
(Address) Wallace Ida

15. Filed Sept 15 1921 F L Jung Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. 8th 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1 1921 to Sept 8 1921
that I last saw h[illegible] alive on Sept 8 1921
and that death occurred on the date stated above, at 6 P. M.
The CAUSE OF DEATH* was as follows:
Cellmonary Tubercolosis
(Duration) 2 Yrs. ... mos. ... ds.
Contributory (Secondary)
(Duration) ... Yrs. ... mos. ... ds.
(Signed) D O'Mowery M. D.
9/15 1921 (Address) Wallace Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence Burke Idaho

19. PLACE OF BURIAL OR REMOVAL: Wallace Ida — DATE OF BURIAL: Sept 13 1921

20. UNDERTAKER: Ward Und Co — ADDRESS: Wallace Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35666
Registered No. 69

1. PLACE OF DEATH

County of Shoshone Registration District No. 70

City of Genus Primary Registration District No. 1011

(No. Genus Idaho St.)

If death occurs away from usual residence, give facts called for under special information.

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OCT 31 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME Marie Torkelson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: widowed (Write the word.)

6. DATE OF BIRTH: ..... 1.....
(Month) (Day) (Year)

7. AGE: 64 Yrs. — Mos. — ds.

IF LESS than 1 day how many..... hrs. or.....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE
(State or Country) Norway

10. NAME OF FATHER: not known

11. BIRTHPLACE OF FATHER
(State or Country) Norway

12. MAIDEN NAME OF MOTHER: not known

13. BIRTHPLACE OF MOTHER
(State or Country) Norway.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Charles Torkelson
(Address) Genus Ida

15. Filed Sept 18 1921 F L Lundin
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. 15th 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 10 1921 to Sept 15 1921 that I last saw h[illegible] alive on Sept 10 1921 and that death occurred on the date stated above, at .....M.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

.....(Duration) .....Yrs.....mos.....ds.

Contributory (Secondary) .....

.....(Duration) .....yrs.....mos.....ds.

(Signed) Dr. Maury M. D.

9/15 1921 (Address) Wallace Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence Genus Idaho

19. PLACE OF BURIAL OR REMOVAL: Wallace Idaho — DATE OF BURIAL: Sept 18 1921

20. UNDERTAKER: Hand Mortuary Co — ADDRESS: Wallace Ida

FOR BINDING — THIS IS A PERMANENT RECORD
...NG INK — ...be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35667
Registered No. 90

1. PLACE OF DEATH

County of Shoshone Registration District No. 70

City of Burke (No.) Hecla Mine St.) Primary Registration District No. 10 C1

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
OCT 31 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME William Finley

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	white	single

6. DATE OF BIRTH ..... 1 .....
(Month) (Day) (Year)

7. AGE 23 Yrs. — Mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Fireman
(b) General nature of industry, business or establishment in which employed (or employer) Hecla Mill

9. BIRTHPLACE (State or Country) Boston

10. NAME OF FATHER J. J. Finley

11. BIRTHPLACE OF FATHER (State or Country) New Foundland

12. MAIDEN NAME OF MOTHER Charlotte McClane

13. BIRTHPLACE OF MOTHER (State or Country) New Foundland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. J. Finley
(Address) Burke Idaho

15. Filed Sept 24 19.... F. L. Jones Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 23 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Struck by Cage Cable broke Fracture Vertebral
(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas. P. Mor[illegible] M. D.
9/23 1921 (Address) Wallace Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence Burke Idaho

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Wallace Idaho	Sept 24 1921

20. UNDERTAKER	ADDRESS
Ward Und Co	Wallace Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35668

Registered No. 27

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Shoshone

City of Wallace

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
OCT 31 1921
BUREAU OF VITAL STATISTICS

Registration District No. 10

Primary Registration District No. 10 11

422 High St.

2. FULL NAME Mary E Hayes

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: Negro

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widowed

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1 (Year)

7. AGE: 70 Yrs. — Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: At Home.

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Arkansas.

10. NAME OF FATHER: Leand Greer.

11. BIRTHPLACE OF FATHER (State or Country): Arkansas

12. MAIDEN NAME OF MOTHER: not Known

13. BIRTHPLACE OF MOTHER (State or Country): Arkansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Rose Fletcher

(Address) Wallace Ida

15. Filed Oct 28 1921 F. L Jeuter Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51068

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 25 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from August 1921, to Sept 25 1921, that I last saw h[illegible] alive on Sept 25 1921, and that death occurred on the date stated above, at 3 30 P.M.

The CAUSE OF DEATH* was as follows:

Tuberculosis Lungs

5

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) D. Mowery M. D.

9/27 1921 (Address) Wallace Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence 422 High St. Wallace Ida

19. PLACE OF BURIAL OR REMOVAL: Wallace Ida — DATE OF BURIAL: Sept 28 1921

20. UNDERTAKER: Ward Hurd Co — ADDRESS: Wallace Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

RECEIVED OCT 31 1921 BUREAU OF STATISTICS

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35669
Registered No. .....

1. PLACE OF DEATH
County of Shoshone Registration District No. 20
City of Wallace Primary Registration District No. 106
If death occurs away from usual residence, give facts called for under special information. (Name of Hospital or Institution) Wallace Hospital St.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary Elaine Hamlin

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH. July (Month) 20 (Day) 1919 (Year)
7. AGE: 2 Yrs. 2 Mos. 6 ds. IF LESS than 1 day how many .... hrs. or .... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer)
9. BIRTHPLACE (State or Country) Oklahoma
10. NAME OF FATHER W. Hamlin
11. BIRTHPLACE OF FATHER (State or Country) Missouri
12. MAIDEN NAME OF MOTHER Elora Hahn
13. BIRTHPLACE OF MOTHER (State or Country) Missouri
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. Hamlin
(Address) Burke Ida.
15. Filed Oct 28 1921 F L Jenkins Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 26 (Day) 1921 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Sept 8 1921 to Sept 26 1921 that I last saw h[illegible] alive on Sept 26 1921 and that death occurred on the date stated above, at 12:30 P.M.
The CAUSE OF DEATH* was as follows:
Ac Poliomyelitis
(Duration) ..... Yrs. ..... mos. 14 ds.
Contributory (Secondary)
(Duration) ..... Yrs. ..... mos. ..... ds.
(Signed) [illegible] M. D.
19.... (Address) Wallace Ida.
*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days, In the State....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Wallace Ida — DATE OF BURIAL: Sept 28 1921
20. UNDERTAKER: B G Moretall — ADDRESS: Wallace

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

RECEIVED OCT 31 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 70

County of Shoshone — Idaho Registration District No. 104

File No. 35670

City of Wallace (No. Wallace Hospital St.)

Registered No. 58

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Jane Bailey

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F.	white	single

6. DATE OF BIRTH ..... 1 .....
(Month) (Day) (Year)

7. AGE 1 Yrs. 5 Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Spokane Wash.

10. NAME OF FATHER Curtis Bailey

11. BIRTHPLACE OF FATHER (State or Country) Missouri

12. MAIDEN NAME OF MOTHER Dorothy Roberts

13. BIRTHPLACE OF MOTHER (State or Country) Montana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Curtis Bailey

(Address) Grace Idaho

15. Filed Aug 2 1921 F L Deuel Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 31 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 7/31/21 19.. to 7/31/21 19..
that I last saw h.. alive on 7/31/21 19..
and that death occurred on the date stated above, at 9:45 P. M.
The CAUSE OF DEATH* was as follows:

Coma Pneumonia

(Duration) ..... Yrs. ..... mos. 4 ds. 5

Contributory (Secondary) Nephritis Chronic

(Duration) ..... yrs. 1 mos. ..... ds.

(Signed) Edward G. Stern M. D.

19.. (Address) Wallace Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence Spokane Wash

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Wallace Ida	Aug 2 1921

20. UNDERTAKER	ADDRESS
Ward Mud Co	Wallace Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-12 M. 6-15-17.

RECEIVED
OCT 31 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35571
Registered No. 59

1. PLACE OF DEATH
County of Shoshone Registration District No. 70
City of Wallace Primary Registration District No. 1011
If death occurs away from usual residence, give facts called for under special information. (St.) St.)
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Edna A. Piper

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Sept (Month) 30 (Day) 1 (Year)

7. AGE: 22 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many .... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Clerk
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ark.

10. NAME OF FATHER: David H Piper

11. BIRTHPLACE OF FATHER (State or Country): Penn

12. MAIDEN NAME OF MOTHER: Orpha Keller

13. BIRTHPLACE OF MOTHER (State or Country): Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Philip E. Piper
(Address) Gem Idaho % F.L.D.M.Co.

15. Filed Aug 7 1921 F L Jenkins Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 2 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 1 1921 to Aug 2 1921
that I last saw her alive on Aug 2 1921
and that death occurred on the date stated above at 9:25 P. M.
The CAUSE OF DEATH was as follows: Acute Myocarditis
(Duration) 1 Days mos. ds.
Contributory (Secondary) Tonsilitis
(Duration) Days mos. ds.
(Signed) Dan Howard M.D.
8/3 1921 (Address) Wallace Ida
State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Wallace Ida — DATE OF BURIAL: Aug. 7 - 1921

20. UNDERTAKER: E. L. Wortell — ADDRESS: Wallace

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

Form V. S. No. 5. 12½M.7-24-11 RECEIVED OCT 31 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35672
Registered No. 60

1. PLACE OF DEATH. Registration District No. 70
County of Shoshone Primary Registration District No. 1011
City of Burke (No. Burke Idaho St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Petra Dahl

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1 (Year)

7. AGE: 71 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Stone
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Norway

10. NAME OF FATHER: Christian Pedersen Grepperud

11. BIRTHPLACE OF FATHER (State or Country): Norway

12. MAIDEN NAME OF MOTHER: Thorine Olivia Gjellum

13. BIRTHPLACE OF MOTHER (State or Country): Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Jos. Doyle
(Address) Burke Ida

15.
Filed Aug 10 1921 F L Dingman
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Aug (Month) 4 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 4 1921, to Aug 4 1921
that I last saw her alive on Aug 4 1921
and that death occurred on the date stated above, at 6 P. M.
The CAUSE OF DEATH* was as follows:
L. C. Pneumonia
(Duration) ..... yrs. ..... mos. 3 ds.
Contributory Cardiac failure
(Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Chas. A. Dietz M. D.
Aug 4 1921 (Address) Burke Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence: Burke Idaho

19. PLACE OF BURIAL OR REMOVAL: Wallace Idaho — DATE OF BURIAL: Aug 10 1921

20. UNDERTAKER: Ward Und Co — ADDRESS: Wallace Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 10

Primary Registration District No. 1011

File No. 35673

Registered No. 61

County of Shoshone

City of Wallace (No. ..., Ward, St.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
OCT 3 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME George Bonnay

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: married (Write the word.)

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1 (Year)

7. AGE: 37 Yrs. — Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Druggist

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: not given

11. BIRTHPLACE OF FATHER (State or Country): Norway.

12. MAIDEN NAME OF MOTHER: not given

13. BIRTHPLACE OF MOTHER (State or Country): Norway.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. George Bonnay

(Address) Wallace Idaho

15. Filed Oct 16 1921 F L Jones Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August (Month) 12 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from — 19..., to — 19...

that I last saw h— alive on — 19...,

and that death occurred on the date stated above, at — M.

The CAUSE OF DEATH* was as follows:

Acute dilatation Heart

..... (Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary) .....

..... (Duration) ... Yrs. ... mos. ... ds.

(Signed) Dr. McAvery Coroner M.D.

8/13 1921 (Address) Wallace Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death? .....

Former or usual residence Wallace Idaho Shipped

19. PLACE OF BURIAL OR REMOVAL: Eagle Grove Iowa | DATE OF BURIAL: Aug 16 1921

20. UNDERTAKER: Ward Undr Co | ADDRESS: Wallace Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
OCT 31 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 76
Primary Registration District No. 1011
(Name) Burke, Sunside Hosp.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35674
Registered No. 6

1. **PLACE OF DEATH**
County of Shoshone
City of Burke
If death occurs away from usual residence, give facts called for under special information.

2. **FULL NAME** Louisa Wilhelmina Hausmann

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. **SEX**: F.

4. **COLOR OR RACE**: white

5. **SINGLE, MARRIED, WIDOWED OR DIVORCED** (Write the word.): married

6. **DATE OF BIRTH**: ..... (Month) ..... (Day) 1 (Year)

7. **AGE**: 51 Yrs. — Mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. **OCCUPATION**
(a) Trade, profession or particular kind of work: At Stover
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. **BIRTHPLACE** (State or Country): Ger.

10. **NAME OF FATHER**: William Schwarze

11. **BIRTHPLACE OF FATHER** (State or Country): Germany

12. **MAIDEN NAME OF MOTHER**: Christina Gerdel

13. **BIRTHPLACE OF MOTHER** (State or Country): Germany

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**
(Informant) Albert Hausmann
(Address) Burke Idaho

15. Filed 8/30 1921 F. C. Quigley Local Registrar
per Mallory

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH**: August (Month) 29 (Day) 1921 (Year)

17. **I HEREBY CERTIFY**, That I attended deceased from Aug 28 1921 to August 29 1921 that I last saw h.w alive on August 28 1921 and that death occurred on the date stated above, at 6 A M.

The CAUSE OF DEATH* was as follows:

Cholelithiasis

..... (Duration) 4 years

Contributory (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

8/29 1921 (Signed) James R Bean M. D.
(Address) Wallace

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions. Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence Burke Idaho

19. **PLACE OF BURIAL OR REMOVAL**: Wallace Idaho — **DATE OF BURIAL**: Aug 30 1921

20. **UNDERTAKER**: Hand Mtd Co — **ADDRESS**: Wallace Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-12 M. 6-15-17.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH — RECEIVED — CERTIFICATE OF DEATH

County of Shoshone — OCT 31 1921 — Registration District No. 70

City of Burke — BUREAU OF VITAL STATISTICS — Primary Registration District No. 1011

If death occurs away from usual residence, give facts called for under special information. — No. ....., ... St.)

2. FULL NAME William S. Hurtt

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35675
Registered No. 32

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. December (Month) 9 (Day) 1873 (Year)

7. AGE: 47 Yrs. 6 Mos. 25 ds.

IF LESS than 1 day how many .... hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Mining
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Arkansas

10. NAME OF FATHER: Sam Hurtt

11. BIRTHPLACE OF FATHER (State or Country): Arkansas

12. MAIDEN NAME OF MOTHER: Sarah Mc Clure

13. BIRTHPLACE OF MOTHER (State or Country): Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Lora Hurtt
(Address) 211 S. 8th Wallace Idaho

15. Filed July 7 1921 — [illegible] Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 5 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191... to ..... 191...
that I last saw h.....alive on ..... 191....
and that death occurred on the date stated above, at ....., ...M.
The CAUSE OF DEATH* was as follows:
Suicide by hanging.
.....
.....
.....(Duration) ..... Yrs..... mos. ..... ds.
Contributory (Secondary) .....
.....(Duration) ..... Yrs..... mos. ..... ds.

7/5 1921 (Signed) Chas. R. Mowery Coroner
(Address) Wallace Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the State....yrs.....mos....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Wallace Ida — DATE OF BURIAL: 7/7 191...

20. UNDERTAKER: D. G. Hartsell — ADDRESS: Wallace

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
OCT 31 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 70

County of Wallace

Registration District No. 1011

File No. 35676

City of 2daho (No. 722 Residence St. St.)

Registered No. 54

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Emma Stringer

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F	White	married

6. DATE OF BIRTH ..... 1 .....
(Month) (Day) (Year)

7. AGE 33 Yrs. — Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Norway.

10. NAME OF FATHER Myer Anderson

11. BIRTHPLACE OF FATHER (State or Country) Norway

12. MAIDEN NAME OF MOTHER Christine Anderson

13. BIRTHPLACE OF MOTHER (State or Country) Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Albert M. Stringer
(Address) Wallace 2daho

15. Filed July 8 1921 F L Jenson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
July (Month) 5 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 4 1921, to July 5 1921
that I last saw h.er alive on July 5 1921
and that death occurred on the date stated above, at P. M.
The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) Two Yrs. — mos. ..... ds.

Contributory (Secondary) Pregnancy - 7th Confinement

(Duration) 1 yrs. — mos. ..... ds.

(Signed) Frank L. Jenson M. D.

July 7 1921 (Address) Wallace, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence Wallace 2daho

19. PLACE OF BURIAL OR REMOVAL Wallace 2daho

DATE OF BURIAL July 8 1921

20. UNDERTAKER Ward Und Co,

ADDRESS Wallace 2da

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51083

FORM V. S. No. 5-12 M. 6-15-17

RECEIVED OCT 31 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35677
Registered No. 53

1. PLACE OF DEATH
County of Shoshone
City of Wallace
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 70
Primary Registration District No. 1061
(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Albert C. Watters

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH. ..... (Month) 1 (Day) ..... (Year)

7. AGE 46 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Miner
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) —

10. NAME OF FATHER —

11. BIRTHPLACE OF FATHER (State or Country) —

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) James R Bean
(Address) .....

15. Filed July 14 1921 F L Jeiss Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH ..... July (Month) 13 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 26 1921 to July 13 1921
that I last saw him alive on July 11 1921
and that death occurred on the date stated above, at 6.45 a.m.

The CAUSE OF DEATH* was as follows:
Pulmonary tuberculosis
.....
.....
..... (Duration) ..... Yrs. 5 mos. ..... ds.

Contributory (Secondary) .....
..... (Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) James R Bean M. D.
7/13 1921 (Address) Wallace

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Wallace Ida	7-14-1921
20. UNDERTAKER B. G. Montell	ADDRESS Wallace

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35678
Registered No. 526

RECEIVED
OCT 21 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Shoshone
Registration District No. 70
Primary Registration District No. 1011
City of Wallace
If death occurs away from usual residence, give facts called for under special information.
No. ..... St.)
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary Jane Hazeltine

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. No information (Month) 1 (Day) 861. (Year)

7. AGE: 61 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many .... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Rhode Island

10. NAME OF FATHER: John Barry

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: No information

13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) JOHN HAZELTINE
(Address) KELLOGG, IDAHO

15. Filed July 26 1921
F. L Deuden
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 23 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1920 to July 23 1921
that I last saw her alive on July 23 1921
and that death occurred on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:
Mitral Regurgitation
heart
(Duration) 1 Yrs. 0 mos. ..... ds.
Contributory (Secondary) Passive Congestion
Liver
(Duration) 1 Yrs. 6 mos. ..... ds.
(Signed) Dr. Mowery M. D.
7/25 1921 (Address) Coeur d'Alene Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Kellogg, Idaho
DATE OF BURIAL: July 26 1921

20. UNDERTAKER: E. B. Thornhill
ADDRESS: Kellogg, Ida.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
OCT 31 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 40
Primary Registration District No. 10 11
File No. 35679
Registered No. 357

1. PLACE OF DEATH

County of Shoshone
City or Town of North Fork Rural (No. North Fork Rural St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Carter

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
M	white	single (Write the word.)

6. DATE OF BIRTH ..... 1.....
(Month) (Day) (Year)

7. AGE about 40 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Day Labors
(b) General nature of industry, business or establishment in which employed (or employer): Logging on River

9. BIRTHPLACE (State or Country): not given

10. NAME OF FATHER: not given

11. BIRTHPLACE OF FATHER (State or Country): not given

12. MAIDEN NAME OF MOTHER: not given

13. BIRTHPLACE OF MOTHER (State or Country): not given

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E E Ward
(Address) Wallace Idaho

15. Filed July 26 1921 F L Jones
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: about May 1st 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows: Drowned in North Fork Coeur d Alene R. while driving Logs
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) None
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Chas D. Howard M.D.
6/27/1921 (Address) Wallace Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence North Fork Rural

19. PLACE OF BURIAL OR REMOVAL: Wallace Idaho
DATE OF BURIAL: June 26 1921

20. UNDERTAKER: Ward Mortuary
ADDRESS: Wallace Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-12 M. 6-15-17.

RECEIVED
OCT 31 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Shoshone
City of Kellogg
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 123
Primary Registration District No. .....
(STATE ..... St.)

File No. 35680
Registered No. 28
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Robert Graham Thatcher

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Dec (Month) 1 (Day) 1912 (Year)

7. AGE: 8 Yrs. 8 Mos. 23 ds.
IF LESS than 1 day how many .... hrs. or .....min.?'

8. OCCUPATION
(a) Trade, profession or particular kind of work: Schoolboy
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Kellogg Shoshone

10. NAME OF FATHER: Alfred Graham Thatcher

11. BIRTHPLACE OF FATHER (State or Country): Berkley Co. West Virginia

12. MAIDEN NAME OF MOTHER: Lizzie Edith Jones

13. BIRTHPLACE OF MOTHER (State or Country): Macon Co Ill

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A G Thatcher
(Address) Kellogg Ida

15. Filed Oct 27 1921 — E E Hart, Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 23 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 10 1921 to Aug 23 1921
that I last saw him alive on Aug. 23 1921
and that death occurred on the date stated above, at 7:30 P.M.

The CAUSE OF DEATH* was as follows:
Typhoid Fever
.....
.....
.....(Duration) ..... Yrs. ..... mos. 2 1 ds.

Contributory (Secondary) .....
.....(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) Alex McCrea M. D.
Oct 27 1921. (Address) Kellogg Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days
Where was disease contracted if not at place of death? Probably Telsoa, Utah
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Kellogg Ida — DATE OF BURIAL: Aug 24 1921

20. UNDERTAKER: M C Thornhill — ADDRESS: Kellogg Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-12 M. 6-15-17.

RECEIVED OCT 31 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 123

Primary Registration District No. .....

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35681
Registered No. 29

1. PLACE OF DEATH
County of Shoshone
City of Kellogg
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME August Simonen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.
Mt. Carmen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Dec (Month) 27 (Day) 1890 (Year)

7. AGE: 30 Yrs. 8 Mos. 5 ds.
IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Finland

10. NAME OF FATHER: John Simonen

11. BIRTHPLACE OF FATHER (State or Country): Finland

12. MAIDEN NAME OF MOTHER: Mary

13. BIRTHPLACE OF MOTHER (State or Country): Finland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Lydia Simonen
(Address)

15. Filed Oct 27 1921 E. E. Hardy Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 2 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1919 to Sept 2 1921
that I last saw h... alive on Sept 2nd 1921
and that death occurred on the date stated above, at 4 P M.

The CAUSE OF DEATH* was as follows:
Chronic pulmonary tuberculosis

(Duration) 3 Yrs. mos. ds.

Contributory (Secondary)
(Duration) Yrs. mos. ds.

(Signed) Alex. Dow Coulter M. D.
Sept 28 1921 (Address) Kellogg Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Kellogg Idaho — DATE OF BURIAL: Sept 4 1921

20. UNDERTAKER: M. Thornhill — ADDRESS: Kellogg Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

123

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35682
Registered No. 38

1. PLACE OF DEATH

County of Shoshone Registration District No.

City of Kellogg Primary Registration District No.

(St.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
OCT 31 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME Walter Anderson Schlueter

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
M	White	Married (Write the word)

6. DATE OF BIRTH: Nov (Month) 14 (Day) 1871 (Year)

7. AGE: 49 Yrs. 2 Mos. 11 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Engineer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Anderson Schlueter

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: Nonf

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. B. Schlueter
(Address) Kellogg, Idaho

15. Filed Oct 27 1921 E E Stod
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 3 (Day), 1921 (Year)
L. P. Mason

17. I HEREBY CERTIFY, That I attended deceased from Sept. 3 1921 to Sept. 3 1921
that I last saw him alive on Sept. 3 1921
and that death occurred on the date stated above, at 11.30 P. M.
The CAUSE OF DEATH* was as follows:

gastric ulcer
perforated at 9. P.M. died 11.30 P.M.

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. P. Mason M. D.
9/2/1921 (Address) Kellogg, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Kellogg Ida	Sept 5 1921
20. UNDERTAKER	ADDRESS
M. C. Thornhill	Kellogg Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
OCT 31 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 123
Primary Registration District No.
File No. 35683
Registered No. 37

1. PLACE OF DEATH
County of Shoshone
City of Kellogg (No. St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ralph Todd Morgan
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6. DATE OF BIRTH: June (Month) 2 (Day) 1867 (Year)

7. AGE: 54 Yrs. 3 Mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Lawyer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: John T. Morgan

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Margaret Tyrone

13. BIRTHPLACE OF MOTHER (State or Country): Penna.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Margaret E. Morgan
(Address) Kellogg Idaho

15. Filed Oct 31 1921
E. E. Hardy
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 4th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 4th 1921, to Sept 4th 1921
that I last saw him alive on Sept 4th 1921,
and that death occurred on the date stated above, at 3:45 P. M.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage

(Duration) ..... Yrs. ..... mos. 1 ds.
Contributory (Secondary) Arteriosclerosis
(Duration) do yrs. ..... mos. ..... ds.
(Signed) M. Linden, M. D.
9/6 1921 (Address) Kellogg Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Coeur d'Alene Idaho — DATE OF BURIAL: Sept 7 1921

20. UNDERTAKER: M. C. Thornbird — ADDRESS: Kellogg Ida.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED OCT 31 19 BUREAU OF STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 123

County of Shoshone

Primary Registration District No.

File No. 35684

City of Wardner (No. , St.)

Registered No. 32

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Leander Stevens

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: August 14th 1883 (Month) (Day) (Year)

7. AGE: 38 Yrs. ~ Mos. 26 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Miner

(b) General nature of industry, business or establishment in which employed (or employer): Lead-Silver - Mines

9. BIRTHPLACE (State or Country): Senecaville, Ohio

10. NAME OF FATHER: Albert Stevens

11. BIRTHPLACE OF FATHER (State or Country): Virginia, U. S. A.

12. MAIDEN NAME OF MOTHER: Mary Susan Hockenberry

13. BIRTHPLACE OF MOTHER (State or Country): Pennsylvania, U. S. A.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Louis Stevens

(Address) Box #694, Kellogg, Idaho

15. Filed Oct 27/ 19 21 E. E. Hardy Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept 9 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ... 19..., to Sept 9 1921, that I last saw h... alive on Sept 9 ~ 1921, and that death occurred on the date stated above, at 9 P.M.

The CAUSE OF DEATH* was as follows:

Fatty Degeneration of
Cardio Dilatation ↑ heart

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) W. L. Lindsay M. D.

9/27 1921 (Address) Kellogg Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Mt. Thornbico	Sept 16 1921
20. UNDERTAKER	ADDRESS
Kellogg Idaho	Kellogg Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED OCT 31 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 123

Primary Registration District No.

File No. 35685

Registered No. 33

County of Shoshone

City of Kellogg (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sophie Radovich

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: August (Month) 14 (Day) Tuesday 1907 (Year)

7. AGE: 14 Yrs. 1 Mos. 6 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Schoolgirl
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Canada

10. NAME OF FATHER: Nicholas Radovich

11. BIRTHPLACE OF FATHER (State or Country): Austria

12. MAIDEN NAME OF MOTHER: Stella

13. BIRTHPLACE OF MOTHER (State or Country): Austria

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Nicholas Radovich
(Address) 134 Riverside Ave. West

15. Filed Oct 27 1921 E E Hart Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 20 (Day) 19 21 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 19 21 to Aug. 14 19 21
that I last saw h er alive on Aug. 14 19 21,
and that death occurred on the date stated above, at A M.
The CAUSE OF DEATH* was as follows:

pulmonary tuberculosis

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. R. Mason M. D.
9/21 19 21 (Address) Kellogg, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Trail, B. C. Canada — DATE OF BURIAL: Sept 24 1921

20. UNDERTAKER: M. C. Thomkins — ADDRESS: Kellogg Ida

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED OCT 31 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 123

County of Shoshone

Primary Registration District No.

File No. 35686

City of Kellogg (No. , St.)

Registered No. 390

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Hector C. Desilets

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: July 12 (Month) (Day) 1854 (Year)

7. AGE: 67 Yrs. 3 Mos. 1 ds.

IF LESS than 1 day: how many ... hrs. or ... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Miner

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Canada

10. NAME OF FATHER:

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. P. Weber

(Address) Kellogg Idaho

15. Filed Oct 27 1921 E. E. Hand Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 14 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 10 1921, to Oct 14 1921, that I last saw him alive on Oct 13 1921, and that death occurred on the date stated above, at 2:25 A.M.

The CAUSE OF DEATH* was as follows:

Acute bronchio-pneumonia

(Duration) 0 Yrs. 0 mos. 6 ds.

Contributory (Secondary) Acute influenza

(Duration) ... yrs. about 10 ds.

(Signed) Alex. O. Graham M. D.

Oct 15 1921 (Address) Kellogg Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Galion Ohio — DATE OF BURIAL: Oct 17 1921

20. UNDERTAKER: M. C. Thornhill — ADDRESS: Kellogg Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Teton

City of Teton (No. ....., St.)

Registration District No. 77

Primary Registration District No. 2176

File No. 35687

Registered No. 76

OCT 24 1921
BUREAU OF VITAL STATISTICS

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Maurice Sylvester McDaniel

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: April 26 1853 (Month) (Day) (Year)

7. AGE: 68 Yrs. 4 Mos. 15 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer): Farming

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: John McDaniel

11. BIRTHPLACE OF FATHER (State or Country): Ohio.

12. MAIDEN NAME OF MOTHER: Christina Stoker

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jesse McDaniel
(Address) Teton Idaho

15. Filed Sept 20th 1921 Martha Marker Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: September 10 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1 1920, to Sept 10 1921, that I last saw him alive on Sept 8 1921, and that death occurred on the date stated above, at 8:15 A.M.

The CAUSE OF DEATH* was as follows:

Chronic infected Bronchitis

Myocarditis

(Duration) 16 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. J. Carverson M. D.

Sept 11 1921 (Address) Driggs Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence Teton County

19. PLACE OF BURIAL OR REMOVAL: [illegible]

DATE OF BURIAL: Sept 15 1921

20. UNDERTAKER: A O Merry

ADDRESS: Driggs

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH — Registration District No. 77 — Primary Registration District No. 2176 — File No. 35688

County of Teton — City of Driggs (No. ..... St.) — Registered No. 17

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Derwent Elmian Luke

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single
6. DATE OF BIRTH: September 12 1919 (Month) (Day) (Year)
7. AGE: 1 Yrs. — Mos. — ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
   (a) Trade, profession or particular kind of work: Infant
   (b) General nature of industry, business or establishment in which employed (or employer): Infant
9. BIRTHPLACE (State or Country): Salt Lake City Utah
10. NAME OF FATHER: C. L. Luke
11. BIRTHPLACE OF FATHER (State or Country): Utah Utah
12. MAIDEN NAME OF MOTHER: Smith Emma
13. BIRTHPLACE OF MOTHER (State or Country): Ore.
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
    (Informant) C. L. Luke
    (Address) Driggs Idaho.
15. Filed Sept 20 1921 — Martha Marker — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: September 17 1921 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from Sept 6 1921, to Sept 12 1921 that I last saw h... alive on Sept 11 1921 and that death occurred on the date stated above, at 6 A.M.
    The CAUSE OF DEATH* was as follows:
    Acute Gastro Enteritis
    ..... (Duration) 1 Yrs. ..... mos. 6 ds.
    Contributory (Secondary) .....
    ..... (Duration) ..... yrs. ..... mos. ..... ds.
    (Signed) J. C. Culbertson M. D.
    Sept 17 1921 (Address) Driggs Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
    At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
    Where was disease contracted if not at place of death? .....
    Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Driggs Cemetery — DATE OF BURIAL: Sept 14 1921

20. UNDERTAKER: W J King — ADDRESS: Driggs, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
OCT 31 1921
BUREAU OF VITAL STATISTICS

Registration District No. 37
Primary Registration District No. 2085
File No. 35690
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of R.R. Twin Falls (St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Esther Lois Schiffler
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): School Girl

6. DATE OF BIRTH: July 23 (Month) (Day) 1904 (Year)

7. AGE: 17 Yrs. 6 Mos. 5 ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: School Girl
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Neb

10. NAME OF FATHER: John Schiffler

11. BIRTHPLACE OF FATHER (State or Country): Neb

12. MAIDEN NAME OF MOTHER: Katherine Loff

13. BIRTHPLACE OF MOTHER (State or Country): Neb

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Schiffler
(Address)

15. Filed Sept 29 1921 John T. Coughlin Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept 28 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 8th 1921, to Sept. 27th 1921, that I last saw her alive on Sept. 27th 1921, and that death occurred on the date stated above, at 2 A.M.

The CAUSE OF DEATH* was as follows:
Typhoid Fever
(Duration) ... Yrs. ... mos. ... ds.
Contributory (Secondary) Myocarditis
(Duration) ... yrs. ... mos. ... ds.

Sept 28 1921 (Signed) Gilbert Telford D.O.
(Address) Twin Falls, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Filer Idaho — DATE OF BURIAL: Sept 1 1921

20. UNDERTAKER: J E Wood — ADDRESS: Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Twin Falls — Registration District No. 34 — Primary Registration District No. 1085 — File No. 35691

City of ..... (No. ..... St.) — Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Margret Bronson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

RECEIVED
OCT 21 1921
BUREAU OF VITAL STATISTICS
STATE OF IDAHO

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): School Girl

6. DATE OF BIRTH: Mch 20 1901 (Month) (Day) (Year)

7. AGE: 20 Yrs. 5 Mos. 16 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: School Girl
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Neb

10. NAME OF FATHER: L Burnell Bronson

11. BIRTHPLACE OF FATHER (State or Country): Neb

12. MAIDEN NAME OF MOTHER: Kathrine Snyder

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Kathryn Bronson
(Address) 362-6th N. Twin Falls, Ida

15. Filed Sep 4th 1921 John F Coughlin Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sep 6 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 3 1921, to Sept 7 1921, that I last saw her alive on Sept 7 1921, and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:
Acute Anterior poliomyelitis

..... (Duration) ..... Yrs. ..... mos. 9 ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Emma C. Crossland M. D.

..... 19..... (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Idaho — DATE OF BURIAL: Sep 8 1921

20. UNDERTAKER: J G Wood — ADDRESS: Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35692

Registered No.

1. PLACE OF DEATH

County of Twin Falls

City of

(No. St.)

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 37

Primary Registration District No. 1085

RECEIVED
OCT 31 1921
BUREAU OF VITAL STATISTICS

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary J Bills

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Oct 10 (Month) (Day) 1848 (Year)

7. AGE: 72 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: retired

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ill

10. NAME OF FATHER: Doris Lastas

11. BIRTHPLACE OF FATHER (State or Country): ohio

12. MAIDEN NAME OF MOTHER: anna Reighley

13. BIRTHPLACE OF MOTHER (State or Country): Ill

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) O D Bills

(Address) Hansen

15. Filed Sept 6 1921 John F Coughlin Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept 3 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 19 1921, to Sept 3 1921, that I last saw h[illegible] alive on Sept 3 1921, and that death occurred on the date stated above, at 1:30 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrage

(Duration) Yrs. mos. 20 ds.

Contributory (Secondary) Nephritis

(Duration) yrs. 1 mos. ds.

(Signed) C S Millard M. D.

Sept 3 1921 (Address) Twin Falls,

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Idaho — DATE OF BURIAL: Sept 4 1921

20. UNDERTAKER: J E Record — ADDRESS: Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
OCT 31 1921
BUREAU OF VITAL STATISTICS

Registration District No. 37
Primary Registration District No. 1085
File No. 35693
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of " "
(If outside limits, give township) (St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Frank A. Arnold.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married.

6. DATE OF BIRTH: 4 (Month) 29 (Day) 1854 (Year)

7. AGE: 67 Yrs. 8 Mos. 2 ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Assistant Judge Police and
(b) General nature of industry, business or establishment in which employed (or employer): Supreme Courts, Hartford, Conn.

9. BIRTHPLACE (State or Country): Haddam, Conn.

10. NAME OF FATHER: Wm. T. Arnold

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Elsner Hall

13. BIRTHPLACE OF MOTHER (State or Country): Haddam Conn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H. W. Sawyer.
(Address) Twin Falls, Idaho.

15. Filed Sept. 12 1921 John F. Loughlin Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 9 (Month) 1 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 3 1921, to Sept. 1 1921, that I last saw h. alive on Sept. 1, 1921, and that death occurred on the date stated above, at 10:00 P.M.

The CAUSE OF DEATH* was as follows:
Nephritis

(Duration) 8 Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) H. W. Sawyer M. D.
9-13 1921 (Address) Twin Falls, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. 1 mos. 20 days. In the State yrs. 3 mos. days
Where was disease contracted if not at place of death? Unknown
Former or usual residence Hartford, Conn.

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Ida
DATE OF BURIAL: 9/5 1921

20. UNDERTAKER: P J Grosman
ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35694
Registered No.

1. PLACE OF DEATH

County of Twin Falls RECEIVED OCT 3 1921 BUREAU OF VITAL STATISTICS Registration District No. 34 Primary Registration District No. 1085

City of Twin Falls (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Stanikla

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Married

6. DATE OF BIRTH ..... 1 ..... (Month) (Day) (Year)

7. AGE 29 Yrs. ..... Mos. ..... ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Housekeeper
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Austria

10. NAME OF FATHER Austria

11. BIRTHPLACE OF FATHER (State or Country) Austria

12. MAIDEN NAME OF MOTHER Austria

13. BIRTHPLACE OF MOTHER (State or Country) Austria

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jos Stanikla
(Address) .....

15. Filed Sept 12 1921 John Hoagland Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Sept 9 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 1 1920, to Sept 9 1921, that I last saw h[illegible] alive on Sept 9 1921, and that death occurred on the date stated above, at 5 P.M.
The CAUSE OF DEATH* was as follows:
(a) Pulmonary Tuberculosis
.....
.....
.....(Duration) 1 Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
.....(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) [illegible] M. D.
19..... (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Twin Falls	Sept 10 1921
20. UNDERTAKER [illegible]	ADDRESS Twin Falls

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35695
Registered No.

RECEIVED
OCT 31 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Twin Falls
City of ..
(No. ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 34
Primary Registration District No. 1865

2. FULL NAME Russel H Bennett

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Married

6. DATE OF BIRTH: Sept. (Month) 7 (Day) 1843 (Year)

7. AGE: 77 Yrs. 11 Mos. 23 ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Locomotive Engineer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Indiana

10. NAME OF FATHER: Thomas H. Bennett

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Howard

13. BIRTHPLACE OF MOTHER (State or Country): Maine

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) County Gen Hospital Records
(Address) Twin Falls, Ida.

15. Filed Sept 12 1921 — John F Coughlin, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 30 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 14 1921 to Aug 30 1921
that I last saw h... alive on Aug 30 1921
and that death occurred on the date stated above, at 5a M.
The CAUSE OF DEATH* was as follows:

Arterial Hemorrhage
(I have not fully determined Cause but Considered Accidental)
(Duration) 5 Yrs. 8 mos. ds.
Contributory Bronchial Pneumonia
(Secondary)
(Duration) yrs. mos. 3 ds.

(Signed) Dr C M Glennie M. D.
19 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Ida
DATE OF BURIAL: 9/2 1921
20. UNDERTAKER: W. J. Freeman
ADDRESS: Twin Falls Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED
OCT 31 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Murphy
State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Twin Falls — Registration District No. 24
City of ... (If not in incorporated limits, write "not") — Primary Registration District No. 1085 — St.)
File No. 35696
Registered No. ...
If death occurs away from usual residence, give facts called for under special information.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Jennie J. Huston

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write one word.): Married

6. DATE OF BIRTH: Oct (Month) 8 (Day) 1886 (Year)

7. AGE: 35 Yrs. 11 Mos. 5 ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Neb.

10. NAME OF FATHER: Wm J. Parson

11. BIRTHPLACE OF FATHER (State or Country): England.

12. MAIDEN NAME OF MOTHER: Martha Gardner

13. BIRTHPLACE OF MOTHER (State or Country): Ohio.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Alexander N. Huston.
(Address) Twin Falls. Ida.

15. Filed Sept 16 1921 — John H Coughlin, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: ~~Dec~~ Sept (Month) 13 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1 1921, to Sept 12 1921, that I last saw her alive on Sept 12 1921, and that death occurred on the date stated above, at 9 P.M.
The CAUSE OF DEATH* was as follows:
Pernicious toxemia of pregnancy
Duration ... Yrs. ... mos. 11 ds.
Contributory (Secondary) Pregnancy (accidental) Phlebitis
Duration ... yrs. ... mos. 30 ds.
(Signed) F. S. Mauzepeau M. D.
9/13 1921 (Address) Twin Falls, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Ida. — DATE OF BURIAL: 9/14 1921

20. UNDERTAKER: P. G. Rossman — ADDRESS: Twin Falls Ida.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED
OCT 31 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 24
Primary Registration District No. 1085
File No. 35698
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of (No. St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Einar Alden

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Sep (Month) 24 (Day) 1886 (Year)

7. AGE: 35 Yrs. 11 Mos. 27 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Einar Alden

11. BIRTHPLACE OF FATHER (State or Country): Norway

12. MAIDEN NAME OF MOTHER: Nellie Nelson

13. BIRTHPLACE OF MOTHER (State or Country): Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) B.N. Rundahl
(Address) Twin Falls, Ida.

15. Filed Sept 23 1921 John Flaughlin
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sep (Month) 21 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased on Sept 13 1921, [redacted] 19..., that I last saw h[redacted] alive on Sept 13 1921, and that death occurred on the date stated above, at 4:00 A.M.

The CAUSE OF DEATH* was as follows:
Tuberculosis of throat.

(Duration) 2 Yrs. mos. ds.
Contributory (Secondary) Locomotor ataxia
(Duration) 4 yrs. mos. ds.

(Signed) H.W. Wilson M. D.
Sept 23 1921 (Address) [redacted] Twin Falls, Ida

*State the Disease Causing De[redacted]or in deaths from Violent Causes, state (1) Means of Injury; and (2) w[redacted]er Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Ida — DATE OF BURIAL: Sep 25 1921

20. UNDERTAKER: J.C. Everett — ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

RECEIVED OCT 31 1921 BUREAU OF VITAL STATISTICS

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 34
Primary Registration District No. 12 & 25
File No. 35699
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of ... (No.) ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Laurette K. Backer
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fe
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.):

6. DATE OF BIRTH: Aug (Month) 1 (Day) 1914 (Year)

7. AGE: 7 Yrs. ... Mos. ... ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: School Girl
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Carl S Green

11. BIRTHPLACE OF FATHER (State or Country): Not known

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. A. Tessling
(Address)

15. Filed Sept 22 1921 — Johan Youngblood, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 21 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 19, 1921, to Sept 21 1921, that I last saw her alive on Sept 21 1921, and that death occurred on the date stated above, at 4 P M.

The CAUSE OF DEATH* was as follows:
Diphtheria

(Duration) ... Yrs. ... mos. 5 ds.

Contributory (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) Hal Biles M. D.
Sept 22 1921 (Address) Twin Falls, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Ida — DATE OF BURIAL: 11 22 1921

20. UNDERTAKER: L. L. Wood — ADDRESS: Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-12-25 M. 1-19.

RECEIVED
OCT 31 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 34
Primary Registration District No. 1085

Davis

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35700
Registered No.

PLACE OF DEATH
County of Twin Falls
City of " "
(No.) (St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Anna M Voss

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6. DATE OF BIRTH: May (Month) 20 (Day) 188- (Year)

7. AGE: 39 Yrs. 4 Mos. 4 ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kan

10. NAME OF FATHER: Chas Schenck

11. BIRTHPLACE OF FATHER (State or Country): Ger.

12. MAIDEN NAME OF MOTHER: Don't Know

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): J M Voss
(Address): Kimberly, Ida.

15. Filed Sept 26 1921 John J Coughlin Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 24 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 1921, to Sept 24 1921, that I last saw h[illegible] alive on Sept 24 1921, and that death occurred on the date stated above, at 10 P.M.
The CAUSE OF DEATH* was as follows: Carcinoma ? Sigmoid

(Duration) ? Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.
9/24 1921 (Address) Kimberly Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Ida
DATE OF BURIAL: 9/25 1921

20. UNDERTAKER: C. G. Grossman
ADDRESS: Twin Falls Ida.

WMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

Boise.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35701

Registered No.

1. PLACE OF DEATH

County of Twin Falls

City of " "

(No. STATISTICS St.)

Registration District No. 37

Primary Registration District No. 1085

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Anna Chieda

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Oct (Month) 1 (Day) 1886 (Year)

7. AGE: 34 Yrs. 11 Mos. 20 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer): -

9. BIRTHPLACE (State or Country): Norway.

10. NAME OF FATHER: Andrew Olson

11. BIRTHPLACE OF FATHER (State or Country): Norway.

12. MAIDEN NAME OF MOTHER: Carrie Olson

13. BIRTHPLACE OF MOTHER (State or Country): Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chas E Chieda
(Address) Route 2. Buhl. Ida

15. Filed 9 26 1921 John F Coughlin Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 21 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 19, 1921, to Sept. 21, 1921, that I last saw h e alive on Sept 21, 1921, and that death occurred on the date stated above, at 12 P.M.

The CAUSE OF DEATH* was as follows:

Chronic infectious endocarditis.

..... (Duration) ..... Yrs. 4 mos. ..... ds.

Contributory (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Raf Bieler, M. D.

Sept 26 1921. (Address) Twin Falls, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Buhl Ida — DATE OF BURIAL: 9/23 1921

20. UNDERTAKER: P. J. Grossman — ADDRESS: Twin Falls Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

V. S. No. 5—25 M. 1-19.

Pike

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED

Registration District No. 24

Primary Registration District No. 1085

File No. 35702

Registered No.

PLACE OF DEATH

ty of Twin Falls

of

ath occurs away from residence, give facts for under special in-ation.

BUREAU OF VITAL STATISTICS

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary Agnes V Mahnken

PERSONAL AND STATISTICAL PARTICULARS

X	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
male	White	Single

ATE OF BIRTH

May (Month) 13 (Day) 1921 (Year)

GE

Yrs. 4 Mos. 3 ds.

IF LESS than 1 day how many hrs. or min.?

CCUPATION

Trade, profession or ular kind of work —

General nature of in-, business or estab-nt in which employ-r employer) —

IRTHPLACE (State or Country) Edeen Idaho.

AME OF THER Fred Mahnken

IRTHPLACE FATHER (State or Country) Utah.

AIDEN NAME MOTHER Sylvia Crutchfield

IRTHPLACE MOTHER (State or Country) Idaho

HE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

rmant) Fred Mahnken.

(Address) Edeen, Idaho

Sept 26 1921 John F Coughlin Local Registrar

RK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 15 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 13th 1921, to Sept 15 1921, that I last saw h[illegible] alive on 9/14/21 1921, and that death occurred on the date stated above, at [illegible] M.

The CAUSE OF DEATH*, was as follows:

Intestinal intoxication

(Duration) Yrs. mos. 3 ds.

Contributory (Secondary) Pernicious vomiting during pregnancy (Duration) [illegible] yrs. mos. ds.

(Signed) C. G. Pike M. D.

7/13 1921 (Address) Twin Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Twin Falls, Ida | DATE OF BURIAL Sept 17 1921

20. UNDERTAKER C. J. Gassman | ADDRESS Twin Falls

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35703

OCT 31 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Twin Falls
Registration District No. 37
Primary Registration District No. 1085
City of ..... (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Annabelle Sears
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: fe
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: aug (Month) 1 (Day) 1 (Year)

7. AGE: 36 Yrs. 1 Mos. 24 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Kansas

10. NAME OF FATHER: John Kinder

11. BIRTHPLACE OF FATHER (State or Country): Ill

12. MAIDEN NAME OF MOTHER: Katy ~~Hall~~ Kennedy

13. BIRTHPLACE OF MOTHER (State or Country): Ind

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. P. Sears
(Address) .....

15. Filed Sept 27 1921. John W. Condie Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sep (Month) 24 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 21 1921, to Sept. 24 1921
that I last saw h[er] alive on Sept 24, 1921,
and that death occurred on the date stated above, at 9.30 P.M.
The CAUSE OF DEATH* was as follows:
Septicaemia, following ruptured appendix, ~~[illegible]~~ and
(Duration) ~~[illegible]~~ Yrs. 1 mos. ..... ds.
Contributory (Secondary) Miscarriage and empyema,
(Duration) ..... yrs. ..... mos. 21 ds.
(Signed) C. D. Weaver, M. D.
19..... (Address) Twin Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Ida — DATE OF BURIAL: Sep 27 1921

20. UNDERTAKER: L. E. Hurst — ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

FORM V. S. No. 5-A—25 M. 1-19.

REC'D OCT 31 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37

Registration District No. 1 1 85

File No. 35705

Registered No.

1. PLACE OF DEATH

County of Twin Falls

City of

(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sarah J. Williams

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
fe	white	Married

6. DATE OF BIRTH: April 27 (Month) (Day) 1862 (Year)

7. AGE: 59 Yrs. 5 Mos. 4 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ind

10. NAME OF FATHER: William Englewood

11. BIRTHPLACE OF FATHER (State or Country): Pa. Germany

12. MAIDEN NAME OF MOTHER: Mat Kramer

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. J. Williams
(Address)

15. Filed Sept 29 1921 John W. Coughlin Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 27 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 20 — 1921, to Sept 26 — 1921, that I last saw h.. alive on Sept 26 1921, and that death occurred on the date stated above, at 1 P.M.
The CAUSE OF DEATH* was as follows:

Apoplexy (2nd Stroke)

(Duration) Yrs. mos. 3 ds.
Contributory (Secondary) Arterio Sclerosis —
(Duration) yrs. mos. ds.

(Signed) Denicon L. Standley M. D.
9/27 1921 (Address) Twin Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Ida — DATE OF BURIAL 19

20. UNDERTAKER: J. E. Wood — ADDRESS Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED OCT 5 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1885
File No. 35706
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of (Ward / Village / Town) (St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Frances M Champlin

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Nov 1 (Month) (Day) 1839 (Year)

7. AGE: 81 Yrs. 10 Mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Maid
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): S D

10. NAME OF FATHER: J W Champlin

11. BIRTHPLACE OF FATHER (State or Country): Ill

12. MAIDEN NAME OF MOTHER: Anna S Shepherd

13. BIRTHPLACE OF MOTHER (State or Country): America

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): L W Champlin
(Address): Twin Falls Ida

15. Filed Sept 29 1921 John V Coughlin Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sep (Month) 26 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9/14/1921, to 9/26/1921, that I last saw h[illegible] alive on 9/26/* 1921, and that death occurred on the date stated above, at 9[illegible] M.

The CAUSE OF DEATH* was as follows:

Hypostatic pneumonia

(Duration) ..... Yrs. ..... mos. 12 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) L. W. Champlin M. D.

9/27/1921 (Address) Twin Falls, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Ida — DATE OF BURIAL ..... 19.....

20. UNDERTAKER: L E Evertt — ADDRESS: Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
OCT 31 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 39
Primary Registration District No. 2087
File No. 35708
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of Buhl (No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Joseph Methven
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write word): Married

6. DATE OF BIRTH: Feb (Month) 28 (Day) 1903 (Year)

7. AGE: 18 Yrs. 7 Mos. — ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Washington.

10. NAME OF FATHER: John F Methven

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Sarah Lekmann

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Fred P. Methven
(Address) Buhl Ida

15. Filed 10-1 1921 — J. V. Murphy, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 28 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 28 1921 to Sept 28 1921 that I last saw him alive on Sept 28 1921, and that death occurred on the date stated above, at 2:00 P. M.
The CAUSE OF DEATH* was as follows:
Strychnine poison.

(Duration) Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) F. A. Marsh M. D.
Oct 1921 (Address) Buhl Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Buhl Cemetery — DATE OF BURIAL: 10/2 1921
20. UNDERTAKER: Howell & Rugg — ADDRESS: Buhl Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 39

Primary Registration District No. 2077

File No. 35709

County of Twin Falls

City of ..... (No. ..... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James Henry Methven

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6. DATE OF BIRTH: April (Month) 10 (Day) 1856 (Year)

7. AGE: 65 Yrs. 5 Mos. 8 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: James Methven

11. BIRTHPLACE OF FATHER (State or Country): Not known

12. MAIDEN NAME OF MOTHER: M. Roberton

13. BIRTHPLACE OF MOTHER (State or Country): Not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. H. Ferguson

(Address) .....

15. Filed 9-19 1921 — J. A. Murphy, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. (Month) 18 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 10, 1921, to Sept. 18 1921, that I last saw him alive on Sept. 17 1921, and that death occurred on the date stated above, at 9:30 A.M.

The CAUSE OF DEATH* was as follows:

Ulceration of Stomach

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. A. Marsh M. D.

9/19 1921 (Address) Buhl Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF ~~BURIAL~~ OR REMOVAL: Cozad. Neb. — DATE OF BURIAL ..... 19.....

20. UNDERTAKER: Howells & Rugg — ADDRESS Buhl Ida

PRECINCT OR WARD

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 42

35740

City or Village Nampa (No. 2 E. Front St.) Registered No.

If death occurs away from usual residence, give facts called for under special information.

BUREAU OF VITAL STATISTICS

2. FULL NAME Milo Clark Yerkes

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: March (Month) 10 (Day) 1887 (Year)

7. AGE: 34 Yrs. 5 Mos. 6 ds.

IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Stenographer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: S.Yerkes

11. BIRTHPLACE OF FATHER (State or Country): Indiana

12. MAIDEN NAME OF MOTHER: Catherine Hight

13. BIRTHPLACE OF MOTHER (State or Country): Penn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Alvina Yerkes

(Address) Nampa Idaho

15. Filed Sept. 15 1921 Pearle Dodds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug. (Month) 15 (Day) 19 21 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1 1921 to Aug 15 1921 that I last saw him alive on Aug 15 1921 and that death occurred on the date stated above, at 1 P. M.

The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis

(Duration) 3 Yrs. mos. ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed) H P Rose M. D.

Aug 16 1921 (Address) Nampa Ida

State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Kohlerlawn Cem Nampa Idaho — DATE OF BURIAL: 8/17/ 1921

20. UNDERTAKER: Fred K.Robinson — ADDRESS: Nampa Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FOR [redacted] 5-25 M. 1-16-13

RECEIVED OCT 31 1921 BUREAU OF STATISTICS

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35711

Registered No. .....

1. PLACE OF DEATH.

Registration District No. 87

Primary Registration District No. .....

County of Washington

City of Midvale (If outside limits, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Gordon Edward Kilborn

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: ~~Female~~ Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. July (Month) 15 (Day) 1908 (Year)

7. AGE: 12 Yrs. 8 Mos. 11 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country)

10. NAME OF FATHER: Ira Kilborn

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER: Hattie Chapman

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Hattie G. Kilborn

(Address) .....

15. Filed 3-26-1921 F. A. Schmidt Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 26 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mch 25 1921, to ..... 191..., that I last saw him alive on March 25 1921, and that death occured on the date stated above, at 7 a M.

The CAUSE OF DEATH* was as follows:

Uraemic poisoning

.....(Duration) .....Yrs. .....mos. .....ds.

Contributory (Secondary) .....

.....(Duration) .....yrs. .....mos. .....ds.

(Signed) W. P. Seeley M. D.

3/26 1921 (Address) Midvale, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Midvale Cemetery — DATE OF BURIAL: Mar 27 1921

20. UNDERTAKER: L R Latimer — ADDRESS: Midvale Ida

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35712

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No. 87

Primary Registration District No. .....

County of Washington

City of Mundall (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
OCT 31 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME Curry Bunton

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE: .....Yrs. 39 .....Mos. .....ds.

IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Tenn

10. NAME OF FATHER Jack Bunton

11. BIRTHPLACE OF FATHER (State or Country) Tenn

12. MAIDEN NAME OF MOTHER Molly Vines

13. BIRTHPLACE OF MOTHER (State or Country) Tenn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sol Bunton

(Address) Ligurus oregon

15.

Filed Aug 21 1921 Fadelmud Local Registrar

SYMS - YORK CO., PTRS. & SOLS. 24858

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
August (Month) 21 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 21 1921, to Aug 21 1921, that I last saw him alive on Aug 21 1921, and that death occured on the date stated above, at 5:30 P.M.

The CAUSE OF DEATH* was as follows:
Suicide by drinking Carbolic Acid

.....(Duration) .....Yrs. .....mos. .....ds.

Contributory (Secondary) .....

.....(Duration .....yrs. .....mos. .....ds.

(Signed) F. A. Schmuck M. D.

8-21 1921 (Address) Mundall Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Mundale	Aug 23 1921
20. UNDERTAKER	ADDRESS
F. A. Schmuck	Mundale

90

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED OCT 31 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35713

Registered No. .....

1. PLACE OF DEATH.

Registration District No. 8 7

Primary Registration District No. .....

County of Washington

City of Mawall No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Laura F. Allin

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. July (Month) 20 (Day) 1871 (Year)

7. AGE: 50 Yrs. 4 Mos. 18 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: home wife
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Mo

10. NAME OF FATHER: John Cooper

11. BIRTHPLACE OF FATHER (State or Country): .....

12. MAIDEN NAME OF MOTHER: Martha J Spurgeon

13. BIRTHPLACE OF MOTHER (State or Country): .....

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Jas. E. Pease
(Address) Deer Park Wash.

15. Filed July 10 – 1921 F A Schmitz Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 8 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1916, to July 8 – 1921, that I last saw h alive on July 8 – 1921, and that death occured on the date stated above, at 8 A M.

The CAUSE OF DEATH* was as follows:
Bronchial asthma. Ty
Hypertrophy of adenoids
Chronic. Uncontrollable asthma
(Duration) 6 Yrs. mos. ds.
Contributory (Secondary) Paralysis Heart.
(Duration yrs. mos. ds.

(Signed) F A Schmitz M. D.
7-9 1921 (Address) Medical Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mawall Cemetary — DATE OF BURIAL: July 11 1921

20. UNDERTAKER: C R K Sahmett — ADDRESS: Medical Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

EVANS - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-19.

RECEIVED NOV 1 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35714
Registered No. 36

1. PLACE OF DEATH
County of Blaine
City of Near Carey (If outside limits, give Township) St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 57
Primary Registration District No. 2075

2. FULL NAME William B. Troxell.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH: Feb. (Month) 18 (Day) 1899 (Year)

7. AGE: 22 Yrs. 9 Mos. 14 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Eng. Machinist
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: James A. Troxell

11. BIRTHPLACE OF FATHER (State or Country): Ind.

12. MAIDEN NAME OF MOTHER: Dora May Bickell

13. BIRTHPLACE OF MOTHER (State or Country): Ind.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) James A. Troxell
(Address) Box 884 Twin Falls, Ida

15. Filed Nov-1 1921 — R. H. Wright — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 2 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct-2 1921 to Oct-2 1921 that I last saw h[illegible] alive on dead Oct 2 1921, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage

X (Duration) X Yrs. X mos. X ds.

Contributory (Secondary)
X (Duration) X yrs. X mos. ds.

(Signed) Houston E. Snyder M. D.
19 (Address) Carey, Ida. Coroner

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls, Ida. DATE OF BURIAL: Oct 4 1921

20. UNDERTAKER: J. J. Grossman ADDRESS: Twin Falls.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-A—25 M. 1-19.

35715

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 9
Primary Registration District No. 2005
(No. ..... St.)

File No. 35715
Registered No. 108

1. PLACE OF DEATH

County of Canyon
City of Middleton

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Yasuo Nishioka

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	Japanese Yellow	Married

6. DATE OF BIRTH: March (Month) 14 (Day) 1921 (Year)

7. AGE: Yrs. 7 Mos. 4 ds. — IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Taiichi Nishioka

11. BIRTHPLACE OF FATHER (State or Country) Japan

12. MAIDEN NAME OF MOTHER Takigawa

13. BIRTHPLACE OF MOTHER (State or Country) Japan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) [illegible]
(Address) .....

15. Filed Oct. 18 1921 John L. Meyer Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 18 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 18 1921, to Oct 18 1921
that I last saw him alive on Oct 17 1921
and that death occurred on the date stated above, at 2,30 A.M.
The CAUSE OF DEATH* was as follows:
Congested Lung Trouble
.....
.....
(Duration) ..... Yrs. ..... mos. 4 ds.
Contributory (Secondary) None
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) J. W. Farmer M. D.
10-18-1921 (Address) Middleton Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Middleton Ida — DATE OF BURIAL ..... 19.....

20. UNDERTAKER CASE FURNITURE CO. — ADDRESS Caldwell

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

35716

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35716

Registered No. 332

1. PLACE OF DEATH

County of Ada

City of Boise.

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 7

Primary Registration District No. 1604

(No. St Lukes Hospital St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William W. Biddle

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
M.	White.	Married (or widowed)

6. DATE OF BIRTH Oct 23, 1860 (Month) (Day) (Year)

7. AGE 61 Yrs. Mos. 18 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer.

(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country) Penn.

10. NAME OF FATHER David Biddle

11. BIRTHPLACE OF FATHER (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Hannah Spangle

13. BIRTHPLACE OF MOTHER (State or Country) Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Porter Biddle

(Address) Meridian Idaho R 2 Box 41

15. Filed Nov 15 1921 R. V. Trout Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov 11 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 11 1921, to Nov 11 1921, that I last saw h.. alive on Nov 11 1921, and that death occurred on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:

Shock. due to
Intestinal obstruction.

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Edward J. Bunn M. D.

Nov 14 1921 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Morris Hill Cemetery. **DATE OF BURIAL** Nov 15 1921

20. UNDERTAKER Summers & Krebs **ADDRESS** Boise Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3571
Registered No. 953

1. PLACE OF DEATH
County of Ada
City of Boise
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 7
Primary Registration District No. 1007
(No. 807 Grove St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Friedel Fretzer

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: (Month) (Day) 1849 (Year)

7. AGE: 72 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Stone Cutter
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Austria

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Clyde E. Dunmers
(Address) Boise Idaho

15. Filed Dec 6 19 21 R. H. Pratt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: (Month) Dec. (Day) 5 19 21 (Year)

17. I HEREBY CERTIFY, That I ~~attended~~ saw deceased ~~from~~ Dec 5 19 21, ~~to 19~~, ~~that I last saw h alive on 19~~, ~~and that death occurred on the date stated above, at~~ 3 6 P.M.

The CAUSE OF DEATH* was as follows:
Valvular Heart disease

(Duration) Yrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) Clyde E. Dunmers Coroner A.M.A. [illegible]
12/6 1921 (Address) Boise Ada County

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Dec 7 19 21
20. UNDERTAKER: Dunmers & Krebs — ADDRESS: Boise Idg

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35718
Registered No. 348

1. PLACE OF DEATH
Registration District No. 3
Primary Registration District No. 1004
County of Ada
City of Boise, No. St. Lukes Hospital, St.)
If death occurs away from usual residence, give facts called for under special information.

RECEIVED
NOV 30 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME Jesse Roberts
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)
6. DATE OF BIRTH: Aug - 6 - 1877 (Month) (Day) (Year)
7. AGE: 44 Yrs. 3 Mos. 20 ds. (IF LESS than 1 day how many ..... hrs. or ..... min.?)
8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry, business or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Fort Klamath Falls, Ore
10. NAME OF FATHER: Unknown
11. BIRTHPLACE OF FATHER (State or Country): "
12. MAIDEN NAME OF MOTHER: "
13. BIRTHPLACE OF MOTHER (State or Country): "
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) O. McBratney
(Address) Boise Idaho
15. Filed Dec. 1 1921 R. H. Fros Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov 26 - 1921 (Month) (Day) 19 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Nov 23 1921 to Nov 26 1921 that I last saw h.. alive on Nov 25 1921 and that death occurred on the date stated above, at 7.45 P.M.
The CAUSE OF DEATH* was as follows:
Pneumonia - fracture of femur
(Duration) ..... Yrs. ..... mos. 7 ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) [illegible] M. D.
11/28/21 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 12/1/21
20. UNDERTAKER: O. McBratney — ADDRESS: Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-25 M. 1-19.

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NOV 30 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No.
Registration District No.
File No. 35719
Registered No. 316

1. PLACE OF DEATH
County of Ada
City of Boise (No. 110 W. Bannock St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs Henry Wuest.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widow (Write the word.)

6. DATE OF BIRTH: June 21st 1876 (Month) (Day) (Year)

7. AGE: 45 Yrs. 4 Mos. 8 ds.
IF LESS than 1 day how many..... hrs. or..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Des Moines Iowa

10. NAME OF FATHER: John Wuest

11. BIRTHPLACE OF FATHER (State or Country): Switzerland

12. MAIDEN NAME OF MOTHER: Mary Olsen

13. BIRTHPLACE OF MOTHER (State or Country): Norway.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Conrad Wuest
(Address) Boise, Ida

15. Filed Nov 1 1921 R. N. Pratt Local Registrar
Fahrman

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 29th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 1917 19..., to Oct 29 1921
that I last saw h.. alive on Oct 25 1921
and that death occurred on the date stated above, at 3 A. M.
The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis

(Duration) 10 Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) Wm B. Fahrman M. D.
11/1 1921 (Address) Boise Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence Ada County, Idaho

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery | DATE OF BURIAL: 11/1 1921
20. UNDERTAKER: Schreiber & Hidenfaden (Boise) | ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED NOV 30 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35720
Registered No. 317

1. PLACE OF DEATH
County of Ada Registration District No.
City of So Boise Primary Registration District No.
(If not in incorporated territory, give township.) (No. 1904 Broadway St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Clyde D. Loughrey

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: April 25th 1921 (Month) (Day) (Year)

7. AGE: Yrs. 6 Mos. 7 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Clyde Loughrey

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Alta Flora Hillier

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Owen L. Smith
(Address) 1911 N. 14.

15. Filed Nov 1 1921 R A Pratt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov 1st 1921. (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 14 1921, to Oct 31 1921, that I last saw him alive on Nov 1st 1921, and that death occurred on the date stated above, at 1-P M.

The CAUSE OF DEATH* was as follows:

Dysentery

(Duration) Yrs. mos. 21 ds.

Contributory (Secondary) Pyogenic skin infection

(Duration) yrs. mos. 14 ds.

(Signed) Harold W Stone M. D.

11/1 1921 (Address) 410 Overland Bldg.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 11/2 1921

20. UNDERTAKER: Schreiber & Sidenfaden — ADDRESS: Boise Ida

Dr. Stone

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY; PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

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FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

RECEIVED
NOV 30 1921
BUREAU OF VITAL STATISTICS

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35722
Registered No. 319

1. PLACE OF DEATH

Registration District No. 2
Primary Registration District No. 1004
County of Ada
City of Boise. (If outside limits, give township) St. Lukes Hospital. St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Albert Jordi

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word.): Single

6. DATE OF BIRTH: — (Month) — (Day) 1843 (Year)

7. AGE: 78 Yrs. — Mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Stockman
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Switzerland

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Harry Looney
(Address) Jordan Valley Oregon

15. Filed Nov 4 1921 R. H. Pratt Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov 1 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 3 1921, to Nov 1 1921, that I last saw h[illegible] alive on Oct 31 1921, and that death occurred on the date stated above, at 11 A M.

The CAUSE OF DEATH* was as follows:

Uremic infection

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary) Chronic nephritis

(Duration) 4 yrs. mos. ds.

(Signed) W. D. Saddoris M. D.

Nov 4 1921 (Address) Boise, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cem — DATE OF BURIAL: Nov 3 1921

20. UNDERTAKER: Simmons & Kebo — ADDRESS: Boise Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

RECEIVED NOV 30 1921 BUREAU OF VITAL STATISTICS

Brotton

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35723
Registered No. 330

1. PLACE OF DEATH
County of Ada
City of Boise
(No. 410. Union St.)
Registration District No. 2
Primary Registration District No. 1004
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Helen Celia Clark

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.): Widow

6. DATE OF BIRTH: Oct (Month) 23 (Day) 1844 (Year)

7. AGE: 77 Yrs. 0 Mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New York.

10. NAME OF FATHER: Stephen Barnum

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Priscilla Grey

13. BIRTHPLACE OF MOTHER (State or Country): Vermont

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Edward Willis Clark
(Address) 325 Overland Bldg Boise

15. Filed Nov 4 1921
R. H. Pratt
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 3 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 24 1921, to Nov 3 1921, that I last saw her alive on June 24 1921, and that death occurred on the date stated above, at 3 P.M.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage

(Duration) ..... Yrs. ..... mos. 10 min ds.
Contributory (Secondary) Respiratory Paralysis
(Duration) ..... yrs. ..... mos. 1 min ds.

(Signed) F. N. Bratton M. D.
Nov 3 1921 (Address) Boise, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery
DATE OF BURIAL: Nov 4 1921
20. UNDERTAKER: Summers & Krebs
ADDRESS: Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
NOV 30 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 3574
Registered No. 371

1. PLACE OF DEATH
County of Ada
City of Boise (No. 1015 Michigan Ave & Howe St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary J. Nugent.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.
4. COLOR OR RACE: White.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widow (Widower)

6. DATE OF BIRTH: Dec 15 (Month) (Day) 1832 (Year)

7. AGE: 88 Yrs. 10 Mos. 17 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: Eudicut Clark.

11. BIRTHPLACE OF FATHER (State or Country): Penn.

12. MAIDEN NAME OF MOTHER: Temperance Rendall

13. BIRTHPLACE OF MOTHER (State or Country): Penn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) L. T. Nugent
(Address) Boise City Idaho

15. Filed Nov. 4 1921 R. V. Pratt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov 1 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 30th 1921, to Nov 1st 1921, that I last saw her alive on Nov 1st 1921, and that death occurred on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:

Senility

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Acute gastritis

(Duration) ..... yrs. ..... mos. 7 ds.

(Signed) J. E. Froom M. D.

11-3-1921 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cem — DATE OF BURIAL: Nov 4 1921

20. UNDERTAKER: Summers & Kelly — ADDRESS: Boise Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED NOV 30 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35725
Registered No. 222

1. PLACE OF DEATH
County of Ada
City of Boise (No. St. Lukes Hospital St.)
Registration District No. 2
Primary Registration District No. 1004
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Edith Gould Dory

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Oct. 3d 1889 (Month) (Day) (Year)

7. AGE: 32 Yrs. 1 Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: James Gould

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C.M.Dory
(Address) Nampa Idaho

15. Filed Nov 4 1921 R. H. Pratt Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov 2 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 30 1921 to Nov 2 1921
that I last saw h alive on Nov 2 1921
and that death occurred on the date stated above, at 11 P M.

The CAUSE OF DEATH* was as follows:
Pulmonary Embolism
following Abdominal Operation

(Duration) Yrs. mos. 1 ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) James L Stewart M. D.
11/4 1921 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Nampa Ida
DATE OF BURIAL: 11/13/21

20. UNDERTAKER: Summers & York
ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

(Stewart)

FORM V. S. No. 5-25 M. 1-19.

RECEIVED NOV 30 1921 BUREAU OF VITAL STATISTICS STATE OF IDAHO

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35726
Registered No. 3[illegible]

1. PLACE OF DEATH
County of Ada. Registration District No. 2
City of Boise (No. 40 Broadway, 40 Boise St.) Primary Registration District No. Boise 4
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Floral Carr Henderlider
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: — — 1848
(Month) (Day) (Year)

7. AGE: 73 Yrs. — Mos. — ds.
IF LESS than 1 day how many ____ hrs. or ____ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Indiana.

10. NAME OF FATHER: Martin Henderlider.

11. BIRTHPLACE OF FATHER (State or Country): Dont Know

12. MAIDEN NAME OF MOTHER: Rachel Peck.

13. BIRTHPLACE OF MOTHER (State or Country): Dont Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W McBratney
(Address) Boise Idaho.

15. Filed Nov 5 1921 R H Pratt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 4 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 24 1921, to Nov 4 1921, that I last saw him alive on Nov 3rd 1921, and that death occurred on the date stated above, at 1950 M.

The CAUSE OF DEATH* was as follows: Toxaemia — Obstruction of Pylorus — Bronchopneumonia — Chronic Nephritis

(Duration) ____ Yrs. ____ mos. ____ ds.

Contributory (Secondary) Bronchopneumonia

(Duration) ____ yrs. ____ mos. ____ ds.

11/24/21 (Signed) C. L. Dutton M. D.
(Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 11/6/21

20. UNDERTAKER: W McBratney — ADDRESS: Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
NOV 30 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH Lamborn

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35727
Registered No. 524

1. PLACE OF DEATH
County of Ada Registration District No. 2
City of Boise (No. 410 State St.) Primary Registration District No. 1004

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Albert Forest Junstrum

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	White	Single

6. DATE OF BIRTH: May (Month) 2 (Day) 1916 (Year)

7. AGE: 5 Yrs. 6 Mos. 2 ds. IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Forest W Junstrum

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Mabel E. Douglas

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Forest W. Junstrum
(Address) Boise Idaho R. 4,

15. Filed Nov 5 1921 R. N. Pratt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: November 4 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from November 2 1921, to November 4, 1921, that I last saw h~~im~~ alive on November 4, 1921, and that death occurred on the date stated above, at 6 00 P.M.

The CAUSE OF DEATH* was as follows:
Broncho-Pneumonia

(Duration) ... Yrs. ... mos. 7 ds.

Contributory (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) Ernest E. Lamborn M. D.
11/5/1921 (Address) Boise, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. 2 days. In the State 5 yrs. 6 mos. ... days
Where was disease contracted if not at place of death? Boise, Idaho R. 4.
Former or usual residence Boise, Idaho R 4.

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Nov 6 1921

20. UNDERTAKER: Summers & Tubbs — ADDRESS: Boise Idg

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35728
Registered No. 85

RECEIVED
NOV 30 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 2
Primary Registration District No. 1004

County of Ada
City of Boise (No. 520 Utah St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Joseph Alson Hamilton

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Dec. (Month) 9 (Day) 1865 (Year)

7. AGE: 55 Yrs. 10 Mos. 27 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Constructor foreman
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Penn.

10. NAME OF FATHER: William Hamilton

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Ida J. Hamilton
(Address) 1520 N. Utah St.

15. Filed Nov 7 1921 R. N. Pruett Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 6 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 10/18 1921 to 11/6 1921 that I last saw him alive on 11/6 1921 and that death occurred on the date stated above, at 9 A.M.
The CAUSE OF DEATH* was as follows:
Hemiplegia (Cerebral Hemorrhage)
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Arterio-Sclerosis
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Fred A. Alvord M. D.
11/7 1921 (Address) Boise

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 11/8 1921

20. UNDERTAKER: Schreiber & Sidenfaden — ADDRESS: Boise
by Pittenger

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

BYRD-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35729

Registered No. 321

RECEIVED
NOV 30 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 2

Primary Registration District No. 1004

County of Ada

City of Boise (If not in incorporated limits, give township) No. 1514 North 15th St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Ann Cooper

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: June (Month) 3 (Day) 1857 (Year)

7. AGE: 64 Yrs. 5 Mos. 3 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Retired Housewife

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Dublin Ireland

10. NAME OF FATHER: Dan Sullivan

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Not obtainable

13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ernest C. Fietze.

(Address) Boise.

15. Filed Nov. 7 1921

R. N. Pratt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 6 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 22 1921 to Nov 6 1921

that I last saw her alive on Nov 1 1921

and that death occurred on the date stated above, at 12 10 P.M.

The CAUSE OF DEATH* was as follows:

Senility

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Nursing.

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Ralph Hall M. D.

11/7 1921 (Address) Boise

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: St Johns Cemetery — DATE OF BURIAL: 11 8 1921

20. UNDERTAKER: Schreiber & Sidenfaden — ADDRESS: Boise

for Pack.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

Beach.

RECEIVED NOV 30 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35730
Registered No. 328

1. PLACE OF DEATH
County of Ada Registration District No. 2
City of Boise. Primary Registration District No. 1004
If death occurs away from usual residence, give facts called for under special information. 110 Oakland St.)
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Martha J. Compton

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widowed (Write the word.)

6. DATE OF BIRTH: June 4 (Month) (Day) 1844 (Year)

7. AGE: 77 Yrs. 4 Mos. 6 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Ohio.

10. NAME OF FATHER: John C. Luke.

11. BIRTHPLACE OF FATHER (State or Country): Ohio.

12. MAIDEN NAME OF MOTHER: Phoebe Sanders

13. BIRTHPLACE OF MOTHER (State or Country): Penn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Warren Compton
(Address) Boise Idy

15. Filed Nov 17 1921 R. W. Pratt Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov 10 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 2nd 1921, to Nov 10th 1921, that I last saw h.r alive on Nov 6th 1921, and that death occurred on the date stated above, at 3:20 A M.

The CAUSE OF DEATH* was as follows:

Apoplexy —

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John Burke M. D.

Nov 12 1921 (Address) Boise Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cem — DATE OF BURIAL: Nov 13 1921

20. UNDERTAKER: Summers & Kebo. — ADDRESS: Boise Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED NOV 30 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35731

Registered No. 379

1. PLACE OF DEATH

County of Ada Registration District No. 2

City of Boise Primary Registration District No. 1004

(No. 410 Hyde St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jennie May Conner

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Aug (Month) 30 (Day) 1882 (Year)

7. AGE: 39 Yrs. 2 Mos. 12 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Sedalia, Mo,

10. NAME OF FATHER: Jas. W. Butler

11. BIRTHPLACE OF FATHER (State or Country): Ind

12. MAIDEN NAME OF MOTHER: Mary Frances Arnett

13. BIRTHPLACE OF MOTHER (State or Country): American

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) G. W. Conner

(Address) Star Idaho

15. Filed Nov 14 1921 R. H. Pratt Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 12 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 8 1921, to Nov. 12 1921, that I last saw her alive on Nov 11 1921, and that death occurred on the date stated above, at 1-40 M.

The CAUSE OF DEATH* was as follows:

General peritonitis, (Toxaemia)

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) L. P. McCallu M. D.

11/14 1921 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence Star Idaho

19. PLACE OF BURIAL OR REMOVAL: Star Cemetery — DATE OF BURIAL: 11 14 1921

20. UNDERTAKER: Schreiber & Redenbaugh — ADDRESS: Boise

Dr. McCallu

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 9
Primary Registration District No. 1404
File No. 35732
Registered No. 2a/

1. PLACE OF DEATH

County of Ada RECEIVED
City of Boise NOV 30 1921 No. 1402 N. 15 St.)
BUREAU OF VITAL STATISTICS

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Claus Rasmussen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	White	married

6. DATE OF BIRTH March 1 (Month) (Day) 1848 (Year)

7. AGE 73 Yrs. 8 Mos. 12 Ds. IF LESS than 1 day how many ____ hrs. or ____ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Denmark

10. NAME OF FATHER Claus Rasmussen

11. BIRTHPLACE OF FATHER (State or Country) Denmark

12. MAIDEN NAME OF MOTHER Elizabeth,

13. BIRTHPLACE OF MOTHER (State or Country) Denmark.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Emma Rasmussen
(Address) 1402 N. 15th Boise

15. Filed Nov. 15 1921 R. H. Pratt Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. (Month) 13 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 12 1921 to Nov 13 1921
that I last saw h[illegible] alive on Nov 12 1921
and that death occurred on the date stated above, at 6.30 M.
The CAUSE OF DEATH* was as follows:
Apoplexy

(Duration) Yrs. mos. 1 ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) P P French M. D.
Nov 15 1921 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Morris Hill Cemetery | DATE OF BURIAL Nov. 16 1921

20. UNDERTAKER Summers & Turbe | ADDRESS Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

RECEIVED NOV 30 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35732
Registered No. 332

1. PLACE OF DEATH
County of Ada
City of Boise (No. 109, N. 14th St.)
Registration District No. 9
Primary Registration District No. 1004

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Frederick Erastus Bush Walker

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH: May 16 1856 (Month) (Day) (Year)

7. AGE: 65 Yrs. 5 Mos. 29 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Electrician
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Buena Vista Co Wis

10. NAME OF FATHER: John J. Walker

11. BIRTHPLACE OF FATHER (State or Country): U. S. A

12. MAIDEN NAME OF MOTHER: Nanna Walker

13. BIRTHPLACE OF MOTHER (State or Country): U. S. A.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. A. Walker
(Address) Boise

15. Filed Nov. 15 1921 — R. C. Grant, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 13 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 1st 1921 to Nov 13 1921
that I last saw h. alive on Nov 13 1921,
and that death occurred on the date stated above, at 6-0 M.

The CAUSE OF DEATH* was as follows:

Edema of Lungs
Cardio-Vascular Renal disease

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Edward F. Dorr M. D.
11/15 1921 (Address) Boise Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Masonic Cemetery	11/15 1921
20. UNDERTAKER	**ADDRESS**
Schreiber & Siedentopf	Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED NOV 30 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35734

Registered No. 3993

1. PLACE OF DEATH

County of Ada Registration District No. 2

City of Boise (No. 926 East Bannock St.) Primary Registration District No. 1004

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Clara Lockwood.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.)
Female	White	Widows

6. DATE OF BIRTH: Nov 27 (Month) 1844 (Day) 1 (Year)

7. AGE: 76 Yrs. 11 Mos. 17 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mass

10. NAME OF FATHER: Mr Delknap

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Miss Grace

13. BIRTHPLACE OF MOTHER (State or Country): Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Nellie Thompson
(Address) Roberts, Idaho

15. Filed Nov 16 1921 R. H. Pratt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 13 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 12th 1921, to Nov. 13th 1921, that I last saw h[illegible] alive on Nov 12 1921, and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:
Mitral valve Regurg
(Duration) ——— Yrs. ——— mos. ——— ds.
Contributory (Secondary) arterio-sclerosis
(Duration) 3 or 4 yrs. ——— mos. ——— ds.

(Signed) Jno. R. [illegible] M. D.
11-15 1921 (Address) Boise Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 11/16 1921

20. UNDERTAKER: Schreiber & Sidenfaden — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
NOV 30 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
Registration District No. 8
Primary Registration District No. 100 4
County of Ada
City of Boise (No. St Lukes Hospital St.)
If death occurs away from usual residence, give facts called for under special information.

File No. 35735
Registered No. 335
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William Losh

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
M.	White	Single (write the word.)

6. DATE OF BIRTH: Aug 19 (Month) (Day) 1851 (Year)

7. AGE: 70 Yrs. 3 Mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Joseph Losh

11. BIRTHPLACE OF FATHER (State or Country): Unknown, ~~Iowa~~

12. MAIDEN NAME OF MOTHER: Jane Hyle

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J E Kyle
(Address) Caldwell

15. Filed Nov 18 1921 — R. H. Coats, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov 16 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 5 1921, to Nov-16 1921, that I last saw him alive on Nov-16 1921, and that death occurred on the date stated above, at 1 P. M.

The CAUSE OF DEATH* was as follows:
Myo cardites
Endo Carditis

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) R J Coleman M. D.
11/17 1921 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Nov 1921

20. UNDERTAKER: Summers & Krebs — ADDRESS: Boise Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35736
Registered No. 5326

RECEIVED
NOV 30 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Ada
City of Boise (No. 1410 State St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No. 1 or 4

2. FULL NAME Emma Jake

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: married (Write the word.)

6. DATE OF BIRTH: Jan 7 (Month) (Day) 1884 (Year)

7. AGE: 37 Yrs. 10 Mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Rasmus Peterson

11. BIRTHPLACE OF FATHER (State or Country): Denmark.

12. MAIDEN NAME OF MOTHER: Minni Peterson

13. BIRTHPLACE OF MOTHER (State or Country): Denmark.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. [illegible]
(Address) Boise Idaho.

15. Filed Nov 21 1921 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 11 (Month) 18 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11/9 1921, to 11/18 1921, that I last saw her alive on 11/18 1921 and that death occurred on the date stated above, at 4P M.

The CAUSE OF DEATH* was as follows:
Acute nephritis
Atrophy of liver
(Duration) ..... Yrs. ..... mos. 18 ds.
Contributory (Secondary) Acute nephritis
(Duration) ..... yrs. ..... mos. 18 ds.

(Signed) Ralph Falk M. D.
11/22 1921 (Address) Boise

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Nov 21 1921
20. UNDERTAKER: Summers & Tribs — ADDRESS: Boise Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED
NOV 30 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Ada — Registration District No. 4

City of Boise — Primary Registration District No. 4

(No. Hillpomona Hospital St.)

File No. 35737

Registered No. 339

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charles Clinton Vaughan

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.)
M.	W.	Single

6. DATE OF BIRTH Dec 27 - 1866
(Month) (Day) (Year)

7. AGE 54 Yrs. 10 Mos. 23 ds.
IF LESS than 1 day how many ____ hrs. or ____ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Oregon.

10. NAME OF FATHER J. W. Vaughan

11. BIRTHPLACE OF FATHER (State or Country) Virginia

12. MAIDEN NAME OF MOTHER Ann Briggs.

13. BIRTHPLACE OF MOTHER (State or Country) Dont Know.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W McBratney
(Address) Boise Idaho

15. Filed Nov 22 1921 — R. H. Pruett, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov 20 - 1921
(Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ____ 19__, to ____ 19__, that I last saw h__ alive on ____ 19__, and that death occurred on the date stated above, at ____ M.
The CAUSE OF DEATH* was as follows:

(Duration) ____ Yrs. ____ mos. ____ ds.

Contributory (Secondary)

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) ____ M. D.
11/21/21 19__ (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Eugene, Oregon	19__

20. UNDERTAKER W McBratney — ADDRESS Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-25 M. 1-19.

RECEIVED NOV 30 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Ada — Registration District No. 7

City of Boise (No. 410 State St.) — Primary Registration District No. 1004

File No. 35738

Registered No. 34

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Michael Murphy

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: March (Month) — (Day) — 1848 (Year)

7. AGE: 73 Yrs. 8 Mos. ds.

IF LESS than 1 day: how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Mining and

(b) General nature of industry, business or establishment in which employed (or employer): Ranching

9. BIRTHPLACE (State or Country): Ireland

10. NAME OF FATHER: Not obtainable

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Not obtainable

13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Gertrude Myles Keller

(Address) 1020 E. Jefferson, Boise, Ida.

15. Filed Nov 23 1921 — R. H. Pratt, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: November (Month) — 22nd (Day) — 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 15th 1921, to Nov 22 1921, that I last saw h.i.m. alive on Nov 22 1921, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia, due to Chronic Arterio Sclerosis and myocarditis

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) L. D. McCalla M. D.

11/23 1921 (Address) L. D. McCalla

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence Garden Valley Ida

19. PLACE OF BURIAL OR REMOVAL: St Johns Cemetery — DATE OF BURIAL: 11/25 1921

20. UNDERTAKER: Scherber & Sidenfaden — ADDRESS: Boise Ida

L. D. McCalla

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19. RECEIVED NOV 30 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35739
Registered No. 342

1. PLACE OF DEATH
Registration District No. 7
Primary Registration District No. 1 1/2 W
County of Ada
City of So. Boise (No. 1109 Lincoln St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Andrew Algren

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Widower

6. DATE OF BIRTH: Oct (Month) 20 (Day) 185X (Year)

7. AGE: 70 Yrs. 1 Mos. — ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired Miner
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER: Andrew Algren

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Not obtainable

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Ruby Lamanby
(Address): Boise Ida.

15. Filed Nov 22 1921 P. H. Pratt Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 20 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I ~~attended~~ saw deceased from Nov. 21 1921 to ..... 19.....
that I last saw ~~him~~ alive on dead Nov. 21 1921
and that death occurred on the date stated above, at 11P M.

The CAUSE OF DEATH* was as follows:
Valvular Heart disease

.....(Duration) .....Yrs. .....mos. .....ds.

Contributory (Secondary)

.....(Duration) .....yrs. .....mos. .....ds.

(Signed) Clyde E. Dunnum Coroner
Nov 22 1921 (Address) Boise Idaho Ada County

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 11/25 1921

20. UNDERTAKER: Schreiber & Nickerson — ADDRESS: Boise Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY; PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19. RECEIVED NOV 30 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35741
Registered No. 2475

1. PLACE OF DEATH
County of Ada
City of Boise.
Registration District No. 2
Primary Registration District No. 1004
(No. St. Lukes Hospital St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mollie M. Rowe.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F.	White.	Married

6. DATE OF BIRTH: mar 22 1896 (Month) (Day) (Year)

7. AGE: 25 Yrs. 8 Mos. 4 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Wisconsin

10. NAME OF FATHER: William Kidd

11. BIRTHPLACE OF FATHER (State or Country): Wisconsin

12. MAIDEN NAME OF MOTHER: Lucinda Spry.

13. BIRTHPLACE OF MOTHER (State or Country): Wisconsin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Norman Rowe
(Address) Boise Idaho

15. Filed Nov 26 1921 R. H. Pratt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: nov 25 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 24 1921, to Nov 25 1921, that I last saw h[illegible] alive on Nov 24 1921, and that death occurred on the date stated above, at 7:45 M.

The CAUSE OF DEATH* was as follows:
Anuria Endocarditis
Toxic Pneumonia
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) James L Pleasants M. D.
11/26 1921 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Canton Wis. DATE OF BURIAL: Nov 27 1921

20. UNDERTAKER: Summers Furn. Co. ADDRESS: Boise Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
NOV 30 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 25712
Registered No. 346

1. PLACE OF DEATH
County of Ada — Registration District No. 2
City of Boise — Registration District No. 1004
(No. 1415 Harrison Blvd. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Marie Irvine Mourse

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F.	White	Married

6. DATE OF BIRTH: Sept 7 (Month) (Day) 1869 (Year)

7. AGE: 52 Yrs. 2 Mos. 24 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: Samuel R. Crawford.

11. BIRTHPLACE OF FATHER (State or Country): Ohio.

12. MAIDEN NAME OF MOTHER: Marie Irvine

13. BIRTHPLACE OF MOTHER (State or Country): Ohio.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Harry Webb.
(Address): Boise Idaho

15. Filed Nov 29 1921 — R. H. Trail, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: November 26th 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 19th 1921, to Nov 26th 1921, that I last saw her alive on Nov. 26th 1921, and that death occurred on the date stated above, at 10:30 P.M.

The CAUSE OF DEATH* was as follows:
Pneumonia - Lobar
(Duration) — Yrs. — mos. 7 ds.
Contributory (Secondary) Chronic Arterial hyper tension, and Cardiac hypertrophy (Duration) 3 or 4 yrs. — mos. — ds.

(Signed) L. M. Taylor M. D.
11/28 1921 (Address) Boise Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. 1 days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Morris Hill Cem.	Nov 27 1921
20. UNDERTAKER	ADDRESS
Summers & Webb.	Boise Ida.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

French.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
NOV 30 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Ada
City of Boise (If not in incorporated place, give township) No. 116 No. 17 St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No.
File No. 3543
Registered No. 347
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Earl W. Cahoon.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: April 9 (Month) (Day) 1879 (Year)

7. AGE: 42 Yrs. 7 Mos. 18 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Clerk.
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): New York.

10. NAME OF FATHER: Dexter G. Cahoon.

11. BIRTHPLACE OF FATHER (State or Country): New York.

12. MAIDEN NAME OF MOTHER: Augusta Fobes.

13. BIRTHPLACE OF MOTHER (State or Country): New York.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Earl W. Cahoon
(Address) Boise Ida. 116 N 11th St

15.
Filed Nov. 29 1921
R. N. Frost
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov 28 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 27 1921 to Nov 27 1921 that I last saw h..... alive on Nov 27 1921, and that death occurred on the date stated above, at 1 A.M.
The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... Yrs. ..... mos. 4 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) P. P. French M. D.
11-29 1921 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cem. DATE OF BURIAL: Nov 29 1921

20. UNDERTAKER: Summers & Kibbs. ADDRESS: Boise Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
NOV 30 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 5

Primary Registration District No. 2007

File No. 35744

Registered No. 74

County of Ada

City of Boise (No. House, Street or Rural Route) Station. 2 miles West of Boise St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James Meek.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married.

6. DATE OF BIRTH: Jan. 22, 1854.
(Month) (Day) (Year)

7. AGE: 67 Yrs. 9 Mos. 22 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ky.

10. NAME OF FATHER: John Meek.

11. BIRTHPLACE OF FATHER (State or Country): Not Known

12. MAIDEN NAME OF MOTHER: ?

13. BIRTHPLACE OF MOTHER (State or Country): ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. McBratney
(Address) Boise. Ida

15. Filed Nov 17 1921 R. H. Stead Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov 15 - 1921
(Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on about 3 months 1920.
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Cancer of Stomach
(Duration) 1 Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) James H. Stewart M. D.
11/16 19 21 (Address) Boise. Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 11/17/21 19

20. UNDERTAKER: W. McBratney — ADDRESS: Boise Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35745
Registered No. 75

RECEIVED
NOV 30 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Ada
Registration District No. 8
Primary Registration District No. 2208
City of Barber (Or Mile East of Boise St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elia Bartlett Nicols.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.
4. COLOR OR RACE: White.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: M (Write the word).

6. DATE OF BIRTH: Sep 27, 1850 (Month) (Day) (Year)

7. AGE: 71 Yrs. 1 Mos. 29 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Ill.

10. NAME OF FATHER: Elbridge Garry.

11. BIRTHPLACE OF FATHER (State or Country): West Va

12. MAIDEN NAME OF MOTHER: Sarah Potter.

13. BIRTHPLACE OF MOTHER (State or Country): Penn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Emma N. Thorn
(Address) Pasha Station Wash.

15. Filed Nov 26 1921 — R. H. Pratt, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov 26 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 10 1921, to Nov 26 1921, that I last saw her alive on Nov 15 1921, and that death occurred on the date stated above, at 8-9 A.M.

The CAUSE OF DEATH* was as follows:
Myocarditis
(Duration) ... Yrs. 4 mos. ... ds.
Contributory (Secondary) Senility
(Duration) ... Yrs. ... mos. ... ds.

(Signed) L. D. Anderson M. D.
19 ... (Address) 319 Idaho Bldg

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Nov 27 1921

20. UNDERTAKER: Summers & Cobb. — ADDRESS: Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35746

Registered No. 76

RECEIVED
NOV 30 1927
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 8

Primary Registration District No. 2090

County of Ada

City of

No. Star. St. Alden Chapel

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Baby De Mayer

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Nov (Month) 24th (Day) 1921 (Year)

7. AGE: ... Yrs. ... Mos. 6 ds.

IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ada County. Idaho

10. NAME OF FATHER: Ed De Mayer

11. BIRTHPLACE OF FATHER (State or Country): Belgium

12. MAIDEN NAME OF MOTHER: Emma Gifford

13. BIRTHPLACE OF MOTHER (State or Country): Belgium

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ed De Mayer

(Address) Boise. Idaho.

15. Filed Nov. 26 1921 — H. H. Pratt, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 26th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 24 1921 to Nov 26 1921 that I last saw h. im alive on Nov 24 1921 and that death occurred on the date stated above, at 2 A. M.

The CAUSE OF DEATH* was as follows:

Convulsions - following abdominal birth

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) I. Newbrook M. D.

Nov 26 1921 (Address) Boise Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: St Johns Cemetery — DATE OF BURIAL: 11/22 1921

20. UNDERTAKER: Schreiber & Siebenforn — ADDRESS: Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

Dr. 13266

FORM V. S. No. 5-25 M-1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35747

Registered No. [illegible]

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

RECEIVED NOV 30 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 8

Primary Registration District No. 2698

County of Boise

City of Jerusalem (If outside city limits, write "No") Boise Star Route Box 10 (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Maurice Quinn

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: May (Month) 24 (Day) 1855 (Year)

7. AGE: 66 Yrs. 3 Mos. 4 ds.

IF LESS than 1 day: how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer and

(b) General nature of industry, business or establishment in which employed (or employer): Stock Raiser

9. BIRTHPLACE (State or Country): Mass.

10. NAME OF FATHER: John Quinn

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER: Ellen Kern

13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Harold Quinn

(Address) Horseshoe Bend Idaho

15. Filed Nov. 29 1921. R. H. Pratt, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 28 (Day) 1921. (Year)

17. I HEREBY CERTIFY, That I ~~attended~~ deceased ~~from~~ died Nov. 28 1921 that I last saw him alive on Nov. 28 1921 and that death occurred on the date stated above, at 11:45 P.M.

The CAUSE OF DEATH* was as follows:

Apoplexy fell over dead at his house, Called Dr. [illegible] Coroner after death

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Wilford H. Quinn Son

19..... (Address) Horseshoe Bend

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former usual residence Jerusalem Boise Co

19. PLACE OF BURIAL OR REMOVAL: St. Johns Cemetery — DATE OF BURIAL: 11/30 1921.

20. UNDERTAKER: Schreiber & Heidenfaden — ADDRESS: Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED NOV 30 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH.

35748

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 4

Registered No. 60

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No. 116

County of Bingham

Subdivision Registration District No. 2155

City of Springfield

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Eva Hawker

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. Oct (Month) 9 (Day) 1921 (Year)

7. AGE ..... Yrs. ..... Mos. 8 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Robert Samuel Hawker

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Lois Edna Eudora

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lois E. Hawker

(Address) Springfield Ida

15. Filed Oct 17 21 191 Incamentium, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 17 (Day) 21 191 (Year)

17. I HEREBY CERTIFY, That I attended deceased from birth 191..., to Oct 17 1921, that I last saw h[er] alive on Oct 16 1921, and that death occured on the date stated above, at 5A M.

The CAUSE OF DEATH* was as follows:

Premature birth
7th month

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) W. C. Incamentium M. D.

Oct 17 1921 (Address) Aberdeen Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Springfield Ida — DATE OF BURIAL: Oct 18 21 191

20. UNDERTAKER: Friends — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SOBS. 24653

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED
NOV 30 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35749

Registered No. 19

Registration District No. .....

Primary Registration District No. 11

1. PLACE OF DEATH

County of Ada

City of Meridian (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William C. Schaefer

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH: Oct (Month) 30 (Day) 1910 (Year)

7. AGE: 10 Yrs. 11 Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: School Boy
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Wisconsin

10. NAME OF FATHER: Joseph Schaefer

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Annie Krueger

13. BIRTHPLACE OF MOTHER (State or Country): N. Y.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Emma Schaefer
(Address) Meridian

15. Filed Nov. 5 1921 N. F. Neal Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 1 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1 1921, to Sept 9 1921, that I last saw h.im alive on Sept 21 1921, and that death occurred on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

(Duration) ..... Yrs. 1 mos. ..... ds.

Contributory (Secondary) Appendiceal abcess

(Duration) ..... yrs. 1½ mos. ..... ds.

(Signed) J. R. Numbers M. D.

Oct 3 1921 (Address) Meridian Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Meridian Ida — DATE OF BURIAL: Oct 5 1921

20. UNDERTAKER: W. B. Waters — ADDRESS: Meridian

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED
NOV 30 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3575C
Registered No. 20

1. PLACE OF DEATH
County of Ada. Registration District No.
Primary Registration District No. 11
City of Meridian (No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Cecil Carpenter
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write this word.)
Male.	White	Single

6. DATE OF BIRTH: April (Month) 10 (Day) 1913 (Year)

7. AGE: 6 Yrs. 4 Mos. 28 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: School boy
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Albion Cassia Co.

10. NAME OF FATHER: Harry D Carpenter

11. BIRTHPLACE OF FATHER (State or Country): Michigan

12. MAIDEN NAME OF MOTHER: Rose E. Mills

13. BIRTHPLACE OF MOTHER (State or Country): Wisconsin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Harry D Carpenter
(Address) Meridian Idaho

15. Filed 11/5 1921 H. F. Nash Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 6 (Day) 1921 (Year)

17. I HEREBY CERTIFY, ~~That I attended deceased from~~ Came to his death, Oct 6 1921 that I last saw h..... alive on ..... 19....., and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Accidental drowning
Fell in irrigation ditch
(Duration) Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) Clyde E. Summers Coroner
Oct 7 1921 (Address) Boise Ada County

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Meridian Cemetery — DATE OF BURIAL: Oct. 8 1921

20. UNDERTAKER: W Preston Meridian Idaho — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED NOV 30 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 9+10

Primary Registration District No.

File No. 3575

County of Ada

City of Boise (or Eagle, Idaho, St.)

Registered No. 1

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Loss Cleo Woods

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M.	W.	Single

6. DATE OF BIRTH Jan. - 14 - 1911
(Month) (Day) (Year)

7. AGE 10 Yrs. 10 Mos. - 16 - ds.

If LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business or establishment in which employed (or employer) In School

9. BIRTHPLACE (State or Country) Eagle Idaho

10. NAME OF FATHER J. F. Woods,

11. BIRTHPLACE OF FATHER (State or Country) Arkansas

12. MAIDEN NAME OF MOTHER Ellen Canafax

13. BIRTHPLACE OF MOTHER (State or Country) Ark Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. McBratney
(Address) Boise, Idaho

15. Filed Nov. 19 21 Orville Jackson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov 18 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 14 1921, to Nov 18 1921 that I last saw h.. alive on Nov 18 1921, and that death occurred on the date stated above, at 1:00 P.M.
The CAUSE OF DEATH* was as follows:

Labar Pneumonia
(Duration) ..... Yrs. ..... mos. 4 ds.
Contributory (Secondary) Endocarditis
(Duration) 4 yrs. ..... mos. ..... ds.

(Signed) Grover Hall M. D.
Nov 18 1921 (Address) Eagle

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Dry Creek Cemetery	11 - 22 1921

20. UNDERTAKER	ADDRESS
W. McBratney	Boise Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Ada — Registration District No. 9 + 10 — 35752

City of ——— (If outside city limits, give township.) — Primary Registration District No. ——— — File No. 5

If death occurs away from usual residence, give facts called for under special information. — 2. FULL NAME William N. A. Shaffer. — Registered No. ———

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

RECEIVED NOV 30 1921 BUREAU OF VITAL STATISTICS

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word.)
M.	White.	Married

6. DATE OF BIRTH: May 10 (Month) (Day) 1839 (Year)

7. AGE: 82 Yrs. 6 Mos. 4 ds. — IF LESS than 1 day how many ——— hrs. or ——— min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer.
(b) General nature of industry, business or establishment in which employed (or employer): ———

9. BIRTHPLACE (State or Country): Virginia

10. NAME OF FATHER: William Shaffer.

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. A. Shaffer
(Address) ———

15. Filed Nov. 15 19 21 — Orville Johnson, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 14 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 19 21 to Nov 14 19 21
that I last saw h[illegible] alive on Nov 14 19 21
and that death occurred on the date stated above, at ——— M.
The CAUSE OF DEATH* was as follows:
Angina Pectoris

(Duration) ——— Yrs. ——— mos. 1 ds.
Contributory (Secondary) Senility
(Duration) ——— yrs. ——— mos. ——— ds.
(Signed) C. W. Hall M. D.
19 ——— (Address) Star Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ——— yrs. ——— mos. ——— days. In the State ——— yrs. ——— mos. ——— days
Where was disease contracted if not at place of death? ———
Former or usual residence ———

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Star Cemetery	Nov 16 1921
20. UNDERTAKER	ADDRESS
Summers & Cobb.	Boise Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED NOV 30 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

35753

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Ada — Registration District No. 9 & 10

City of 5 miles South of Star — Primary Registration District No.

File No. 1

Registered No. 1

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Doris Audrey Bowen.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word.)
F.	White.	Single

6. DATE OF BIRTH: June (Month) 2 (Day) 1911 (Year)

7. AGE: 10 Yrs. 4 Mos. 28 ds. — IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Student.
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: Charles Bowen

11. BIRTHPLACE OF FATHER (State or Country): Iowa.

12. MAIDEN NAME OF MOTHER: Laura Cumming

13. BIRTHPLACE OF MOTHER (State or Country): Iowa.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chas Bowen
(Address) Meridian Ida

15. Filed Nov. 21 19 21 — Orville Jepsen, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct 30 (Month) (Day) 19 21 (Year)

17. I HEREBY CERTIFY, That I ~~attended~~ saw deceased ~~from~~ Oct 30 1921, ~~to~~ ..... 19....., ~~that I last saw h alive on~~ ..... 19....., and that death occurred on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:
Accidently killed by automobile turned over and fractured skull.
(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Clyde E Summers Coroner M.D.
6/31 1921 (Address) Boise Ada County

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Meridian Ida — DATE OF BURIAL: Dec. 2 1921

20. UNDERTAKER: Summers & Gebs. — ADDRESS: Boise Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

35754

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 4-10

Primary Registration District No.

File No.

County of Ada

City of Eagle (No. , St.)

Registered No. 1

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Evelyn Snell

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.): Infant

6. DATE OF BIRTH: Nov. (Month) 1 (Day) 1921 (Year)

7. AGE: ..... yrs. ..... mos. 6 ds.

IF LESS than 1 day how many ..... *hrs.* or ..... *min.*?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Eagle Idaho

10. NAME OF FATHER: L. L. Snell

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Lizzie McGrath

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) L. L. Snell

(Address) Eagle, Ida.

15. Filed Nov. 7 1921 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 6 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 1 1921, to Nov 6. 1921 that I last saw h[illegible] alive on Nov. 6 1921, and that death occurred on the date stated above, at 6.30 P. M.

The CAUSE OF DEATH* was as follows:

malnutrition

(Duration) ..... yrs. ..... mos. 6 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.

19..... (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Dry Creek Cemetery — DATE OF BURIAL: 11/7 1921

20. UNDERTAKER: Schreiber & Hedenstedt — ADDRESS: Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

Registration District No. 9 + 10 35755

Primary Registration District No.

(No. , St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

Registered No.

1. PLACE OF DEATH

County of Ada

City of Eagle

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lee Elmer Harris

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: July (Month) 3 (Day) 21 (Year)

7. AGE: Yrs. 4 Mos. 16 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Boise

10. NAME OF FATHER: J. E. Harris

11. BIRTHPLACE OF FATHER (State or Country): Nebraska.

12. MAIDEN NAME OF MOTHER: Ora E. Brown

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. E. Harris

(Address) Eagle Idaho

15. Filed Nov. 20 19 24

Orville Jackson
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: November (Month) 19 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 8 1924., to Nov 9 1924 that I last saw h. him alive on Nov 9 1924., and that death occurred on the date stated above, at 2: A.M.

The CAUSE OF DEATH* was as follows:

Accidental suffocation

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Gramyr Hall M. D.

Nov 19 1924. (Address) Eagle Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mary's Hill — DATE OF BURIAL: Nov. 20 1924

20. UNDERTAKER: Summers & Kings — ADDRESS: Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED NOV 30 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35757

Registered No.

1. PLACE OF DEATH

County of Ada ; Registration District No.

City of Meridian ; Primary Registration District No.

(If outside limits of city or village, give township.) (St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Victor Overton

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH: Dec. (Month) 13 (Day) 1903 (Year)

7. AGE: 18 Yrs. 11 Mos. 9 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: School boy
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ark. - Washington Co

10. NAME OF FATHER: John Overton

11. BIRTHPLACE OF FATHER (State or Country): Washington Co Ark.

12. MAIDEN NAME OF MOTHER: Anna Johnson

13. BIRTHPLACE OF MOTHER (State or Country): Washington Co Ark.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): J. B. Overton
(Address): Meridian Idaho

15. Filed 12/3 1921 — N. F. Neal, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 20 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 15th 1921 to Nov 20 1921 that I last saw h.im alive on Nov 20 1921, and that death occurred on the date stated above, at 8:30 P.M.

The CAUSE OF DEATH* was as follows:
Double Pneumonia
Bronchial

(Duration) Yrs. mos. 6 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) N. F. Neal M. D.

19 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Meridian — DATE OF BURIAL 19

20. UNDERTAKER: W. D. Bailey Meridian — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

...D FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35758
Registered No.

RECEIVED
NOV 30 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No.
Primary Registration District No.
County of Ada
City of Meridian (No.) (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME. Elizabeth Pittman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Female	White	Married

6. DATE OF BIRTH: Nov. 22. 1865 (Month) (Day) (Year)

7. AGE: 56 Yrs. Mos. 11 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House Keeper
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Salt Lake City Utah

10. NAME OF FATHER: Henry Billman

11. BIRTHPLACE OF FATHER (State or Country): Ohio.

12. MAIDEN NAME OF MOTHER: Elizabeth Barnes

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Sidney Pittman
(Address) Meridian R. No. 2.

15. Filed 12-5 1921 H F Neal Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. 3. 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at 5 P. M.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
Arteriosclerosis
(Duration) 5 Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) H. F. Neal M. D.
12-5 1921 (Address) Meridian

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Nampa Idaho	Dec. 7 1921
20. UNDERTAKER	ADDRESS
W. B. Maleer	Meridian Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED
NOV 30 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

35759

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 124
Registration District No. 1702
File No. 1
Registered No. 37

1. PLACE OF DEATH

County of Ada

City of Kuna (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Infant Jerome

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Fem	White	

6. DATE OF BIRTH: Oct (Month) 25 (Day) 1921 (Year)

7. AGE: 0 Yrs. 0 Mos. 0 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: 0
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ida

10. NAME OF FATHER: L. P. Jerome

11. BIRTHPLACE OF FATHER (State or Country): Ino

12. MAIDEN NAME OF MOTHER: Edna Lower

13. BIRTHPLACE OF MOTHER (State or Country): Ino

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) L. P. Jerome
(Address)

15. Filed 11-2 1921 Wyle Stivens, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 26 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 25 1921, to Oct 26 1921, that I last saw h[illegible] alive on Oct 26 1921 and that death occurred on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:

Prematurity

(Duration) ..... Yrs. ..... mos. 1 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) M. D. Sims M. D.

Oct 26 1921 (Address) Nampa Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Kuna Cem. DATE OF BURIAL: 10-27-1921

20. UNDERTAKER: F. R. Robinson ADDRESS: [illegible]

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED
NOV 30 19
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84

Local Registration District No. 2161

File No. 35760

Registered No.

1. PLACE OF DEATH

County of Bannock

City of Bancroft (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Francis Smeath

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F	white	widow

6. DATE OF BIRTH: Feb 20, 1836 (Month) (Day) 1 (Year)

7. AGE: 85 Yrs. 7 Mos. ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: H.W.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: John Henry Barker

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: ?????? Jaape

13. BIRTHPLACE OF MOTHER (State or Country): France

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J.C. Smeath (son)
(Address) Bancroft

15. Filed 11-1 19 2
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: October 31 (Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 19, to 19, that I last saw h alive on 19, and that death occurred on the date stated above, at M.
The CAUSE OF DEATH* was as follows:
Senility Chronic

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

19 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Montpelior	19
20. UNDERTAKER	**ADDRESS**
F.M.Williams	Mont

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
NOV 30 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 84

Primary Registration District No. 2161

File No. 35761

County of Bannock

City of Bancroft (No. ....., ... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME George Denton

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
M	W	single (Write the word.)

6. DATE OF BIRTH: March 30, 1911 (Month) (Day) 1 (Year)

7. AGE: 10 Yrs. 6 Mos. 19 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: school boy
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Bancroft, Idaho

10. NAME OF FATHER: Alfred Denton

11. BIRTHPLACE OF FATHER (State or Country): Nebraska

12. MAIDEN NAME OF MOTHER: Louisa Smith

13. BIRTHPLACE OF MOTHER (State or Country): Logan Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Thomas Edgeley
(Address) Bancroft

15. Filed 11-1 1921 — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: October 19, 1921 (Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 28 19 21, to October 19 19 21, that I last saw h im alive on October 18 19 21 and that death occurred on the date stated above, at 4 A M.

The CAUSE OF DEATH* was as follows:

Typhoid fever

..... (Duration) ..... Yrs. ..... mos. 25 ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

10-19 21 (Address) Bancroft

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Logan Utah	..... 19 .....
20. UNDERTAKER	ADDRESS
G. A. Lundquist	Logan

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

35762

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
NOV 30 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 28

County of Bannock

Primary Registration District No. 2141

File No. 44

City of Pocatello (No. 357 N Harrison St.)

Registered No. 3669

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Ann Small

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Divorced

6. DATE OF BIRTH: Dec. (Month) 4 (Day) 1847 (Year)

7. AGE: 72 Yrs. 10 Mos. 2 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): England.

10. NAME OF FATHER: Henry Burton

11. BIRTHPLACE OF FATHER (State or Country): England.

12. MAIDEN NAME OF MOTHER: Sarah Sanderson

13. BIRTHPLACE OF MOTHER (State or Country): England.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Elizabeth [illegible]
(Address) 357 N. Harrison

15. Filed 12/4 1924

J. H. Young
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. (Month) 5 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1 1921, to Oct 5 1921
that I last saw her alive on Oct 5 1921
and that death occurred on the date stated above, at 12:30 P.M.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) 5 Yrs. mos. ds.

Contributory (Secondary) Apoplexy 3rd attack

(Duration) Yrs. 1 mos. ds.

(Signed) A. M. Newton M. D.

Oct 6 1921 (Address) Pocatello Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Summer Bros.	Oct 8 1921

20. UNDERTAKER: H. E. McKan. ADDRESS: 215 S. Main Pocatello Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-25 M. 1-19.

RECEIVED NOV 30 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

35763

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Bannock
City of Pocatello
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 28
Primary Registration District No. 2141
File No. 44
Registered No. 8670
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

186 N Harrison St.)

2. FULL NAME Forest Glenn Dutton

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH: Oct (Month) 5 (Day) 1921 (Year)

7. AGE: Yrs. 1 Mos. 3 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Pocatello

10. NAME OF FATHER: Joseph Earl Dutton

11. BIRTHPLACE OF FATHER (State or Country): Pocatello

12. MAIDEN NAME OF MOTHER: Florence Bailey

13. BIRTHPLACE OF MOTHER (State or Country): Ogden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Florence Bailey
(Address) Pocatello

15. Filed 10/7 1921 — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 8 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 8 1921, to Oct 8 1921, that I last saw him alive on Oct 8 1921, and that death occurred on the date stated above, at 4:10 a. M.

The CAUSE OF DEATH* was as follows:
Septicemia following infection of umbilicus & circumcision

(Duration) ..... Yrs. ..... mos. 6 ds.
Contributory (Secondary): Enteritis
(Duration) ..... yrs. ..... mos. 4 ds.

(Signed) A. M. Newton M. D.
Oct 7 1921 (Address) Pocatello, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Tranients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Pocatello Cemetery — DATE OF BURIAL: 10/10 1921

20. UNDERTAKER: P. T. Parker — ADDRESS: Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51068

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

35764

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
NOV 30 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Bannock Registration District No. 28

City of Pocatello Registration District No. 216 / Pocatello - 2d St.)

File No. 44

Registered No. 8671

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George W. Logan.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): widower

6. DATE OF BIRTH: Nov (Month) 15 (Day) 1846 (Year)

7. AGE: 74 Yrs. 10 Mos. 9 ds.

IF LESS than 1 day how many..... hrs. or.....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired Railroad
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Jackson Mich.

10. NAME OF FATHER: George W. Logan.

11. BIRTHPLACE OF FATHER (State or Country): Jackson Mich

12. MAIDEN NAME OF MOTHER: Almeria Bogardus

13. BIRTHPLACE OF MOTHER (State or Country): New York.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Mandel L. Broome.
(Address) Rep Bus

15. Filed 12/9 1921

J. Young
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 8 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h[illegible] alive on ..... 19.....
and that death occurred on the date stated above, at 6a M.

The CAUSE OF DEATH* was as follows:

Chronic Asthma

.....(Duration) .....Yrs.....mos.....ds.

Contributory (Secondary)

.....(Duration) .....yrs.....mos.....ds.

(Signed) S S Grogan Coroner M. D.

12/9/1921 (Address) Pocatello Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Walla Walla Wash. DATE OF BURIAL: Oct 1921

20. UNDERTAKER: [illegible] ADDRESS: Pocatello Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 3-25 M. 1-19.

CERTIFICATE OF DEATH

35765

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 44

Registered No. 3672

RECEIVED
NOV 10 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Bannock

City of Pocatello

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2

Primary Registration District No. 2141

(No. Prog North 1st St.)

2. FULL NAME Alfred Dassalli

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6. DATE OF BIRTH: (Month) (Day) 1886 (Year)

7. AGE: 35 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: City Dairy work

(b) General nature of industry, business or establishment in which employed (or employer): Employed

9. BIRTHPLACE (State or Country): Switzerland

10. NAME OF FATHER: Jos. Dassalli

11. BIRTHPLACE OF FATHER (State or Country): Switzerland

12. MAIDEN NAME OF MOTHER: [illegible]

13. BIRTHPLACE OF MOTHER (State or Country): Paris France

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Herbert Smith

(Address) Pocatello

15. Filed 10/11 1921

J. H. Lynn
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct 8 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 6, 1921 to Oct 8 1921 that I last saw him alive on Oct 8 1921 and that death occurred on the date stated above, at 8 P.M.

The CAUSE OF DEATH* was as follows:

Gun shot wound of the abdomen.

(Duration) Yrs. mos. 2 ds.

Contributory (Secondary) Pentonitis

(Duration) yrs. mos. 2 ds.

(Signed) J. H. Lynn M. D.

Oct 10th 1921 (Address) Pocatello

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: I O O F Cemetery DATE OF BURIAL: 10/11 1921

20. UNDERTAKER: W. J. Walker ADDRESS: Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
NOV 30 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

35766

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Bannock — Registration District No. 28
City of Pocatello — Primary Registration District No. 2141 — File No. 44
(No. 646 N Sherman St.) — Registered No. 3673

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Evaline Brady

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: April (Month) 18 (Day) 19?? (Year)

7. AGE: Yrs. 70 Mos. 25 ds.
IF LESS than 1 day how many..... hrs. or..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Pocatello

10. NAME OF FATHER: Florence W. Brady

11. BIRTHPLACE OF FATHER (State or Country): Illinois

12. MAIDEN NAME OF MOTHER: Vera Cameron

13. BIRTHPLACE OF MOTHER (State or Country): Nevada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Florence W Brady
(Address) Pocatello

15. Filed 12/2 1921 — J. Young, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 17 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 7 1921, to Oct 11 1921, that I last saw her alive on Oct 11 1921, and that death occurred on the date stated above, at 2:20 A.M.

The CAUSE OF DEATH* was as follows:
Acute enteritis

(Duration) ... Yrs. ... mos. ... ds.
Contributory (Secondary): None
(Duration) ... yrs. ... mos. ... ds.

(Signed) A M Newton M. D.
Oct 12 1921 (Address) Rm Bldg Pocatello

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Pocatello Cemetery — DATE OF BURIAL: 10/13 1921

20. UNDERTAKER: M. Walker — ADDRESS: Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

28 35767 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
NOV 30 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 28
Primary Registration District No. 2161
File No. 44
Registered No. 8674

County of Bannock
City of Pocatello (If not in hospital, give ward) North Main St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME La Oral May Houghton

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Infant (Write the word.)

6. DATE OF BIRTH: October 8 1921 (Month) (Day) (Year)

7. AGE: — Yrs. — Mos. 4 ds.
IF LESS than 1 day: how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Pocatello Ida.

10. NAME OF FATHER: Ned Houghton

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Gienlieta Hillman

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ned Houghton
(Address) 407 N. Main

15. Filed 10/12 1921 J. H. Young Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: October 12 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 10/8 1921, to 10-12 1921, that I last saw h.er alive on 10-11 1921, and that death occurred on the date stated above, at 5P M.

The CAUSE OF DEATH* was as follows:
Patent foramen Ovale

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. H. Young M. D.
10/12 1921 (Address) Pocatello

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain View Cem — DATE OF BURIAL: Oct 13 1921

20. UNDERTAKER: Schumacher & Hall — ADDRESS: Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-A—25 M. 1-19.

35768

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED NOV 30 1921 BUREAU OF VITAL STATISTICS

Registration District No. 28

Primary Registration District No. 2161

File No. 44

Registered No. 3675

1. PLACE OF DEATH

County of Bannock

City of Pocatello (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME James B. Davis.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
male	white	widower

6. DATE OF BIRTH: July (Month) 21 (Day) 1853 (Year)

7. AGE: 68 Yrs. 2 Mos. 21 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business or establishment in which employed (or employer): Railroad Machinist

9. BIRTHPLACE (State or Country): England.

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) F. M. Davis
(Address) Shelley Idaho

15. Filed 12/14 1921 J. H. Young Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 11 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 10 1921 to Oct 11 1921
that I last saw h[illegible] alive on Oct 11 1921
and that death occurred on the date stated above, at 3.30 P.M.
The CAUSE OF DEATH was as follows:

Contusion following Injury from train injury

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Jno. H. Mooney M. D.
Oct 14 1921 (Address) Pocatello Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Salt Lake City Ut.	Oct 19 21

20. UNDERTAKER: [illegible] McCann ADDRESS Pocatello, Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED NOV 30 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

35769 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 28

County of Bannock — Local Registration District No. 2161 — File No. 44

City or ... Pocatello — No. 1357 N. Garfield St.) — Registered No. 3676

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Walter B Getty

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH — (Month) (Day) (Year)
Near as Known 1855

7. AGE — Yrs. Mos. ds. — IF LESS than 1 day or ... min.?
76 Exact date unknown

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business or establishment in which employed (or employer): Farmer

9. BIRTHPLACE (State or Country): Canada

10. NAME OF FATHER: John Getty

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Lydia Jackson

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Rose Lang
(Address) 928 S. Sauter, Sgt.

15. Filed 10/16 1921 — J P Young, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH — (Month) (Day) (Year)
Oct 14th 1921

17. I HEREBY CERTIFY, That I attended deceased from Oct 1st 1921 to Oct 14th 1921 that I last saw him alive on Oct 14th 1921 and that death occurred on the date stated above, at ... M.

The CAUSE OF DEATH* was as follows:
Senility

(Duration) Yrs. 2 mos. ds.

Contributory (Secondary): none

(Duration) yrs. mos. ds.

(Signed) ... M. D.

Oct 16th 1921 (Address) Pocatello Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain View — DATE OF BURIAL: Oct 16 1921

20. UNDERTAKER: Schumacher & Lee — ADDRESS: Pocatello Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
NOV 30 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

35770
28

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. .....

County of Bannock — Primary Registration District No. 2161

City of Pocatello (If outside city limits, give township.) 321 Buchanan St.)

File No. 40

Registered No. 3677

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Callan Phillips

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Infant (Write the word.)

6. DATE OF BIRTH: September 19 21 (Month) (Day) (Year)

7. AGE: — Yrs. — Mos. 26 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Pocatello Ida.

10. NAME OF FATHER: J. L. Phillips

11. BIRTHPLACE OF FATHER (State or Country): Ogden Ut

12. MAIDEN NAME OF MOTHER: Elizabeth Unsworth

13. BIRTHPLACE OF MOTHER (State or Country): Ogden Ut

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. L. Phillips

(Address) 321 North Buchanan

15. Filed 12/15 1921

J. W. Lamey Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: October 15 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 13 1921, to Oct 15 1921

that I last saw h.er alive on Oct 14 1921,

and that death occurred on the date stated above, at 7 A. M.,

The CAUSE OF DEATH* was as follows:

Bowel Infection
Enteritis

(Duration) Yrs. mos. 6 ds.

Contributory (Secondary) Premature birth

(Duration) yrs. mos. ds.

(Signed) John J. Roof M. D.

Oct 15 1921 (Address) Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain View Ogden — DATE OF BURIAL: Oct 15 19

20. UNDERTAKER: Schumacher & Hall — ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

RECEIVED NOV 30 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

35771

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 28

Primary Registration District No. 2141

File No. 44

Registered No. 3678

1. PLACE OF DEATH

County of Bannock

City of Pocatello (No. 231 N. 6th St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Infant Anselmo

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: Italian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Child (Write the word.)

6. DATE OF BIRTH: Oct 16th 1921 (Month) (Day) (Year)

7. AGE: Still Born Yrs. Mos. ds.

IF LESS than 1 day how many 5½ hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Frank Anselmo

11. BIRTHPLACE OF FATHER (State or Country) Italy

12. MAIDEN NAME OF MOTHER Flora Gratie

13. BIRTHPLACE OF MOTHER (State or Country) Italy

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Frank Anselmo

(Address) 231 N. 6th St.

15. Filed 10/17 1921 J. H. Young Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 10 (Month) 16 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 10-16 1921, to 10-16 1921 that I last saw her alive on 10-16 1921 and that death occurred on the date stated above, at 2P M.

The CAUSE OF DEATH* was as follows:

Patent Foramen Ovale

(Duration) Yrs. mos. ds.

Contributory (Secondary) Premature

(Duration) yrs. mos. ds.

(Signed) J. H. Young M. D.

10/17 1921 (Address) Pocatello Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ...yrs...mos...days. In the State ...yrs...mos...days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain View — DATE OF BURIAL: Oct 17 1921

20. UNDERTAKER: Schumacher & Stahl — ADDRESS: City

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 6-25 M. 1-19.

CERTIFICATE OF DEATH 35772

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 44

Registered No. 3679

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

RECEIVED NOV 30 1921 BUREAU OF STATISTICS

1. PLACE OF DEATH

Registration District No. 28

County of Bannock Primary Registration District No. 2161

City of Pocatello (If not in city give village or township) (Ward) (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs D. J. Wilson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: (Month) (Day) 1860 (Year)

7. AGE: 61 Yrs. Mos. ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: — Wooley

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: /

13. BIRTHPLACE OF MOTHER (State or Country): /

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) D. J. Wilson
(Address) Spencer Ida

15. Filed 1917- 1921 J. Blaney Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 16 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 7 1921 to Oct 16 1921 that I last saw her alive on Oct 16 1921, and that death occurred on the date stated above, at 9 M.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) — Yrs. — mos. 12 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) D. Kinney M. D.

Oct 17 1921 (Address) Spencer Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death — yrs. — mos. 9 days. In the State yrs. mos. days
Where was disease contracted if not at place of death? at Spencer Ida
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Spencer Ida — DATE OF BURIAL: 10 19 21

20. UNDERTAKER: T. T. Walker — ADDRESS: Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-[illegible]

CERTIFICATE OF DEATH

35773

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
NOV 30 1921
BUREAU OF V. S.

1. PLACE OF DEATH

Registration District No. 28

Primary Registration District No. 2161

File No. 4

County of Bannock

City of Pocatello (No. [illegible] St.)

Registered No. 3600

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Frank Mace

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): unknown

6. DATE OF BIRTH: unknown (Month) (Day) 1 (Year)

7. AGE: about 32 years (Yrs.) (Mos.) (ds.)

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: unknown

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): unknown

10. NAME OF FATHER: unknown

11. BIRTHPLACE OF FATHER (State or Country): unknown

12. MAIDEN NAME OF MOTHER: unknown

13. BIRTHPLACE OF MOTHER (State or Country): unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Family & Friends

(Address) Pocatello Idaho

15.

Filed 10/19 1921

J. H. Young
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 16 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....

that I last saw h..... alive on ..... 19.....

and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Gun Shot Wound

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) S. S. Ferguson Coroner M. D.

10-19 1921 (Address) Pocatello Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain View | DATE OF BURIAL: Oct 19 1921

20. UNDERTAKER: Schumacher & Hoy | ADDRESS: Pocatello Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

RECEIVED NOV 30 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

35774 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 28

County of Bannock Primary Registration District No. 2161 File No. 47

City of Pocatello (No. South of City St.) Registered No. 3681

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Orpha E Dash

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6. DATE OF BIRTH: Feb 8th 1870 (Month) (Day) (Year)

7. AGE: 51 Yrs. 8 Mos. 10 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Minn

10. NAME OF FATHER: Elias Engle

11. BIRTHPLACE OF FATHER (State or Country): unknown

12. MAIDEN NAME OF MOTHER: Thornburg

13. BIRTHPLACE OF MOTHER (State or Country): unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Geo. Dash
(Address) P.O. Box 685 Pocatello

15. Filed 10/22 1921

Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Unknown 19.... (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Myocarditis

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) S. E. Ferguson Coroner M. D.

10/22/1921 (Address) Pocatello

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Portland Oregon — DATE OF BURIAL: Oct 23 1921

20. UNDERTAKER: Schumacher Bros — ADDRESS: Pocatello Idaho

FORM V. S. No. 5-25 M. 4-19.

CERTIFICATE OF DEATH

35775

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bannock — Registration District No. 28

City of Pocatello — Primary Registration District No. 2141

(No. St. — Hospital — St.)

File No. 44

Registered No. 3682

If death occurs away from usual residence, give facts called for under special information.

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NOV 30 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME Gladys Simmons

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Single

6. DATE OF BIRTH — Oct (Month) 20 (Day) 1907 (Year)

7. AGE — 14 Yrs. Mos. 7 ds. — IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: School Girl
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Jamestown Calif

10. NAME OF FATHER: James Simmons

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Alma Dubsort

13. BIRTHPLACE OF MOTHER (State or Country): Rockford Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Alma Simmons
(Address): Ranch So of Pocatello

15.
Filed 11/28 1921 — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH — Oct (Month) 27 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 25 1921, to Oct 27 1921, that I last saw her alive on Oct 27 1921, and that death occurred on the date stated above, at 2:30 P.M.

The CAUSE OF DEATH* was as follows:
Brights disease

(Duration) 1½ Yrs. mos. ds.

Contributory (Secondary): uremic coma & convulsions.

(Duration) yrs. mos. 2 ds.

(Signed) [signature] M. D.

Oct 27 1921 (Address) Pocatello Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients or Recent Residents.)
At place of death yrs. mos. 2 days. In the State yrs. mos. days

Where was disease contracted if not at place of death? —

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Mt View	11/29 1921

20. UNDERTAKER	ADDRESS
W T Walker	Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
DEC 8 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

35776

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 28
Primary Registration District No. 7161
File No. 44
Registered No. 3683

1. PLACE OF DEATH

County of Bannock
City of Pocatello
(No. Louraine Hotel St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charles Henry Rose

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Unknown (Month) 1868 (Year)

7. AGE: 45 Yrs. — Mos. — ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Mger Louraine
(b) General nature of industry, business or establishment in which employed (or employer): Hotel

9. BIRTHPLACE (State or Country): Wisconsin

10. NAME OF FATHER: Henry Rose

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Mary Gumbart

13. BIRTHPLACE OF MOTHER (State or Country): Pennsylvania

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Charles H Rose
(Address) Louraine Hotel

15. Filed 11/4 1921
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Charles Henry Rose
November (Month) 2 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from October 22 1921, to November 2 1921, that I last saw him alive on November 2 1921, and that death occurred on the date stated above, at 7.30 P M.
The CAUSE OF DEATH* was as follows:

Pleural Pneumonia

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary) ...

(Duration) ... yrs. ... mos. ... ds.

(Signed) James H Smith M. D.
11/4 1921 (Address) Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain View Cem — DATE OF BURIAL: Nov 5 1921

20. UNDERTAKER: Schumacher & Hall — ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED

CERTIFICATE OF DEATH

28 35777

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No.

Primary Registration District No. 2161

File No. 44

County of Bannock

City of Pocatello (No. 129 - No 5th St.)

Registered No. 3684

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME J. B. Sessions

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: July (Month) ... (Day) ... 1862 (Year)

7. AGE: 59 Yrs. — Mos. — ds.

IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Carpenter

(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Alabama

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. J. B. Sessions

(Address) 129 - No 5th

15. Filed 11/5 1921

J. B. Sessions
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: November (Month) 3 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 29 1921, to Nov 3 1921, that I last saw h[illegible] alive on Nov 3 1921, and that death occurred on the date stated above, at 4 P M.

The CAUSE OF DEATH* was as follows:

Labar Pneumonia

(Duration) ... Yrs. ... mos. 5 ds.

Contributory (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) John J Rodf M. D.

11/4 1921 (Address) Pocatello

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain View Cem. | DATE OF BURIAL: Nov 6 1921

20. UNDERTAKER: Schumacher & Hall | ADDRESS: Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

35779 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED DEC 8 1921 BUREAU OF VITAL STATISTICS

Registration District No. 2141
Primary Registration District No. 45
File No. 3686

1. PLACE OF DEATH
County of Bannock
City of Pocatello (If outside limits of city or village, give township) No. 344 No. Main St. (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs Ann Coffey

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widowed (Write the word.)

6. DATE OF BIRTH: May - (Month) (Day) 1845 (Year)

7. AGE: 76 Yrs. Mos. ds. Exact date unknown.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ireland.

10. NAME OF FATHER: John Burke.

11. BIRTHPLACE OF FATHER (State or Country): Ireland.

12. MAIDEN NAME OF MOTHER: Mary Jones.

13. BIRTHPLACE OF MOTHER (State or Country): Ireland.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ann Coffey
(Address) Pocatello, Idaho

15. Filed 11/5 1921 J. R. Thomas Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov 3rd 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 25 1921, to Nov 3rd 1921 that I last saw h[illegible] alive on Nov 3rd 1921 and that death occurred on the date stated above, at 7:30 P.M.

The CAUSE OF DEATH* was as follows:

Pleuro pneumonia

(Duration) Yrs. mos. ds.

Contributory (Secondary) Pyelonephritis -

(Duration) yrs. mos. ds.

(Signed) H. Alcott M. D.

Nov 5th 1921 (Address) Pocatello Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain View
DATE OF BURIAL: Nov 7 1921

20. UNDERTAKER: D. Chambers Hall
ADDRESS: City

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

35780

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 28

Primary Registration District No. 2141

File No. 43

Registered No. 3687

1. PLACE OF DEATH

County of Bannock

City of Pocatello

(No. 503 N. 14th ave St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lucy M. Soule

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6. DATE OF BIRTH: Oct (Month) 1. (Day) 1847 (Year)

7. AGE: 74 Yrs. 1 Mos. 7 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New York State

10. NAME OF FATHER: Not Known

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Henry Soule

(Address) Pocatello, Idaho

15. Filed Nov 8 1921

J. M. Young
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 7 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 11 1921, to Nov 8 1921, that I last saw h[illegible] alive on Sept 25 1921, and that death occurred on the date stated above, at 2:30 A.M.

The CAUSE OF DEATH* was as follows:

Aortic insufficiency, Mitral insufficiency, Tuberculosis, Chronic nephritis

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Senility

(Duration) several years mos. ..... ds.

(Signed) J. M. Young M. D.

Nov 8 1921 (Address) Pocatello, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2, whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 24 yrs. [illegible] mos. [illegible] days In the State Pocatello yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence Wisconsin

19. PLACE OF BURIAL OR REMOVAL: Mt View Cem — DATE OF BURIAL: Nov 9 1921

20. UNDERTAKER: H. L. McHan — ADDRESS: Pocatello Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

35781

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED DEC 8 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Bannock Registration District No. 28

City of Pocatello (If not in incorporated place, give township) Primary Registration District No. 2141

No. St. Anthony Hospital St.)

File No. 45

Registered No. 36 58

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sarah Gertrude Shaw.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6. DATE OF BIRTH: March 6th 1867 (Month) (Day) (Year)

7. AGE: 54 Yrs. 8 Mos. 2 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Provo Utah

10. NAME OF FATHER: John Nelson

11. BIRTHPLACE OF FATHER (State or Country): Logan Utah

12. MAIDEN NAME OF MOTHER: Sarah Adelaide Wheeler

13. BIRTHPLACE OF MOTHER (State or Country): Ogden Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): John Nelson
(Address): Pocatello

15. Filed 11/9 1921 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. 8 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 8 1921 to Nov 8 1921 that I last saw her alive on Nov 8 1921 and that death occurred on the date stated above, 2:11 M.

The CAUSE OF DEATH* was as follows:

Peritonitis

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Rupture (left) Ectopic Pregnancy

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Hamner C Irwin M. D.

11/8 1921 (Address) Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Black Foot Ida — DATE OF BURIAL: 11 10 1921

20. UNDERTAKER: P. A. Walker — ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK. THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

35782

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 28
Primary Registration District No. 2147
File No. 43
Registered No. 3689

1. PLACE OF DEATH

County of Bannock
City of Pocatello (No. Ogden Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John A. Manison

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single
6. DATE OF BIRTH: May 28 1892 (Month) (Day) (Year)
7. AGE: 29 Yrs. 5 Mos. 12 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Patrolman
(b) General nature of industry, business or establishment in which employed (or employer)
9. BIRTHPLACE (State or Country): Texas
10. NAME OF FATHER: James N. Manison
11. BIRTHPLACE OF FATHER (State or Country): Ill —
12. MAIDEN NAME OF MOTHER: Sarah E. Hobbes
13. BIRTHPLACE OF MOTHER (State or Country): Ill —
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Fred Manison
(Address) Pocatello R.F.D. #1
15. Filed Nov 10 1921 J. H. Lyons Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov 10th 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 13 1921 to Nov 9th 1921 that I last saw him alive on Nov 9th 1921 and that death occurred on the date stated above, at 8.20 P.M.

The CAUSE OF DEATH* was as follows:

General peritonitis
from extravasation of
urine
(Duration) ..... Yrs. ..... mos. 5 ds.
Contributory (Secondary) Injured Kidney
(Duration) 2 yrs. ..... mos. ..... ds.

(Signed) J. H. Lyons M. D.
(Address) J. H. Lyons Pocatello
Nov 10th 1921

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain View | DATE OF BURIAL: Nov 12 1921
20. UNDERTAKER: Schumacher & Hall | ADDRESS: City Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

35783

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 28
Primary Registration District No. 2141
File No. 45
Registered No. 3690

1. PLACE OF DEATH
County of Bannock
City of Pocatello
(No. 517 So. 7th ave. St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Emma H. Ridgeway
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Widow

6. DATE OF BIRTH: June (Month) 27 (Day) 1849 (Year)

7. AGE: 72 Yrs. 4 Mos. 14 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Lived with Son
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: William Orr.

11. BIRTHPLACE OF FATHER (State or Country): Not Known

12. MAIDEN NAME OF MOTHER: Minerva Drennen

13. BIRTHPLACE OF MOTHER (State or Country): Not Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) George Ridgeway
(Address) Pocatello Idaho

15. Filed Nov 10 1921
J. H. Summers
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 10 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 10 1921 to Nov. 10 1921
that I last saw her alive on Nov. 10 1921
and that death occurred on the date stated above, at 12 Noon
The CAUSE OF DEATH* was as follows:
Cerebral Haemorrhage (apoplexy)
(Duration) — Yrs. — mos. 1/4 ds.
Contributory (Secondary) Arteriosclerosis
(Duration) 5 yrs. — mos. — ds.
(Signed) H. J. Howard M. D.
11/10 1921 (Address) Pocatello Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients or Recent Residents.)
At place of death 10 yrs. ..... mos. ..... days. In the State 10 yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence Boulder Colo.

19. PLACE OF BURIAL OR REMOVAL: Mt View Pocatello — DATE OF BURIAL: Nov. 12 1921

20. UNDERTAKER: H. L. McHan — ADDRESS: Pocatello Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-25 M. 1-19.

35784

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 28
Primary Registration District No. 2141
File No. 45
Registered No. 3691

1. PLACE OF DEATH
County of Bannock
City of Pocatello
If death occurs away from usual residence, give facts called for under special information.
(No. 143 S. Hanson St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Elizabeth Phalen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widowed
6. DATE OF BIRTH: Sept 11 1848 (Month) (Day) (Year)
7. AGE: 73 Yrs. 2 Mos. 1 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business or establishment in which employed (or employer)
9. BIRTHPLACE (State or Country): Ohio
10. NAME OF FATHER: William McGlinchey
11. BIRTHPLACE OF FATHER (State or Country): Ireland
12. MAIDEN NAME OF MOTHER: Elizabeth Doris
13. BIRTHPLACE OF MOTHER (State or Country): Ireland
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) James Jassett
(Address) Pocatello Idaho
15. Filed Nov 12 1921
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: November 11th 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 1st 1921, to November 11th 1921, that I last saw her alive on November 10th 1921, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Fibrous Myocarditis

(Duration) 1 Yrs. ..... mos. ..... ds.

Contributory (Secondary) Arterio-sclerosis

(Duration) 1 Yrs. ..... mos. ..... ds.

(Signed) Wm. A. Bryden M. D.

11/12 1921 (Address) Pocatello, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Riverview Mass — DATE OF BURIAL: Nov 14 1921

20. UNDERTAKER: Schumacher & Hall — ADDRESS: City Pocatello

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED DEC 8 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

28 35785

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 28

County of Bannock — Primary Registration District No. 2161 — File No. 45

City of Hy... (Ward) Fyhee (No.) Broadway (St.) — Registered No. 3692

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Thomas Lawrence Briscoe

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: October 4 (Month) (Day) 879 (Year)

7. AGE: 42 Yrs. 1 Mos. 7 ds.

IF LESS than 1 day: how many ... hrs. or ... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Monroe Utah

10. NAME OF FATHER: Thomas Briscoe

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Martha A Barney

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Thomas Briscoe

(Address) Fyhee

15. Filed 12/12 1921 — [signature], Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: November 11 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from November 4, 1921, to Nov 11 1921, that I last saw him alive on Nov 11 1921, and that death occurred on the date stated above, at 5 40 P.M.

The CAUSE OF DEATH* was as follows:

Typhoid Fever
Four 2 Mo

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary): none

(Duration) ... yrs. ... mos. ... ds.

(Signed) James M Smith M. D.

Nov 12 1921 (Address) Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain View Cem — DATE OF BURIAL: Nov 13 1921

20. UNDERTAKER: Schumacher & Hall — ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

35786

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 28
Primary Registration District No. 2141
File No. 91
Registered No. 3693

1. PLACE OF DEATH
County of Bannock
City of Pocatello (No. 324 North 12 St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lynn Narr

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH March 17 1921
(Month) (Day) (Year)

7. AGE Yrs. 7 Mos. 27 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Pocatello

10. NAME OF FATHER Wm Narr

11. BIRTHPLACE OF FATHER (State or Country) Kansas

12. MAIDEN NAME OF MOTHER Myrtle Duncan

13. BIRTHPLACE OF MOTHER (State or Country) Ills

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wm Narr
(Address) Pocatello

15. Filed 11/14 1921 J. P. Young Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov 13 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 13th 1921, to Nov 13 1921, that I last saw h.. alive on Nov 13 1921, and that death occurred on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows: Vomiting & diarrhoea

(Duration) Yrs. ..... mos. 1 ds.

Contributory (Secondary) none.

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E. H. Lynn M. D.
Nov 14 1921 (Address) Pocatello Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL I.O.O.F. New Cemetery | DATE OF BURIAL 11/14 1921

20. UNDERTAKER H. H. Walker | ADDRESS Pocatello

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

28 35787 Dr Roberts

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 45

Registered No. 3694

1. PLACE OF DEATH

County of Bannock

City of Pocatello

Registration District No.

Primary Registration District No. 2141

(No. 817 So Harrison St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Raymond Ellis Bradley

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Infant (Write the word.)

6. DATE OF BIRTH: November 14 1921 (Month) (Day) (Year)

7. AGE: ——Yrs. ——Mos. 1 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Pocatello Idaho

10. NAME OF FATHER: Isaac M. Bradley

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Ivy Ward.

13. BIRTHPLACE OF MOTHER (State or Country): Montana.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Isaac M Bradley

(Address) Pocatello Ida.

15. Filed 11/15 1921

J. J. Jones
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: November 15 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11-14 1921, to 11-15 1921, that I last saw h— alive on 11-15 1921, and that death occurred on the date stated above, at 8 30 A.M.

The CAUSE OF DEATH* was as follows:

Asphyxia neonatorum

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. J. Jones M. D.

11/15 1921 (Address) Pocatello

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain View Cem — DATE OF BURIAL: Nov 15 1921

20. UNDERTAKER: Schumacher & Hall — ADDRESS: Pocatello

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

28 35788

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 41

Registered No. 3695

1. PLACE OF DEATH

County of Bannock

City of Pocatello

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No. 2141

(No. Lyons Bros Addition St.)

2. FULL NAME Angelina Street

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widowed

6. DATE OF BIRTH: Feb. (Month) 7 (Day) 1864 (Year)

7. AGE: 57 Yrs. 2 Mos. 9 ds.

IF LESS than 1 day how many..... hrs. or.....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: Bernard Wheelhouse

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Elizabeth Feather

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Helen Sisten

(Address) Minidoka

15. Filed 11/16 1921

Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 16 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 17 1921, to Nov 16 1921, that I last saw h[illegible] alive on Nov 16 1921 and that death occurred on the date stated above, at 9a M.

The CAUSE OF DEATH* was as follows: Carcinoma of cervical glands of the breast

(Duration) 1 Yrs. — mos. — ds.

Contributory (Secondary) Malnutrition

(Duration) — yrs. — mos. — ds.

(Signed) J. W. Ingram M. D.

11/16 1921 (Address) Pocatello

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death — yrs. 4 mos. — days. In the State 7 yrs. — mos. — days

Where was disease contracted if not at place of death? do not know

Former or usual residence Minidoka

19. PLACE OF BURIAL OR REMOVAL: N. View cemetery — DATE OF BURIAL: 11/18 1921

20. UNDERTAKER: N. T. Naden — ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19

RECEIVED
DEC 8 1921
VITAL STATISTICS

35790

CERTIFICATE OF DEATH

28

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 2161

Primary Registration District No.

File No. 41

County of Bannock

City of Pocatello (No. General Hospital St.)

Registered No. 3697

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Edna May Cox

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: June (Month) 4 (Day) 1921 (Year)

7. AGE: 13 Yrs. 5 Mos. 15 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Student

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mammoth Utah

10. NAME OF FATHER: George B. Cox

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Eliza V. Busch

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) George B. Cox

(Address) 740 S. N. Johnson

15. Filed Nov 21 1921

J. H. Young
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 19 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jun 1 1921, to Nov 19 1921, that I last saw h.. alive on 19 Nov 1921, and that death occurred on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows:

Primus Thrombosis

(Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary): Acute Mastoiditis

(Duration) ..... yrs. ..... mos. 3 ds.

(Signed) C W Card M. D.

Nov 19 1921 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 4 yrs. ..... mos. ..... days. In the State 4 yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence Utah.

19. PLACE OF BURIAL OR REMOVAL: Mt View Cem. DATE OF BURIAL: Nov 22 1921

20. UNDERTAKER: H. L. McClain ADDRESS: Pocatello, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

35791

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 28
Primary Registration District No. 2141
File No. 45
Registered No. 3698

1. PLACE OF DEATH
County of Bannock
City of Pocatello
(No. 916 Wayne ave St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Berta May Pellum

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single

6. DATE OF BIRTH: Feb 26 1921 (Month) (Day) (Year)

7. AGE: — Yrs. 8 Mos. 26 ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Pocatello, Ida.

10. NAME OF FATHER: Bartlett P. Pellum

11. BIRTHPLACE OF FATHER (State or Country): Preston Idaho

12. MAIDEN NAME OF MOTHER: Esther Hattle

13. BIRTHPLACE OF MOTHER (State or Country): Cash Jct. Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Bartlett P. Pellum
(Address) Pocatello, Idaho

15. Filed Nov 21 1921

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: November 21 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11-16 1921, to Nov 21 1921
that I last saw her alive on Nov 21 1921
and that death occurred on the date stated above, at 1 A.M.
The CAUSE OF DEATH* was as follows:

Diphtheria

(Duration) ... Yrs. ... mos. 4 ds.
Contributory (Secondary): Pneumonia Bronchial
(Duration) ... yrs. ... mos. 1 ds.

(Signed) W. W. Brothers M. D.
11/21 1921 (Address) Pocatello, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death? In Pocatello
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mt View Cem. DATE OF BURIAL: Nov 22 1921

20. UNDERTAKER: H. L. McHan ADDRESS: Pocatello Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-25 M. 1-19.

35792

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 28
Primary Registration District No. 2161
File No. 45
Registered No. 3699

1. PLACE OF DEATH
County of Bannock
City of Pocatello
(No. St. Anthony St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Arnold Dinis Quantrell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Infant

6. DATE OF BIRTH: June (Month) 18 (Day) 1921 (Year)

7. AGE: — Yrs. 5 Mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): American Falls

10. NAME OF FATHER: F. C. Quantrell

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Ora McCowan

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) F. C. Quantrell
(Address) Aberdeen

15. Filed 11/22 1921
J. R. Young
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: November (Month) 22 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 21 1921 to Nov 22 1921
that I last saw h— alive on Nov. 22 1921,
and that death occurred on the date stated above, at 6:30 P.M.
The CAUSE OF DEATH* was as follows:

Pyelitis

(Duration) ..... Yrs. ..... mos. 21 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. R. Young M. D.
11-22 1921 (Address) Pocatello Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Aberdeen Idaho — DATE OF BURIAL: Nov 24 1921

20. UNDERTAKER: Schumacher & Hall — ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

RECEIVED DEC 3 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

35793

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 28

County of Bannock — Primary Registration District No. 2161 — File No. 43

City of Pocatello — (No. 939 North Arimo St.) — Registered No. 3700

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George Thomas Murgatroyd

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: December 12 1886 (Month) (Day) (Year)

7. AGE: 34 Yrs. 11 Mos. 3 ds.

IF LESS than 1 day: how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Restraunt
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): South Dakota

10. NAME OF FATHER: Thomas Murgatroyd

11. BIRTHPLACE OF FATHER (State or Country): Pennsylvania

12. MAIDEN NAME OF MOTHER: — Boyer

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs G. T. Murgatroyd
(Address) 939 N Arimo

15. Filed 11/26 1921

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: November 25 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 19th 1921 to Nov 25th 1921 that I last saw h.. alive on Nov 24th 1921 and that death occurred on the date stated above, at 2:45½ M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... Yrs. ..... mos. 6 ds.

Contributory (Secondary): none

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) O. H. Lynn M. D.

Nov 25 1921 (Address) Pocatello Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Logan Utah — DATE OF BURIAL: Nov 27 1921

20. UNDERTAKER: Summerhays Hall — ADDRESS: Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

35794

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 28
Primary Registration District No. 2146
File No. 45
Registered No. 3201

1. PLACE OF DEATH
County of Bannock
City of Pocatello
No. Ward Road from Crystal to Pocatello

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME W. C. Snyder

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

...n of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH ...that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: January (Month) 26 (Day) 1861 (Year)

7. AGE: 60 Yrs. 10 Mos. 28 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Fact Master
(b) General nature of industry, business or establishment in which employed (or employer): Crystal Ice

9. BIRTHPLACE (State or Country): Tenn

10. NAME OF FATHER: Wm Snyder

11. BIRTHPLACE OF FATHER (State or Country): /

12. MAIDEN NAME OF MOTHER: Anna Deaber

13. BIRTHPLACE OF MOTHER (State or Country): /

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. W. C. Snyder
(Address) Crystal

11/26 1921

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 23 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 23 1921, to Nov 23 1921, that I last saw h... alive on Nov. 1921, and that death occurred on the date stated above, at 8:30 P.M.

The CAUSE OF DEATH* was as follows:

apoplexy.

Died on Road from

(Duration) ... Yrs. ... mos. ... ds.

Crystal to Pocatello, Ida

Contributory (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) J. W. Lyons M. D.

Nov 23 1921 (Address) Pocatello Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Pocatello | DATE OF BURIAL: 11 27 1921

20. UNDERTAKER: F. A. Tucker ADDRESS: Pocatello

...O., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

35795

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 28
Primary Registration District No. 2161
File No. 45
Registered No. 3702

1. PLACE OF DEATH
County of Bannock
City of Pocatello
(No. 1452 N. Main St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ina Mary Barnes
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widowed

6. DATE OF BIRTH: May 15th (Month) 1877 (Day) (Year)

7. AGE: 44 Yrs. 6 Mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Grocery Buyer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Peter Hughes

11. BIRTHPLACE OF FATHER (State or Country): unknown

12. MAIDEN NAME OF MOTHER: Margaret Foley

13. BIRTHPLACE OF MOTHER (State or Country): unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. W. J. Barnes
(Address) Pocatello Ida.

15. Filed 11/28 1921
J. Young
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov 25th (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 8 1921, to Nov 25 1921, that I last saw h.. alive on Nov 25 1921, and that death occurred on the date stated above, at 1030 A. M.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
(Duration) ..... Yrs. ..... mos. 17 ds.
Contributory (Secondary) None
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Asa Newton M. D.
Nov 25 1921 (Address) Kane Bldg Pocatello Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain View — DATE OF BURIAL: Nov 29 1921

20. UNDERTAKER: Schumacher & Hall — ADDRESS: City

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

28 35706

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bannock — Registration District No. 28 — File No. 43

City of Pocatello — Primary Registration District No. 7161 — Registered No. 3703

(No. 746 So 9 St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mrs. Nelda Nestrom and Infant Boy

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Sept 12 1886 (Month) (Day) (Year)

7. AGE: 36 Yrs. 2 Mos. 16 ds.

IF LESS than 1 day how many.....hrs. or.....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER: Swinsky Nestberg

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: /

13. BIRTHPLACE OF MOTHER (State or Country): /

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Carl Nestrom
(Address) 746 So 9th.

15. Filed 11/28 1921

J. H. Lynn, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov 28 21 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 27th 19.., to Nov 28 19 21
that I last saw her alive on Nov 28 19 21
and that death occurred on the date stated above, at 5 a. M.

The CAUSE OF DEATH* was as follows:
child-birth

.....(Duration) .....Yrs. .....mos. 1 ds.

Contributory (Secondary) Pneumonia

.....(Duration) .....yrs. .....mos. .....ds.

(Signed) J. H. Lynn M. D.

Nov 28th 1921 (Address) Pocatello Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: I.O.O.F. Cemetery — DATE OF BURIAL: 11 30 1921

20. UNDERTAKER: H. M. Walker — ADDRESS: Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

January 4, 1921.

Dr. J. [illegible] Young,

Pocatello, Idaho.

Dear Doctor:

Upon compiling our statistics for the death certificates sent in the early part of December we find you filed a certificate for Mrs. Hulda Westrom "and Infant". Will you kindly have the undertaker make out a certificate for the child as a death certificate should only be made for one person. No doubt this escaped your notice. The Undertaker was W. M. Walker, and the physician J. H. Lynn.

Respectfully yours,

F. W. Almond, M. D.
Medical Advisor.

OCT 03 1996

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

35707

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 28

Primary Registration District No. 2161

File No. 45

County of Bannock

City of Pocatello (No. 441 N. Garfield St.)

Registered No. 3704

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Joseph Reuss

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married

6. DATE OF BIRTH: Sept (Month) 29 (Day) 1858 (Year)

7. AGE: 63 Yrs. 1 Mos. 29 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Butcher
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: Balthasar Reuss

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Dorothea Haefler

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Emma Reuss
(Address) 441 N. Garfield Pocatello Ida.

15. Filed Nov 28 1921

J. Mooney
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 27 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 15 1921, to Nov 27 1921, that I last saw h[illegible] alive on Nov 27 1921, and that death occurred on the date stated above, at 5:30 P.M.

The CAUSE OF DEATH* was as follows:

Cancer of Stomach

(Duration) 3 Yrs.? mos. ds.

Contributory (Secondary) General Carcinomatosis

(Duration) yrs. mos. ds.

(Signed) Hamner C. Davis M. D.

11/27 1921 (Address) Pocatello Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 32 yrs. mos. days. In the State 32 yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence Colorado.

19. PLACE OF BURIAL OR REMOVAL: Mt View Cem — DATE OF BURIAL: Nov 30 1921

20. UNDERTAKER: H. L. McMahon — ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH 35708

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 53

County of Bear Lake. Primary Registration District No.

File No. 16

City of Bloomington, (No. St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

RECEIVED DEC 12 1921 BUREAU OF VITAL STATISTICS

2. FULL NAME John Dunford.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH: May (Month) 8 (Day) 1877 (Year)

7. AGE: 44 Yrs. 6 Mos. 17 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Merchant.
(b) General nature of industry, business or establishment in which employed (or employer): (Retired 6 years)

9. BIRTHPLACE (State or Country): England.

10. NAME OF FATHER: John Dunford.

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Ann Stokes.

13. BIRTHPLACE OF MOTHER (State or Country): England.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) James L. Dunford,
(Address) Paris, Idaho.

15. Filed Nov 28 1921 Mrs. J. L. Skinner Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 25 (Day) 1921. (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 25 1921 to Nov 25 1921 that I last saw h alive on Nov 25 1921, and that death occurred on the date stated above, at 7.40 P.M.

The CAUSE OF DEATH* was as follows:
Acute Dilatation of Heart

(Duration) Yrs. mos. 1 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) C. O. Moore M. D.
11/28 1921 (Address) Paris Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Providence, Rhode Island — DATE OF BURIAL: Dec. 5 1921.

20. UNDERTAKER: F. M. Williams — ADDRESS: Montpelier, Idah

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35700

Registered No. .....

Registration District No. .....

Primary Registration District No. 57

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Bear Lake

City of St. Charles

2. FULL NAME Annie Floyd Bunderson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Nov (Month) 28 (Day) 1891 (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... House Wife

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) St Charles

10. NAME OF FATHER Lenard Floyd.

11. BIRTHPLACE OF FATHER (State or Country) Maschusets

12. MAIDEN NAME OF MOTHER Emma Foster

13. BIRTHPLACE OF MOTHER (State or Country) England.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Orphi Bunderson

(Address) St Charles Id.

15. Filed Nov 2 1921

John Matson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 27 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 3 1921, to Oct 27 1921, that I last saw her alive on Oct 26 1921, and that death occured on the date stated above, at 11 45a M.

The CAUSE OF DEATH* was as follows:

Eclampsia - follow childbirth

Septicaemia from retained placenta

Complicated with Inflamation of Gall Bladder

(Duration) ..... Yrs. 1 mos. 3 ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) C. O. Moore M. D.

11/1 1921 (Address) Paris Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: St Charles Id. DATE OF BURIAL: Oct 30 1921

20. UNDERTAKER ..... ADDRESS .....

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

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SYMS - YORK CO., PTRS. & BOKS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35800
Registered No. .....

1. PLACE OF DEATH.
County of Bear Lake
City of St Charles
Registration District No. .....
Primary Registration District No. 55
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Helen Irene Rich

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: girl
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH.
Aug (Month) 15 (Day) 1910 (Year)
1910

7. AGE
1 Yrs. 11 Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) St Charles Idaho

10. NAME OF FATHER Edwin L Rich

11. BIRTHPLACE OF FATHER (State or Country) Paris Idaho

12. MAIDEN NAME OF MOTHER Lyra Booth

13. BIRTHPLACE OF MOTHER (State or Country) St Charles Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Edwin Charles Rich
(Address) St Charles Id.

15.
Filed Nov 2 1911 John Mattson Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24854

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
July (Month) 12 (Day) 1911 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Heart Failure
no Dr in attendance
.....(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
.....(Duration ..... yrs. ..... mos. ..... ds.
(Signed) ..... M. D.
..... 19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: St Charles Id. DATE OF BURIAL: July 15 1911

20. UNDERTAKER ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
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F[illegible]1-19.

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[illegible]EATH [illegible] OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. [illegible] Registration District .....
County of Bear Lake ... Registration District No. 5-5- ... File No. 35801
City of St Charles ... St.) ... Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Evelyn. Bunderson.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female.

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.):

6. DATE OF BIRTH: Nov. (Month) 9 (Day) 1921 (Year)

7. AGE: ... Yrs. ... Mos. 18 ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Baby.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): St Charles.

10. NAME OF FATHER: Boon Bunderson

11. BIRTHPLACE OF FATHER (State or Country): Sweden.

12. MAIDEN NAME OF MOTHER: Agustus Pehrsson

13. BIRTHPLACE OF MOTHER (State or Country): Sweden.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Boon Bunderson
(Address) St Charles Ida

15. Filed Nov 30 1921 John Mattson Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 27 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 27, 1921, to Nov 27 1921, that I last saw her alive on Nov 27 1921, and that death occurred on the date stated above, at 3.00 P.M.

The CAUSE OF DEATH* was as follows:
Pneumonia from. Heart. Leakage failure to close of. [illegible] Foramen Ovale.

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary) ...
(Duration) ... yrs. ... mos. ... ds.

(Signed) A E Hutton M. D.
11/28/21. (Address) Paris Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: St Charles. DATE OF BURIAL: 11/30/21

20. UNDERTAKER: Ver. ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

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MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35803

Registered No. 46

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1. PLACE OF DEATH

County of Benewah — Registration District No. 32

City of St. Maries — Primary Registration District No. 2049

(No. of House) (St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Andrew Gunderson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH: ..... 1 ..... (Month) (Day) (Year)

7. AGE: About 64 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Geo Mitchell

(Address) St Maries

15. Filed Dec 3 1921 — H E Hunt, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 10 (Month) 24 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1 1921, to Oct 24 1921, that I last saw h.... alive on Oct 24 1921, and that death occurred on the date stated above, at 9a M.

The CAUSE OF DEATH* was as follows:

Gangrene of Leg due to Thrombosis

(Duration) Yrs. 2 mos. 0 ds.

Contributory (Secondary) Typhoid Pneumonia

(Duration) 6 yrs. 0 mos. 0 ds.

(Signed) A. D. Platt, M. D.

10/25 1921 (Address) St Maries, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Woodlawn Cem — DATE OF BURIAL: Dec 3 1921

20. UNDERTAKER: Mitchell & Merriger — ADDRESS: St Maries

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

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FORM V. S. No. 5-25 M. 1-19.

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CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 32

Primary Registration District No. 2049

File No. 35804

County of Benewah

City of St Maries (No. , St.)

Registered No. 45

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Rebecca Greer Sowell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Fem	White	married

6. DATE OF BIRTH: May (Month) 16 (Day) 1863 (Year)

7. AGE: 58 Yrs. 5 Mos. 17 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Texas

10. NAME OF FATHER: David G. Kincaid

11. BIRTHPLACE OF FATHER (State or Country): Texas.

12. MAIDEN NAME OF MOTHER: Elizabeth Allen

13. BIRTHPLACE OF MOTHER (State or Country): Texas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Lewis D Sowell
(Address) St Maries

15. Filed Nov. 4 1921 H E Hunt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 3 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 1 1921 to Nov 3 1921 that I last saw her alive on Oct 1 1921, and that death occurred on the date stated above, at 4.45 P.M.

The CAUSE OF DEATH* was as follows: A
Lupus - Carcinoma

(Duration) 10 Yrs. — mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) O D Hall M. D.

Nov 4 1921 (Address) St Maries Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Woodlawn	11-5- 1921
20. UNDERTAKER	ADDRESS
H E Hunt Co	St Maries

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

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FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35805

Registered No. 44

1. PLACE OF DEATH

County of Benewah — Registration District No. 33

City of St Maries — Primary Registration District No. 2077

(St.)

If death occurs away from usual residence, give facts called for under special information.

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2. FULL NAME Mrs Alice Agnes Frost

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: married (Write the word.)

6. DATE OF BIRTH: March (Month) 7 (Day) 1886 (Year)

7. AGE: 35 Yrs. 7 Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: housewife

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Michigan

10. NAME OF FATHER: Albert Marin

11. BIRTHPLACE OF FATHER (State or Country): Canada

12. MAIDEN NAME OF MOTHER: Mary Paisman

13. BIRTHPLACE OF MOTHER (State or Country): Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Peter F Frost

(Address) St. Maries Ida

15. Filed Oct 6 1921

H G [illegible]
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 5 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 20th 1921 to Oct 5 1921 that I last saw h[illegible] alive on Oct 5 1921 and that death occurred on the date stated above, at 10:45 A.M.

The CAUSE OF DEATH* was as follows:

Hemmorage from Bowels due to Cancer of Liver

General breaking down condition

(Duration) Yrs. mos. 15 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) A O Platt M. D.

Oct 5 1921 (Address) St Maries Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF ~~BURIAL OR~~ REMOVAL: Harrison Ida

DATE OF BURIAL: 11/7 1921

20. UNDERTAKER: H E Hunt Co

ADDRESS: St. Maries Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

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CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 32
Primary Registration District No. 2049

File No. 35806
Registered No. 43

1. PLACE OF DEATH

County of Bennewah
City of St Maries (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sylvia Palmer

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: June (Month) 12 (Day) 1913 (Year)

7. AGE: 8 Yrs. Mos. 3 ds. 21
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Cherley Idaho.

10. NAME OF FATHER: Mr Bert Palmer.

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER: Elizbeth Isebell Palmer

13. BIRTHPLACE OF MOTHER (State or Country): Minneapolis Minnesota

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs John R Williams
(Address) Clarkia Idaho Boyd

15. Filed Oct 3 1921 — H E Hunt, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 3 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 2 1921 to Oct 3 1921, that I last saw her alive on Oct 3 1921, and that death occurred on the date stated above, at 10 A M.
The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... Yrs. ..... mos. 21 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Owen D Platt M. D.
Oct 3 1921 (Address) St Maries Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL ..... 19.....

20. UNDERTAKER: H E Hunt Co. | ADDRESS: St Maries

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED NOV 30 1921 BUREAU OF VITAL STATISTICS

Registration District No. 31 — 35807

Primary Registration District No. ____

File No. 1

Registered No. 43

1. PLACE OF DEATH.

County of Benewah

City of Demet (No. ____, ____ St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Teresa Augusta

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: Indian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Feb. (Month) ____ (Day) 1904 (Year)

7. AGE: 17 Yrs. ____ Mos. ____ ds.

IF LESS than 1 day how many ____ hrs. or ____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: School girl

(b) General nature of industry, business, or establishment in which employed (or employer): ____

9. BIRTHPLACE (State or Country): Washington

10. NAME OF FATHER: Augusta

11. BIRTHPLACE OF FATHER (State or Country): Washington

12. MAIDEN NAME OF MOTHER: Agnes Jones

13. BIRTHPLACE OF MOTHER (State or Country): Washington

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Louis

(Address) Plummer

15.

Filed Oct 27 1921

J. E. Bilsan
Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24853

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 26 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ____ 191__, to ____ 191__, that I last saw h____ alive on ____ 191__, and that death occured on the date stated above, at ____ M.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) ____ Yrs. ____ mos. ____ ds.

Contributory (Secondary) ____

(Duration ____ yrs. ____ mos. ____ ds.

(Signed) ____ M. D.

19____ (Address) ____

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days

Where was disease contracted if not at place of death? ____

Former or usual residence ____

19. PLACE OF BURIAL OR REMOVAL: Deemet — DATE OF BURIAL: Oct 28 1921

20. UNDERTAKER: J. Falen — ADDRESS: Deemet

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

35808 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
NOV 30 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 21

Primary Registration District No.

File No. 1

County of B

City of (St.)

Registered No. 42

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Agathe Mary Robillard

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
F.	Indian	Married (Write the word.)

6. DATE OF BIRTH

1 1861
(Month) (Day) (Year)

7. AGE

60 about Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Washington

10. NAME OF FATHER Pierre Louis

11. BIRTHPLACE OF FATHER (State or Country) Washington

12. MAIDEN NAME OF MOTHER Mary Louis

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. B. Robillard

(Address)

15.

Filed Dec 18 1921

J. E. Bilhan
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

October 15 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19....., to ..... 19.....,

that I last saw h..... alive on ..... 19.....,

and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

..... 19..... (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Wesmet

DATE OF BURIAL: Oct 21 1921

20. UNDERTAKER: J. Falen

ADDRESS: Wesmet

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

35809

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
DEC 10 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH.

Registration District No. 31

Primary Registration District No.

File No. 1

County of Benewah

City of Dermet (If outside limits, St.)

Registered No. 44

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Rose Big Star

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: Indian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): widowed

6. DATE OF BIRTH. (Month) (Day) (Year): 1890

7. AGE: 90 about Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Washington

10. NAME OF FATHER: Big Star

11. BIRTHPLACE OF FATHER (State or Country): Washington

12. MAIDEN NAME OF MOTHER: Not known

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Louis Basil

(Address) Dermet Ida

15.

Filed Nov. 22 1921

J. L. Bihan
Local Registrar

BYNS - YORK CO., PTRS. & BDRS. 24853

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov. (Month) 20 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,

that I last saw h... alive on ..... 191...,

and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Sudden death - Heart failure

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

19.... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Dermet

DATE OF BURIAL: Nov 22 1921

20. UNDERTAKER: J. Falcon

ADDRESS: Dermet

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

RECEIVED NOV 30 1921 BUREAU OF VITAL STATISTICS

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 1007
File No. 35810
Registered No. 133

1. PLACE OF DEATH

County of Bingham
City of Blackfoot (If outside limits of city or village, write Township.) North Lake St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Unnamed Tindley

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Oct (Month) 3 (Day) 1921 (Year)

7. AGE: ....Yrs....Mos....ds. IF LESS than 1 day how many 14 hrs. or....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Bingham Co Idaho

10. NAME OF FATHER: J W Tindley

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Bernice Tibbs

13. BIRTHPLACE OF MOTHER (State or Country): Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J W Tindley
(Address) Blackfoot Idaho

15. Filed Oct-4 1921 Mrs Hallie L. Peterson Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 4th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased ~~from~~ 10/ 3rd 1921, to ....19.... that I last saw h... alive on Oct 3rd 1921, and that death occurred on the date stated above, at ....M.

The CAUSE OF DEATH* was as follows:
premature birth & mo.
lived 14 hrs.
....(Duration) ....Yrs....mos....ds.

Contributory (Secondary)
....(Duration) ....yrs....mos....ds.

(Signed) J. A. Humphrey M. D.
10/4 1921 (Address) Blackfoot Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Groveland Idaho | DATE OF BURIAL: Oct 4 1921

20. UNDERTAKER: E. T. Funk | ADDRESS: Blackfoot Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

RECEIVED NOV 30 1921 BUREAU OF VITAL STATISTICS

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 1007
File No. 35811
Registered No. 134

1. PLACE OF DEATH.
County of Bingham
City of Blackfoot (No. ... St. 253 North Shunt St.)
If death occurs away from usual residence, give facts called for under special information.
2. FULL NAME Johanna Rivette

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
F	W	Widow

6. DATE OF BIRTH: Oct (Month) 7 (Day) 1852 (Year)

7. AGE: 69 yrs. 6 mos. 6 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession, or particular kind of work: Housekeeper
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Quebec

10. NAME OF FATHER: Wm W. Cleary

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Mary Hickey

13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Frank Rivette
(Address) Twin Falls. Ida

15. Filed Oct. 8 1921 Mrs Nellie E Talbot Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 7 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1- 1921, to Oct 7 1921, that I last saw her alive on Oct 6 1921, and that death occurred on the date stated above, at 4 a. M.

The CAUSE OF DEATH* was as follows:
Broncho-pneumonia
Influenzal type -
(Duration) ... yrs. ... mos. 6 ds.
Contributory (Secondary) Bad Mitral regurgitant
(Duration) about 60 yrs. ... mos. ... ds.

(Signed) R T Jackson M. D.
Oct 7 1921 (Address) Blackfoot

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 2 yrs. 4 mos. ... ds. In the State 2 yrs. 4 mos. ... ds.
Where was Disease contracted, if not at place of death? Home
Former or usual residence Wazzaruille - Conn

19. PLACE OF BURIAL OR REMOVAL: Riverside Cemetery | DATE OF BURIAL ... 191...

20. UNDERTAKER: Peck | ADDRESS Blackfoot

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary firemen,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: *(a) Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers,* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility, (Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL *septicemia*", "PUERPERAL *peritonitis,*" etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train —accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED NOV 30 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35812
Registered No. 133

1. PLACE OF DEATH.
Registration District No. 121
County of Bingham
Primary Registration District No. 1007
City of Blackfoot (If outside city limits, give township) (No. 65 N. Shelling St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME David Wycliffe Stout

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Oct (Month) 7 (Day) 1921 (Year)

7. AGE: ... Yrs. ... Mos. 1 ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Emerald W. Stout

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Geneva Black

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) E. W. Stout
(Address) Blackfoot Ida

15. Filed Oct 8 1921 Mrs Hattie E. Pa... Local Registrar

BYMS - YORK CO., PTRS. & SORS. 24854

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 8 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 7 1921, to Oct 8 1921, that I last saw h[illegible] alive on Oct 7 1921, and that death occured on the date stated above, at 8:30 a M.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency

(Duration) ... Yrs. ... mos. 1 ds.

Contributory (Secondary)

(Duration ... yrs. ... mos. ... ds.

(Signed) W. W. Beck M. D.

Oct 8 1921 (Address) Blackfoot, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs ... mos ... days. In the State ... yrs ... mos ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Grove City Cem, — DATE OF BURIAL: Oct 8 1921

20. UNDERTAKER: Ed L Eyli — ADDRESS: Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35813
Registered No. 36

1. PLACE OF DEATH

Registration District No. 121
Primary Registration District No. 107

County of Bingham
City of Blackfoot (If not in incorporated limits, give township.) No. [illegible] Street (or Rural Route No.) [illegible] St.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
NOV 30 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME William John Kreider

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH: Sept. (Month) 18 (Day) 1921 (Year)

7. AGE: ....Yrs. 2 Mos. 20 ds. IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Bingham Co Idaho

10. NAME OF FATHER: Chas. L. Kreider

11. BIRTHPLACE OF FATHER (State or Country): Bingham Co Idaho

12. MAIDEN NAME OF MOTHER: Minnie Leach

13. BIRTHPLACE OF MOTHER (State or Country): Ill

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chas. L. Kreider
(Address) Blackfoot Ida.

15. Filed Oct 8 1921 Nina Valeria Powell Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 8 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased ~~from~~ 10/5 1921, to .... 19.... that I last saw h.... alive on 10/8 1921 and that death occurred on the date stated above, at 2 P.M.
The CAUSE OF DEATH* was as follows:
Peritonitis
.... (Duration) .... Yrs. .... mos. 2 ds.
Contributory (Secondary)
.... (Duration) .... yrs. .... mos. .... ds.
(Signed) J. O. Humphreys M. D.
10/8 1921 (Address) Blackfoot Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .... yrs. .... mos. .... days. In the State .... yrs. .... mos. .... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Gem Cemetery	Oct 9 1921
20. UNDERTAKER	ADDRESS
E. J. Funk	Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 2194
File No. 35814
Registered No.

RECEIVED
NOV 30 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Bingham
City of Thomas (If outside limits of city or village, write the word "Out.") St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Margaret Bennetta Harman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: March (Month) 25 (Day) 1910 (Year)

7. AGE: 11 Yrs. 6 Mos. 14 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At school
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Thomas, Idaho

10. NAME OF FATHER: Benjamin Harman

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Marcia Hennefer

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Marcia Jackson
(Address) Thomas Idaho

15. Filed Oct. 7 1921 Mrs Nellie E. Fitch Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 9 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 8 1921 to Oct 8 1921 that I last saw her alive on Oct 8 1921, and that death occurred on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:
Internal Hemorrhage Stomach.

(Duration) ..... Yrs. ..... mos. 2 ds.
Contributory (Secondary) Hemophelia
(Duration) 6 yrs. ..... mos. ..... ds.

(Signed) H. J. Simmons M. D.
10/8 1921 (Address) Blackfoot Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Thomas Riverside Cem
DATE OF BURIAL: Oct 10 1921

20. UNDERTAKER: Ed L. Egli
ADDRESS: Blackfoot,

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED NOV 30 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35815
Registered No.

1. PLACE OF DEATH

Registration District No. 121
Primary Registration District No. 2174
County of Bingham
City of Blackfoot (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Parley Frederick Hale

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH: April (Month) 29 (Day) 1917 (Year)

7. AGE: 4 Yrs. 5 Mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Groveland Idaho

10. NAME OF FATHER: Ernest F. Hale

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Mary Peterson

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. F. Hale
(Address) Groveland

15. Filed Oct - 15 1921 Mrs Helen S. Tate Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 14 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 7 1921, to Oct 14 1921 that I last saw him alive on Oct 14 1921 and that death occurred on the date stated above, at 11 P M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia
(Duration) ..... Yrs. ..... mos. 7 ds.
Contributory (Secondary) Pernicious Anemia
(Duration) ..... yrs. 4 mos. ..... ds.

(Signed) W W Beck M. D.
10/15 1921 (Address) Blackfoot, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Groveland — DATE OF BURIAL: Oct 16 1921

20. UNDERTAKER: E. L. Eglin — ADDRESS: Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED NOV 30 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35816

Registered No.

1. PLACE OF DEATH

Registration District No. 21

Primary Registration District No. 1007

County of Bingham

City of Blackfoot (No. 709 So University St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Bernice Wright

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: May (Month) 7 (Day) 1913 (Year)

7. AGE: 8 Yrs. 5 Mos. 11 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: At school

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: James H Wright

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Edith Hapgood

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. H. Wright

(Address) 709 So University

15. Filed Oct 20 1921 Mrs Nalin E. Peterson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 18 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 18 1921, to Oct 18 1921 that I last saw ~~her~~ alive on Oct 18 1921 and that death occurred on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

Burned accidently

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) F. W. Mitchell M. D.

Oct 20 1921 (Address) Blackfoot Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Grove City Cemetery — DATE OF BURIAL: Oct 21 1921

20. UNDERTAKER: Ed L Egli — ADDRESS: Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-1921

RECEIVED NOV 30 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35817

Registered No. .....

1. PLACE OF DEATH. Registration District No. 121

County of Bingham Primary Registration District No. 2194

City of Blackfoot (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Don Nichols Edwards

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Oct (Month) 11 (Day) 1921 (Year)

7. AGE ..... Yrs. ..... Mos. 13 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: John Edwards

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Annie Barnard

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Edwards

(Address) Blackfoot, Ida.

15. Filed Oct. 24 1921 Mrs Nalie E. Peterson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: October (Month) 23 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from October 19 1921, to Oct 23 1921, that I last saw him alive on Oct 22 1921, and that death occured on the date stated above, at 6:20 P M.

The CAUSE OF DEATH* was as follows:

Tetany

(Duration) — Yrs. ..... mos. 4 ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) W W Beck M. D.

1/24 1922 (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Grove City Cemetery — DATE OF BURIAL: Oct 24 1921

20. UNDERTAKER: Ed L Egli — ADDRESS: Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24654

FORM V. S. No. 5-25 M. 1-19.

RECEIVED NOV 30 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bingham — Registration District No. 127

City of Tabor — Primary Registration District No. 2 0 7 4

(No. ..... St.)

File No. 35818

Registered No. 141

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Bernice May Mitchell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6. DATE OF BIRTH: August 6 (Month) (Day) 1919 (Year)

7. AGE: 2 Yrs. 2 Mos. 2 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Springfield Idaho

10. NAME OF FATHER: Rex W. Mitchell

11. BIRTHPLACE OF FATHER (State or Country): Kansas

12. MAIDEN NAME OF MOTHER: Minto Kilian

13. BIRTHPLACE OF MOTHER (State or Country): Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Rex W Mitchell
(Address): Tabor Idaho

15. Filed Oct. 24 1921 Wm Kilian
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: October 23 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 17 1921, to Oct 23 1921, that I last saw her alive on Oct 21 1921, and that death occurred on the date stated above, at 5:20 P.M.

The CAUSE OF DEATH* was as follows:
Gastro Enteritis

(Duration) — Yrs. — mos. 10 ds.
Contributory (Secondary) Acute Meningitis
(Duration) ..... yrs. ..... mos. 3 ds.

(Signed) J B Davis M. D.
10/24 1921 (Address) Blackfoot Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Marsland Idaho — DATE OF BURIAL: Oct 25 1921

20. UNDERTAKER: Rex W Mitchell — ADDRESS: Tabor

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

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FORM V. S. No. 5-25 M. 1-19.

RECEIVED
NOV 30 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 2194
File No. 35819
Registered No. 142

1. PLACE OF DEATH
County of Bingham
City of Idaho Falls (No. 9 mile & Shelley Rd St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Woodruff Harker.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Apr. (Month) 22 (Day) 1919 (Year)

7. AGE: 3 Yrs. X Mos. X ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Non
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Shelley Ida.

10. NAME OF FATHER: J P Harker.

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Maria McOmie

13. BIRTHPLACE OF MOTHER (State or Country): Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J H Harker
(Address) Jameston Ida.

15. Filed Nov. 2 1921 Mrs Nalen E. Tolman Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct 23, 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 6, 1921, to Oct. 23, 1921 that I last saw h[illegible] alive on Oct. 21, 1921 and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Lobar Pneumonia
(Duration) 1 Yrs. 2 mos. 30 ds.
Contributory (Secondary) Oleo colitis
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Jno. O. McClar M. D.
19..... (Address) Idaho Falls, Ida

*State the *Disease Causing Death*; or in deaths from *Violent Causes*, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Shelley. DATE OF BURIAL: Oct 24 1921

20. UNDERTAKER: Jeff Hayes ADDRESS: Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED NOV 30 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35820
Registered No.

1. PLACE OF DEATH
County of Bingham Registration District No. 27
Primary Registration District No. 2114
City of Blackfoot (No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME J. Byron Hatch

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Mar (Month) 2 (Day) 1917 (Year)

7. AGE: 4 Yrs. 7 Mos. 23 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Blackfoot

10. NAME OF FATHER: Jeremiah Hatch

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Zina Wheatley

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Jeremiah Hatch
(Address):

15. Filed Oct 26 1921 W. E. Patrie Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: October (Month) 25 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 23 1921 to Oct 25 1921 that I last saw him alive on Oct 25 1921 and that death occurred on the date stated above, at 4:50 P.M.

The CAUSE OF DEATH* was as follows:
Appendicitis subacute
Suppurating (ruptured).
(Duration) Yrs. mos. 6 ds.
Contributory (Secondary) Operation refused by pts
(Duration) yrs. mos. 1 ds.

(Signed) W. E. Patrie M. D.
Oct 25 1921 (Address) Blackfoot Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Moreland Cem, DATE OF BURIAL: Oct 27 1921

20. UNDERTAKER: Ed L Egli ADDRESS: Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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FORM V. S. No. 5-25 M. 7-16-21

RECEIVED
NOV 30 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35821

Registered No. 144

1. PLACE OF DEATH

Registration District No. 121

Primary Registration District No. 2194

County of Bingham

City of Springfield (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Landon Jedediah Rich

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. March (Month) 11 (Day) 1857 (Year)

7. AGE: 64 Yrs. 7 Mos. 16 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farming

(b) General nature of industry, business, or establishment in which employed (or employer): 0

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Charles C. Rich

11. BIRTHPLACE OF FATHER (State or Country): Kentucky

12. MAIDEN NAME OF MOTHER: Emiline Groverich

13. BIRTHPLACE OF MOTHER (State or Country): New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Dora C. Rich

(Address) Springfield

15. Filed Oct. 24 1921 Mrs Violet E. Peterson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: October (Month) 27 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from October 17 1921, to October 27 1921, that I last saw him alive on October 27 1921, and that death occured on the date stated above, at 9.30 A. M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) — Yrs. — mos. 2 1 ds.

Contributory (Secondary) ..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) A. W. Beck M. D.

10/28 1921 (Address) Blackfoot, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Springfield Ida — DATE OF BURIAL: Oct 30 1921

20. UNDERTAKER: E. L. Egli — ADDRESS: Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

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FORM V. S. No. 5-25 M. 1-19.

RECEIVED
NOV 30 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35822
Registered No. 1193

1. PLACE OF DEATH

Registration District No. 111
Primary Registration District No.

County of Bingham
City of Blackfoot (No. St. Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Charles Barnard

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: 1852 (Month) (Day) (Year)

7. AGE: 69 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: unknown

11. BIRTHPLACE OF FATHER (State or Country): unknown

12. MAIDEN NAME OF MOTHER: unknown

13. BIRTHPLACE OF MOTHER (State or Country): unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) P. G. Eaton M. D. Hospital Records
(Address) Blackfoot Idaho

15. Filed Nov 1 19 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 31 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 6 1921 to Oct 31 1921
that I last saw h[illegible] alive on Oct 31 1921,
and that death occurred on the date stated above, at 1:15 P.M.
The CAUSE OF DEATH* was as follows: G. Hardin
Senile Dementia
(Duration) Yrs. 1 mos. 25 ds.
Contributory (Secondary) Senile Dementia
(Duration) yrs. mos. ds.
(Signed) C. F. Eaton M. D.
Oct 31 1921 (Address) Blackfoot Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. 25 days. In the State 2 yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence Twin Falls Ida

19. PLACE OF BURIAL OR REMOVAL [illegible] DATE OF BURIAL Nov 1 1921

20. UNDERTAKER L. J. Porter ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

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BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35823
Registered No. 146

1. PLACE OF DEATH

County of Bingham
City of Shelley (No. ..... St.)
Registration District No. 27
Primary Registration District No. 2174

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George Washington Bragg.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married.

6. DATE OF BIRTH: March (Month) 23 (Day) 1857 (Year)

7. AGE: 64 Yrs. 7 Mos. 8 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Elbert Co. Georgia.

10. NAME OF FATHER: Russel Bragg.

11. BIRTHPLACE OF FATHER (State or Country): Elbert Co. Georgia

12. MAIDEN NAME OF MOTHER: Chrisey Thompson

13. BIRTHPLACE OF MOTHER (State or Country): Bowman, Ga.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) David Bragg
(Address) Basalt Idaho

15. Filed ..... 19..... Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. (Month) 31 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 10-28-1921, to 10-31-1921, that I last saw h— alive on 10/31-1921, and that death occurred on the date stated above, at 6 A. M.

The CAUSE OF DEATH* was as follows:

Septicemia

..... (Duration) ..... Yrs. ..... mos. 7 ds.

Contributory (Secondary): Traumatic injury to right foot

..... (Duration) ..... yrs. ..... mos. 10 ds.

(Signed) Edwin Coulter M. D.

10/31-1921 (Address) Shelley

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. 1 days. In the State 5 yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? Basalt Idaho

Former or usual residence: Basalt Idaho

19. PLACE OF BURIAL OR REMOVAL: Firth Cemetery — DATE OF BURIAL ..... 19.....

20. UNDERTAKER — ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35824

Registered No. 147

1. PLACE OF DEATH

County of Bingham

Registration District No. 121

Primary Registration District No. 2 9 4

City of Shelley (If outside limits, give township.) St.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
DEC 1 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME Mildred Johnson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: ~~Infant~~ (Write the word.)

6. DATE OF BIRTH: 11 (Month) 1 (Day) 21 (Year)

7. AGE: ....Yrs....Mos....ds.

IF LESS than 1 day how many 2 hrs. or ....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Shelley Ida.

10. NAME OF FATHER: Lester D. Johnson

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Ruby Kelley

13. BIRTHPLACE OF MOTHER (State or Country): Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. E. E. Kelley

(Address) Shelley Ida

15.

Filed ....19....

Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov 1 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11/1, 1921, to 11/1 1921, that I last saw her alive on 11/1 9 A.M. 1921, and that death occurred on the date stated above, at 5-1 A.M.

The CAUSE OF DEATH* was as follows:

Convulsions

....(Duration) ....Yrs. ....mos. 1 ds.

Contributory (Secondary) Premature Birth

....(Duration) ....yrs. ....mos. ....ds.

(Signed) Edwin Cutler M. D.

11/1 1921 (Address) Shelley, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death....yrs....mos....days. In the State....yrs....mos....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Shelley Cemetery | DATE OF BURIAL ....19....

20. UNDERTAKER | ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35825

Registered No. 1178

1. PLACE OF DEATH

County of Bingham

City of Shelley (If outside limits of city or village, write the word "Out" before the name.) St.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED DEC 2 BUREAU OF VITAL STATISTICS

Registration District No. 121

Primary Registration District No. 2 7 14

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Cyrus E. Bates

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Cac.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Jan (Month) 17 (Day) 1849 (Year)

7. AGE: 72 Yrs. 9 Mos. 15 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Brownville New York

10. NAME OF FATHER: Cyrus W. Bates

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Harriet E Mathews

13. BIRTHPLACE OF MOTHER (State or Country): New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Perley Bates

(Address) Shelley Ida

15. Filed Nov. 2 1921 File C.V.

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 1 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 2, 1921, to Nov. 1 1921, that I last saw him alive on Nov 1 1921, and that death occurred on the date stated above, at 7:45 P.M.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency

(Duration) Yrs. 2 mos. ds.

Contributory (Secondary) Myocarditis

(Duration) yrs. 1 mos. ds.

(Signed) D. R. Egbert M. D.

Nov. 2 1921 (Address) Shelley Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Shelley Idaho — DATE OF BURIAL: Nov. 3 1921

20. UNDERTAKER: C. E. Moody — ADDRESS: Idaho Falls Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 2174
File No. 35826
Registered No. 1979

1. PLACE OF DEATH
County of Bingham
City of Blackfoot,
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Reed Pepper
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: April (Month) 30 (Day) 1920 (Year)

7. AGE: 1 Yrs. 5 Mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Blackfoot Idaho

10. NAME OF FATHER: Ray Pepper

11. BIRTHPLACE OF FATHER (State or Country): Payson Utah

12. MAIDEN NAME OF MOTHER: Cora Stevens

13. BIRTHPLACE OF MOTHER (State or Country): Payson Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ray Pepper
(Address) Blackfoot Ida

15. Filed Nov. 3 1921 [illegible]
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 2 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ~ 19..., to ~ 19...,
that I last saw h... alive on ... 19...
and that death occurred on the date stated above, at 5-30 P.M.
The CAUSE OF DEATH* was as follows:

accidentally drowned in irrigation ditch

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) E. L. Egli Coroner M. D.
Nov 3 1921 (Address) Blackfoot, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Grove City Cemetery — DATE OF BURIAL: Nov 4 1921

20. UNDERTAKER: E. L. Egli — ADDRESS: Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 2194
File No. 35827
Registered No. 35827

1. PLACE OF DEATH
County of Bingham
City of Blackfoot (No. State Hospital St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Richard J Wickham
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (write the word.)
6. DATE OF BIRTH: ..... (Month) ..... (Day) 1847 (Year)
7. AGE: 74 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry, business or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): Ireland
10. NAME OF FATHER: unknown
11. BIRTHPLACE OF FATHER (State or Country): Ireland
12. MAIDEN NAME OF MOTHER: unknown
13. BIRTHPLACE OF MOTHER (State or Country): Ireland
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Hospital Records R F Eaton
(Address) Blackfoot. Idaho
15. Filed Nov. 5 1921 ..... Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov 5 1921 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from Nov 7 1908 to Nov 5 1921 that I last saw h/m alive on Nov. 4 1921, and that death occurred on the date stated above, at 1:30 AM.
The CAUSE OF DEATH* was as follows:
Cerebral apoplexy
..... (Duration) ..... Yrs. ..... mos. 7 ds.
Contributory (Secondary) Senile psychosis
..... (Duration) 13 yrs. ..... mos. ..... ds.
(Signed) C. N. Hozum M. D.
Nov 5 1921 (Address) Blackfoot Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 11 yrs. ..... mos. ..... days. In the State 41 yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence Harley Idaho

19. PLACE OF BURIAL OR REMOVAL: Hospital Cemetery — DATE OF BURIAL: Nov. 5 1921
20. UNDERTAKER: L J. Porter — ADDRESS: Blackfoot Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35828

Registered No. 9371

RECEIVED
DEC 1 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 1 31

Primary Registration District No. 2 1 1 4

County of Bingham

City of Blackfoot (or Town of) State Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jane Hurley

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Widowed

6. DATE OF BIRTH: Sept (Month) 14 (Day) 1842 (Year)

7. AGE: 79 Yrs. 1 Mos. 23 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: William Rhonds

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Jane Rhonds

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Hosp Records Mr P J Eaton
(Address) Blackfoot Idaho

15. Filed Nov 7 1921 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 6 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 24 1921 to Nov. 6 1921 that I last saw h[illegible] alive on Nov. 5 1921, and that death occurred on the date stated above, at 2 A M.

The CAUSE OF DEATH* was as follows:
Exhaustion of Senility

(Duration) ..... Yrs. ..... mos. 13 ds.

Contributory (Secondary) Morphine addiction

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W H Loomis M. D.

Nov 7 1921 (Address) Blackfoot Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 2 yrs. 0 mos. 13 days. In the State 1 yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence Payette, Idaho

19. PLACE OF BURIAL OR REMOVAL [illegible] DATE OF BURIAL ..... 19.....

20. UNDERTAKER [illegible] ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35829

Registered No. 152

1. PLACE OF DEATH

County of Bingham

City of Blackfoot (No. State Asylum St.)

Registration District No. 121

Primary Registration District No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME D. F. Baer

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	widower

6. DATE OF BIRTH

..... 1853
(Month) (Day) (Year)

7. AGE

68 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: gardener

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Missouri

10. NAME OF FATHER unknown

11. BIRTHPLACE OF FATHER (State or Country) unknown

12. MAIDEN NAME OF MOTHER unknown

13. BIRTHPLACE OF MOTHER (State or Country) unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Hospital Records by P. J. Eaton

(Address) Blackfoot Idaho

15. Filed Nov. 9 1921

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

November 7 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I ~~attended~~ deceased from April 17 1918 to Nov. 7 1921 that I last saw ~~him~~ alive on Nov. 7 1921, and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

General exhaustion
with heart failure

..... (Duration) ..... Yrs. ..... mos. 5 ds.

Contributory (Secondary) very marked arteriosclerosis

..... (Duration) 3 yrs. ..... mos. ..... ds.

(Signed) C. F. Toone M. D.

Nov. 7 1921 (Address) Blackfoot Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 3 yrs. 6 mos. 20 days. In the State 23 yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence Blackfoot Idaho

19. PLACE OF BURIAL OR REMOVAL: From city cemetery

DATE OF BURIAL: Nov 8 1921

20. UNDERTAKER: E. J. Funk

ADDRESS: Blackfoot Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35830

Registered No. 133

1. PLACE OF DEATH

Registration District No. 121

Primary Registration District No. 2194

County of Bingham

City of Blackfoot (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Roland Lawrence Savage

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Nov (Month) 8 (Day) 1921 (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many 2.7 hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Ralph Savage

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Flora Egbert

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ralph Savage

(Address) Blackfoot Ida

15. Filed Nov [illegible] 191[illegible] Mc Helen E. Yates Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 9 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 8 1921, to Nov 9 1921, that I last saw him alive on Nov 8 1921, and that death occured on the date stated above, at 11:45 A.M.

The CAUSE OF DEATH* was as follows:

Premature Birth

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.

11/14 1921 (Address) Blackfoot Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Firth Ida — DATE OF BURIAL 191

20. UNDERTAKER — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24854

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 131
Primary Registration District No. 107
File No. 35831
Registered No. 134

1. PLACE OF DEATH

County of Bingham
City of Blackfoot (No. 208 South Shoshone St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Laura A. Walson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widow

6. DATE OF BIRTH: June (Month) 16 (Day) 1836 (Year)

7. AGE: 85 Yrs. 4 Mos. 23 ds.
IF LESS than 1 day how many..... hrs. or.....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mass.

10. NAME OF FATHER: L. Gilbert

11. BIRTHPLACE OF FATHER (State or Country): Mass

12. MAIDEN NAME OF MOTHER: Eliza Taylor

13. BIRTHPLACE OF MOTHER (State or Country): Conn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Rosabel W. Chalmers
(Address) Blackfoot

15. Filed Nov 11 1921 Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 9 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 15 1921 to Nov 9 1921 that I last saw her alive on Nov 9 1921 and that death occurred on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:

Cancer Rectum

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Cancer Rectum

(Duration) 1 yrs. ..... mos. ..... ds.

(Signed) H. J. Simmons M. D.

11/10 1921 (Address) Blackfoot Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Grim City Cemetery — DATE OF BURIAL ..... 19.....

20. UNDERTAKER: E. J. Funk — ADDRESS: Blackfoot Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35832

Registered No. ____

RECEIVED DEC 1 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH.

Registration District No. 121

Primary Registration District No. 2 921

County of Bingham

City of Blackfoot (No. ____, ____ St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Rulon Clarence Savage

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Nov (Month) 8 (Day) 1921 (Year)

7. AGE ~ Yrs. ~ Mos. 5 ds.

IF LESS than 1 day how many ____ hrs. or ____ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... None
(b) General nature of industry, business, or establishment in which employed (or employer)...

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Ralph Savage

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Flora Egbert

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Ralph Savage
(Address) Blackfoot, Ida

15. Filed Nov. 14 1921 W. Mc Vaden E. Tate Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 13 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 8 1921, to Nov 13 1921, that I last saw him alive on Nov 8 1921, and that death occured on the date stated above, at 4 P M.

The CAUSE OF DEATH* was as follows:

Premature Birth

(Duration) ____ Yrs. ____ mos. ____ ds.

Contributory (Secondary)

(Duration ____ yrs. ____ mos. ____ ds.

(Signed) W W Beck M. D.

11/14 1921 (Address) Blackfoot Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Fort Ida — DATE OF BURIAL: ____ 191

20. UNDERTAKER — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

BYNS - YORK CO., PTRS. & BORS. 24854

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35833
Registered No. 156

1. PLACE OF DEATH
County of Bingham
City of Groveland (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 1
Primary Registration District No. 12

2. FULL NAME James Harvey Usher

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Sept 4 1873 (Month) (Day) (Year)

7. AGE: 48 Yrs. 2 Mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Indianna

10. NAME OF FATHER: James H Usher

11. BIRTHPLACE OF FATHER (State or Country): U. S.

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Della Usher
(Address) Blackfoot

15. Filed Nov. 16 1921
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. 14 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I ~~attended~~ investigated deceased ~~from~~ Nov. 14 1921, to ..... 19 ..... ~~that I last saw h alive on~~ ..... 19 ..... and that death occurred on the date stated above, at 11 45 M.

The CAUSE OF DEATH* was as follows:

Chest crushed in auto accident

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E. L Egli Coroner

11/16 1921 (Address) Blackfoot

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Groveland Cem. DATE OF BURIAL: Nov 16 1921

20. UNDERTAKER: E. L Egli ADDRESS: Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35834

Registered No. 757

1. PLACE OF DEATH.

County of Bingham Registration District No. 121

City of Blackfoot Primary Registration District No. 1007

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED DEC 1 1921 BUREAU OF VITAL STATISTICS

2. FULL NAME Lilace Hannah Wells

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Oct (Month) 9 (Day) 1905 (Year)

7. AGE: 16 Yrs. 1 Mos. 6 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At school
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Springfield Ida

10. NAME OF FATHER: Erastus N. Wells

11. BIRTHPLACE OF FATHER (State or Country): Willard Ut,

12. MAIDEN NAME OF MOTHER: Mary Moon

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) E. M. Wells,
(Address) Springfield

15. Filed Nov 16 1921 .....
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 15 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 10 1921, to Oct 10 1921, that I last saw h[illegible] alive on Oct 10 1921, and that death occured on the date stated above, at 2 30 P. M.

The CAUSE OF DEATH* was as follows:

Pulmonary Hemorrhage

(Duration) — Yrs. — mos. 2 ds.

Contributory (Secondary) Tuberculosis of Lung + mitral stenosis with regurgitation

(Duration 2 yrs. — mos. — ds.

(Signed) W W Beck M. D.

11/16 1921 (Address) Blackfoot, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Springfield — DATE OF BURIAL: Nov 18 1921

20. UNDERTAKER: E. L. Egli — ADDRESS: Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24654

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35835

Registered No. 13

1. PLACE OF DEATH

Registration District No. 137

Primary Registration District No. 1007

County of Bingham

City of Blackfoot (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Frederick Stanley Johns

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Mar (Month) 6 (Day) 1914 (Year)

7. AGE: 7 Yrs. 8 Mos. 11 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Student

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Sugar City Ida,

10. NAME OF FATHER: Fred N. Johns

11. BIRTHPLACE OF FATHER (State or Country): Ogden Utah

12. MAIDEN NAME OF MOTHER: Olive Virgin

13. BIRTHPLACE OF MOTHER (State or Country): St Charles Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) F. N. Johns

(Address) Blackfoot

15. Filed Nov 12 19 21 Mo Hulser E Pabst
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 17 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 10 1921, to Nov 17 1921 that I last saw him alive on Nov 16 1921 and that death occurred on the date stated above, at 10 25 A. M.

The CAUSE OF DEATH* was as follows:

Endocarditis

(Duration) ..... Yrs. 0 mos. 4 ds.

Contributory (Secondary) Diphtheria

(Duration) ..... yrs. ..... mos. 10 ds.

(Signed) M E Pabst M. D.

19..... (Address) Blackfoot Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Sugar City Ida — DATE OF BURIAL: Nov 18 1921

20. UNDERTAKER: E L Eyl — ADDRESS: Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 21
Primary Registration District No. 2174
File No. 35836
Registered No. 357

1. **PLACE OF DEATH**

County of Bingham
City of Blackfoot
(No. Lava Lode St.)

If death occurs away from usual residence, give facts called for under special information.

2. **FULL NAME** Paulis Dietrich Nelson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. **DATE OF BIRTH** Feb (Month) 16 (Day) 1911 (Year)

7. **AGE** 10 Yrs. 9 Mos. 5 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. **OCCUPATION**
(a) Trade, profession or particular kind of work: School Boy
(b) General nature of industry, business or establishment in which employed (or employer):

9. **BIRTHPLACE** (State or Country) Lava Lode-Idaho

10. **NAME OF FATHER** Carl Nelsen

11. **BIRTHPLACE OF FATHER** (State or Country) Nebraska

12. **MAIDEN NAME OF MOTHER** Arvilla Parker

13. **BIRTHPLACE OF MOTHER** (State or Country) Penn.

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**
(Informant) Alice Y Clarke
(Address) Blackfoot Idaho

15. Filed Nov 22 1921 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH** Nov. (Month) 22. (Day) 1921 (Year)

17. **I HEREBY CERTIFY, That I attended deceased from** Nov 10 1921, to Nov 15 1921 **that I last saw him alive on** Nov 15 1921, **and that death occurred on the date stated above, at** 12 M.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) ..... Yrs. ..... mos. 10 ds.

Contributory (Secondary) Diphtheria

(Duration) ..... yrs. ..... mos. 10 ds.

(Signed) F. A. Mitchell M. D.

19..... (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. **PLACE OF BURIAL OR REMOVAL** Grant City Cemetery — **DATE OF BURIAL** Nov 22 1921

20. **UNDERTAKER** E. S. Funk — **ADDRESS** Blackfoot

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED DEC 1 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Bingham
City of Blackfoot (or Village, or Township) (St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No.

File No. 35837
Registered No. 760

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Anna Georgina Seofield

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Female	White	Single (Never married)

6. DATE OF BIRTH: April (Month) 7 (Day) 1896 (Year)

7. AGE: 25 Yrs. 7 Mos. 16 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Fishaven Idaho

10. NAME OF FATHER: Hyrum P. Seofield

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Jane Bean

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Hyrum P Seofield
(Address) Blackfoot Ida

15.
Filed ..... 19 .....
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: November (Month) 23 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1 1921 to Nov 23rd 1921 that I last saw h[illegible] alive on Nov 23 1921 and that death occurred on the date stated above, at 12:05 M.

The CAUSE OF DEATH* was as follows:
Mitral regurgitation with cirrhosis of liver
(Duration) 1 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. O. Hamplain M. D.
11/25 1921 (Address) Blackfoot Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Grove City Cemetery
DATE OF BURIAL: Nov 28 1921

20. UNDERTAKER: E. L. Egli
ADDRESS: Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 5174
File No. 35838
Registered No. 767

1. PLACE OF DEATH
County of Bonneville
City of Shelley (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Hannah Towers
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widow

6. DATE OF BIRTH: Sep (Month) 1 (Day) 1849 (Year)

7. AGE: 72 Yrs. 2 Mos. 23 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: John Dyson

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Ann Crabtree

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H Towers
(Address) Shelley Idaho

15. Filed Nov 25 1921 Wm Whitt Thurston Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 23 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 15 1921, to Nov. 23 1921, that I last saw her alive on Nov. 22 1921, and that death occurred on the date stated above, at 10 P M.
The CAUSE OF DEATH* was as follows:
Pulmonary Oedema,
(Duration) ..... Yrs. ..... mos. 2 ds.
Contributory (Secondary) Dr Mop
(Duration) ..... yrs. 1 mos. ..... ds.
(Signed) Edwin Coates M. D.
11/25/1921 (Address) Shelley

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Ogden, Ut
DATE OF BURIAL: 11/27/1921

20. UNDERTAKER: E E Dunwoody
ADDRESS: Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

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DEC 1 1921
BUREAU OF VITAL STATISTICS

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35839
Registered No. 162

1. PLACE OF DEATH. Registration District No. 127
County of Bingham Primary Registration District No. 1007
City of Blackfoot (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sarah Ann Nelson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: July (Month) 17 (Day) 1858 (Year)

7. AGE: 63 yrs. 4 mos. 8 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, professsion, or particular kind of work: Housewife
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Enoch Broadbent

11. BIRTHPLACE OF FATHER (State or Country): England ~~England~~

12. MAIDEN NAME OF MOTHER: Keturah Lund

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Leo. Nelson
(Address) Blackfoot

15.
Filed ..... 191.. .....
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 25 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 191.., to Nov 25 – 1921 that I last saw her alive on Nov 23 1921, and that death occurred on the date stated above, at 8:30 P. M.

The CAUSE OF DEATH* was as follows:
Hypotrical attack probably
Causing heart elpasm
(Duration) One-half hour yrs. ..... mos. ..... ds.
Contributory (Secondary) Nervous prostration –
(Duration) 2 yrs. 6 mos. ..... ds.
(Signed) A. L. Jackson M. D.
Nov 25 1921 (Address) Blackfoot

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. 2 mos. 9 ds. In the State 25 yrs. ..... mos. ..... ds.
Where was Disease contracted, if not at place of death? Wyoming
Former or usual residence. Marysville – Idaho

19. PLACE OF BURIAL OR REMOVAL: Riverside Cemetery DATE OF BURIAL: Nov 28 1921

20. UNDERTAKER: E. J. Peck ADDRESS: Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16872

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 2 901
File No. 35840
Registered No.

1. PLACE OF DEATH
County of Bingham
City of Blackfoot
If death occurs away from usual residence, give facts called for under special information.
(No. State Hospital St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Alice Robertson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
female	white	married (Write the word.)

6. DATE OF BIRTH: Aug (Month) 14 (Day) 1867 (Year)

7. AGE: 54 Yrs. 3 Mos. 12 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: unascertained

11. BIRTHPLACE OF FATHER (State or Country): unascertained

12. MAIDEN NAME OF MOTHER: unascertained

13. BIRTHPLACE OF MOTHER (State or Country): unascertained

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Hospital Records R.N. & M.D.
(Address) Blackfoot Idaho

15. Filed Nov 29 1921 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: November (Month) 26 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 28 1917 to Nov 26 1921 that I last saw her alive on Nov 25 1921, and that death occurred on the date stated above, at 2 0 M.

The CAUSE OF DEATH* was as follows:
Gastritis
(Duration) ..... Yrs. ..... mos. 2 ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. J. Corum M. D.
Nov 27 1921 (Address) Blackfoot, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 3 yrs. 11 mos. 28 days. In the State 29 yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence Lowman Idaho

19. PLACE OF BURIAL OR REMOVAL: Hospital Cemetery — DATE OF BURIAL: Nov 29 1921

20. UNDERTAKER: Robi King — ADDRESS: Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 2194
File No. 35841
Registered No. 164

1. PLACE OF DEATH
County of Bingham
City of Fort Hall
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Chris Peter Christensen
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	W.	Married

6. DATE OF BIRTH: May (Month) 7 (Day) 1868 (Year)

7. AGE: 53 Yrs. 6 Mos. 14 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Denmark

10. NAME OF FATHER: Chris. Christensen

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: Dorit Skoot.

13. BIRTHPLACE OF MOTHER (State or Country): Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): albert Hyslop
(Address): Fort Hall, Ida.

15. Filed Nov 25 1921 Nina Hales C. Pitts Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: November 26 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 25 1921 to Nov. 26 1921
that I last saw him alive on Nov. 25 1921,
and that death occurred on the date stated above, at 3:04 P.M.
The CAUSE OF DEATH* was as follows:

Pneumonia

..... (Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.

11/26 1921 (Address) Shelley Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Fort Hall — DATE OF BURIAL: Nov. 28 1921

20. UNDERTAKER: Jeff C. Hayes — ADDRESS: Fort Hall, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 2194
File No. 35842
Registered No. 165

1. PLACE OF DEATH.
County of Bingham
City of Blackfoot
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Albert Turner

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Nov (Month) 29 (Day) 1921 (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or 15 min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Joseph Moroni Turner

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Tula Clark

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Joseph M Turner
(Address) Blackfoot.

15. Filed Nov. 29 1921 Mrs Nellie E. Fate
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Nov (Month) 29 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 29 1921, to Nov 29 1921, that I last saw him alive on Nov 29 1921, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Premature birth
6th month
(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) W W Beck M. D.
19... (Address) Blackfoot, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Grove City Cem
DATE OF BURIAL: 1921

20. UNDERTAKER
ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 24654

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 2194
File No. 35843
Registered No. 166

1. PLACE OF DEATH
County of Bingham
City of Shelley
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Peter Larsen
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	W	Widower

6. DATE OF BIRTH: Jan (Month) 3 (Day) 1877 (Year)

7. AGE: 44 Yrs. 10 Mos. 27 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Butcher and Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Chas. P. Larsen

11. BIRTHPLACE OF FATHER (State or Country): Mo.

12. MAIDEN NAME OF MOTHER: Emma Brooks

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Anthony
(Address) Shelley Ida

15. Filed Nov. 30 1921 Mrs Nellie E. Patrick
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 30 (Day) 21 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 21 1921 to Nov. 30 1921 that I last saw h[illegible] alive on Nov. 29 1921 and that death occurred on the date stated above, at 2.30 P.M.
The CAUSE OF DEATH* was as follows:
Typhoid Fever
(Duration) ..... Yrs. 1 mos. ..... ds.
Contributory (Secondary) Hemorrhage of bowels
(Duration) ..... yrs. ..... mos. 1 ..... ds.
(Signed) F. A. Gilbert M. D.
11/30 1921 (Address) Shelley Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Firth Ida. | DATE OF BURIAL ..... 19.....

20. UNDERTAKER | ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

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SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

35844

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 4

Registered No. 62

1. PLACE OF DEATH.

County of Bingham

City of Aberdeen

Registration District No. 116

Primary Registration District No. 2193

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lena Alice Stambaugh

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. July (Month) 1 (Day) 1879 (Year)

7. AGE: 42 Yrs. 4 Mos. 26 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Sylvester Barnes,

11. BIRTHPLACE OF FATHER (State or Country): Pennsylvania

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) S. F. Stambaugh

(Address) .....

15. Filed Nov 28 21 M. Cameron Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 27 (Day) 21 191 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 8 191 8, to Nov 27 191 21, that I last saw h[er] alive on Nov 24 191 21, and that death occured on the date stated above, at 10:00 M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast

..... (Duration) 3 Yrs. 5 mos. ..... ds.

Contributory (Secondary) Metastatic Carcinoma of Lungs

..... (Duration) 1 yrs. — mos. ..... ds.

(Signed) M. C. McKinnon M. D.

Nov 28 1921 (Address) Aberdeen Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: I.O.O.F. Cemetery Aberdeen Ida

DATE OF BURIAL: Nov 29 191 21

20. UNDERTAKER: Friend

ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

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MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SORS. 24858

FORM V. S. No. 5-25 M. 1-19.

3584

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 116
Primary Registration District No. 2195
File No. 4
Registered No. 61

1. PLACE OF DEATH
County of Bingham
City of Aberdeen
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Annie Elizabeth Monsen
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Nov. (Month) 7 (Day) 1875 (Year)

7. AGE: 46 Yrs. 0 Mos. 16 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Thomas N Bleak

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Elizabeth Olsen

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. H. Monsen
(Address) Aberdeen

15. Filed Nov 25 21 M. C. MacKinnon
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 23 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1918 19..., to Nov 23 1921
that I last saw h.. alive on Nov 7 1921
and that death occurred on the date stated above, at 10 A. M.
The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) 3 Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) M. C. MacKinnon M. D.
Nov 25 1921 (Address) Aberdeen Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Aberdeen Cemetery — DATE OF BURIAL: Nov 27 1921

20. UNDERTAKER: E. L. Egli — ADDRESS: Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 57

Primary Registration District No. 2022

File No. 35846

Registered No. 87

County of Blaine

City of Hailey (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs. L. S. Hafer

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Widowed

6. DATE OF BIRTH

..... (Month) ..... (Day) 1 (Year)

7. AGE

73 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Home wife.

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Indiana.

10. NAME OF FATHER —

11. BIRTHPLACE OF FATHER (State or Country) —

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER (State or Country) —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) X John R. Hafer

(Address) Hailey, Ida

15. Filed 12-1 1921 R. H. Wright Local Registrar

MEDICAL CERTIFICATE OF DEATH

Dietz.

16. DATE OF DEATH Oct. 22 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 5 1921, to Oct 22 1921, that I last saw h.. alive on Oct 22 1921 and that death occurred on the date stated above, at 8 a.m.

The CAUSE OF DEATH* was as follows: Chronic Nephritis

..... (Duration) ..... Yrs. 6 mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) H. H. Wrighton M. D.

19..... (Address) Hailey Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Shoshone, Ida.	Oct 25 1921
20. UNDERTAKER C. P. Harris	ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

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FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35847
Registered No. 38

1. PLACE OF DEATH

RECEIVED
DEC 18 1921
BUREAU OF VITAL STATISTICS

Registration District No. 57
Primary Registration District No. 2022

County of Blaine
City of Hailey (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Wilhelmena Mehle

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: married. (Write the word.)

6. DATE OF BIRTH: Nov. (Month) 2. (Day) 1862 (Year)

7. AGE: 59 Yrs. 11 Mos. 20 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Germany.

10. NAME OF FATHER: Schimmel

11. BIRTHPLACE OF FATHER (State or Country): Germany.

12. MAIDEN NAME OF MOTHER: ~

13. BIRTHPLACE OF MOTHER (State or Country): ~

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H. Mehle
(Address) Hailey Idaho.

15. Filed 12-1 1921 R. H. Wright, Local Registrar

MEDICAL CERTIFICATE OF DEATH

Dutton.

16. DATE OF DEATH: Oct. (Month) 23 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 10 1921, to Oct 23 1921, that I last saw her alive on Oct 23 1921 and that death occurred on the date stated above, at 7 A. M.

The CAUSE OF DEATH* was as follows: Carcinoma of Duodenum

(Duration) Yrs. 1 mos. 13 ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) H H Dutton M. D.
19 (Address) Hailey Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Hailey, Idaho. DATE OF BURIAL: 10-25 1921

20. UNDERTAKER: T. D. Harris ADDRESS: Hailey

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

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FORM V. S. No. 5-25 M. 1-19.

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BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 57

Primary Registration District No. 2022

File No. 35849

Registered No. 40

County of Blaine

City of Gannett (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elizabeth Laird Stanfield.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	married

6. DATE OF BIRTH: Aug. (Month) 13. (Day) 1860. (Year)

7. AGE: 61 Yrs. 1 Mos. 17 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife.
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Scotland.

10. NAME OF FATHER: James L. Jenkins.

11. BIRTHPLACE OF FATHER (State or Country): Scotland.

12. MAIDEN NAME OF MOTHER: ✓

13. BIRTHPLACE OF MOTHER (State or Country): ✓

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wm. H. Stanfield
(Address) Gannett, Ida

15. Filed 12-1 1921 R. H. Wright Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Wright. Oct. (Month) 30- (Day) 1921. (Year)

17. I HEREBY CERTIFY, That I attended deceased from — 19..., to — 19...,
that I last saw h... alive on — 19...,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Encephalitis Lethargica
(Duration) ..... Yrs. ..... mos. 3 weeks ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) R. H. Wright M. D.
11-1 1921 (Address) Hailey, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Sucabee Ida.	11-1 1921
20. UNDERTAKER: P. Harris	ADDRESS: Hailey

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED DEC 12 1921 BUREAU OF VITAL STATISTICS

Registration District No. 57
Primary Registration District No. 2022
File No. 35850
Registered No. 41

1. PLACE OF DEATH
County of Blaine
City of Hailey St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charles Rust.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widower

6. DATE OF BIRTH: Nov 22 1846 (Month) (Day) (Year)

7. AGE: 74 Yrs. 11 Mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer,
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): England.

10. NAME OF FATHER: [illegible]

11. BIRTHPLACE OF FATHER (State or Country): England.

12. MAIDEN NAME OF MOTHER: Cornelia Patton.

13. BIRTHPLACE OF MOTHER (State or Country): England.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Charles Rust
(Address) Hailey Ida.

15. Filed 12-1 1921 R. H. Wright Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. 1st 1921.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1 1921, to ..... 19....., that I last saw him alive on June 1 1921, and that death occurred on the date stated above, at 9 P.M.
The CAUSE OF DEATH* was as follows:
Pneumonia
(Duration) ..... Yrs. ..... mos. 6 ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) J. J. Burnes M. D.
19..... (Address) J. Hailey, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Hailey, Ida — DATE OF BURIAL: 11-6 1921

20. UNDERTAKER: R. D. Harris — ADDRESS: Hailey

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

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FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35851

Registered No. 42

1. PLACE OF DEATH

County of Blaine

City of Hailey

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 57

Primary Registration District No. 3022

2. FULL NAME Edward Fleming

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: April 9 1870 (Month) (Day) (Year)

7. AGE: 51 Yrs. 7 Mos. 7 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Lumberman

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: Elias Estep.

11. BIRTHPLACE OF FATHER (State or Country): Pennsylvania

12. MAIDEN NAME OF MOTHER: Anna Wells.

13. BIRTHPLACE OF MOTHER (State or Country): Ohio.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Lilly Fleming

(Address) Hailey

15. Filed 12-1 1921 R. H. Wright Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. 16 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1 1921 to Nov-16 1921 that I last saw him alive on Nov-16 1921 and that death occurred on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows: Chronic Brights Disease

(Duration) 2 Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) R. H. Wright M. D.

11-17 1921 (Address) Hailey, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Hailey, Ida — DATE OF BURIAL: 11-20 1921

20. UNDERTAKER: R. D. Harris — ADDRESS: Hailey

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

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FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 57
Primary Registration District No. 2022
File No. 35852
Registered No. 43

1. PLACE OF DEATH

County of Blaine
City of Near Garnett (Ida. No. ..... St.)
STATE

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ina Anna Birdsell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Married

6. DATE OF BIRTH: Nov (Month) 8 (Day) 1886 (Year)

7. AGE: 35 Yrs. Mos. 13 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kansas

10. NAME OF FATHER: Comodore Boothe

11. BIRTHPLACE OF FATHER (State or Country): ✓

12. MAIDEN NAME OF MOTHER: ✓

13. BIRTHPLACE OF MOTHER (State or Country): ✓

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Garnett, Ida.
(Address) Ernest Birdsell

15. Filed 12-1 1921 R. H. Wright, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 21 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 19 1921 to Nov 21 1921, that I last saw her alive on Nov 21 1921, and that death occurred on the date stated above, at 4:30 M.

The CAUSE OF DEATH* was as follows:
(a) Diabetes Mellitus
(Duration) / Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) Robert H. Bayley M. D.
Nov 22nd 1921 (Address) Hailey Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Jonesawa Oklahoma	✓ 19

20. UNDERTAKER	ADDRESS
R. D. Harris	Hailey

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

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FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35853
Registered No. 33

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1. PLACE OF DEATH
County of Blaine, Registration District No. 57
City of Bellevue (No. ..... St.) Primary Registration District No. 2022
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Frank O. Turner.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married.

6. DATE OF BIRTH: June (Month) 14 (Day) 1849 (Year)

7. AGE: 72 yrs. 4 Mos. 16 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kentucky.

10. NAME OF FATHER: Johnathan Turner.

11. BIRTHPLACE OF FATHER (State or Country): W. Virginia

12. MAIDEN NAME OF MOTHER: Owens.

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): John Turner
(Address): Hailey, Ida.

15. Filed Nov 1 1921 R. H. Wright
Local Registrar

MEDICAL CERTIFICATE OF DEATH

Teede, Bellevue.

16. DATE OF DEATH: Sept. (Month) 30 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 29 1921, to Sept 30 1921 that I last saw him alive on Sept 30 1921, and that death occurred on the date stated above, at 10 P M.

The CAUSE OF DEATH* was as follows:
Shock due to accident

(Duration) ..... Yrs. ..... mos. 36 hrs ..... ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Edward Teed M. D.
1921 (Address) Bellevue Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Bellevue
DATE OF BURIAL: Dec. 2 1921

20. UNDERTAKER: J. D. Harris
ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

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FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD of HEALTH
Bureau of Vital Statistics

File No. 35854

Registered No. 304

1. PLACE OF DEATH

Registration District No. 57

Primary Registration District No. 2022

County of Blaine

City of Hailey (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

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BUREAU OF VITAL STATISTICS

2. FULL NAME Michael Oleary, Duffy

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Md. (Write the word.)

6. DATE OF BIRTH: Feb 22. (Month) (Day) 1855 (Year)

7. AGE: 66 Yrs. 7 Mos. 18 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Miner

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Canada.

10. NAME OF FATHER: —

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) N. E. Duffy

(Address) Hailey Idaho

15. Filed Nov-1 1921

R. H. Wright
Local Registrar

MEDICAL CERTIFICATE OF DEATH

Wright.

16. DATE OF DEATH: Oct. (Month) 12 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct-7 1921 to Oct-12, 1921 that I last saw him alive on Oct. 12, 1921 and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 10 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Robert H. Wright M. D.

10-13 1921 (Address) Hailey, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Hailey, Ida — DATE OF BURIAL: Oct 14 1921

20. UNDERTAKER: R. D. Harris — ADDRESS: Hailey

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N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

U. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

PLACE OF DEATH.

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BUREAU OF VITAL STATISTICS

Registration District No. 57

Registration District No. 2075

File No. 35855

Registered No. 95

City of Blaine

City of Carey

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Oliver Franklin Lee

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Apr (Month) 22 (Day) 1873 (Year)

7. AGE: 48 Yrs. 4 Mos. 8 Ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: General workman
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Bruns. Idaho

10. NAME OF FATHER: James Lee

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: C. Whitehead

13. BIRTHPLACE OF MOTHER (State or Country): Ind.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mary Lee
(Address) Carey Ida.

15. Filed Nov-1 1921 R. H. Wright Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 16 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 8-26 1921 to 9-14 1921, that I last saw him alive on 9-14 1921 and that death occured on the date stated above, at 12:05 M.

The CAUSE OF DEATH* was as follows:
Chronic Interstitial Nephritis
(Duration) 1 Yrs. 1 mos. ds.
Contributory (Secondary) Mitral stenosis
(Duration) 1 Yrs. 1 mos. ds.
(Signed) Houston C. Snyder M. D.
19 (Address) Carey Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Carey, Ida — DATE OF BURIAL: 9-18 1921

20. UNDERTAKER: — ADDRESS:

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY; PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

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FORM V. S. No. 5-25 M. 1-19.

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CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 78
Primary Registration District No. 2155
File No. 35856
Registered No.

1. PLACE OF DEATH
County of Bonner
City of Sand Point (No. City Hospital St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jack Hartness

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH
Unknown (Month) 1 (Day) 1893 (Year)

7. AGE
28 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Acrobat
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Mich

10. NAME OF FATHER Fred Hartness

11. BIRTHPLACE OF FATHER (State or Country) Unknown

12. MAIDEN NAME OF MOTHER "

13. BIRTHPLACE OF MOTHER "
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Jack Hartness
(Address) Sand Point, Ida.

15.
Filed Nov 8 1921 Floyd Wendle
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 2, 1921.
(Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 2 1921, to Oct 2 1921, that I last saw h.... alive on Oct 2 1921, and that death occurred on the date stated above, at .....M.

The CAUSE OF DEATH* was as follows:
Accidental fall from 2-story building,
(Duration) Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) W R Huntington M. D.
Oct 4 1921 (Address) Sand Point, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence [redacted]

19. PLACE OF BURIAL OR REMOVAL Sand Point, Ida DATE OF BURIAL Oct 9, 1921.

20. UNDERTAKER W H Lewis ADDRESS Sand Point, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

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FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 78

County of Boundary

Primary Registration District No. 2155

City of Rotaine (No.) Rotaine Ida. St.)

File No. 35857

Registered No.

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

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2. FULL NAME Susan Brown

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6. DATE OF BIRTH: Oct 27 (Month) (Day) 1839 (Year)

7. AGE: 82 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Canada

10. NAME OF FATHER: Jno Burk

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. G. Brown

(Address) Rotaine, Ida

15. Filed Nov 6 1921 Floyd Wendle Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct 17 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 17 1921, to Oct 17 1921, that I last saw her alive on Oct 2 1921, and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

~~Accidental, fell~~

Chronic Nephritis

(Duration) 1 Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. R. Wallentine M. D.

Nov 14 1921 (Address) Sand Point Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Sand Point Ida | DATE OF BURIAL: Oct 19 1921

20. UNDERTAKER: B. Rush | ADDRESS: Sand Point Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

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FORM V. S. No. 5-25 M. 1-19.

RECEIVED NOV 8 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35858
Registered No.

1. PLACE OF DEATH

County of Boise — Registration District No. 78

City of Sand Point — Primary Registration District No. 2155

(If outside limits of city or village give township) — No. Lake St. Ida. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Martin Frank

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Unknown (Month) (Day) 1873 (Year)

7. AGE: about 48 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Miner

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ill

10. NAME OF FATHER: Frank

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: ..

13. BIRTHPLACE OF MOTHER (State or Country): ..

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Lake Mines Inc

(Address) Sand Point, Ida.

15. Filed Nov 8 1921 Floyd Wendle Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct 1 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 8 1921 to ... 19..., that I last saw h.. alive on Oct 8 1921, and that death occurred on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:

Head crushed - left arm blown off - internally injured (accidental injury from explosion.)

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) O. F. Page (by E.P.W.) M. D.

Nov 4 1921 (Address) Sand Point, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Sand Point, Ida — DATE OF BURIAL: Nov 1 1921

20. UNDERTAKER: E. P. Engh — ADDRESS: Sand Point, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
NOV 30 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Boundary — Registration District No. 78

City of Sandpoint (No. Cocolalla, Ida. St.) — Primary Registration District No. 2157

File No. 35859

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Magnus Wol

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	White	Single

6. DATE OF BIRTH Unknown 1873
(Month) (Day) (Year)

7. AGE about 48 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Miner
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Norway

10. NAME OF FATHER — Wol

11. BIRTHPLACE OF FATHER (State or Country) Norway

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (State or Country) "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Nels Hanson
(Address) Cocolalla, Ida.

15. Filed Nov 8 1921 — Floyd Wendle, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 10, 1921.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sudden 19.. to Death 19.., that I last saw h.. alive on .., and that death occurred on the date stated above, at ..M.

The CAUSE OF DEATH* was as follows:
Valvular Heart Disease

(Duration) 3 Yrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) Floyd Wendle M.D.
Oct 29, 1921 (Address) Sandpoint, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL — Sandpoint Ida — DATE OF BURIAL Oct 1921

20. UNDERTAKER — ADDRESS Sandpoint Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED NOV 30 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 78

County of Bonneville Primary Registration District No. 2155

City of Idaho Falls (No. City Hospital St.)

File No. 35860

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Frank Dyer

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	White	Married

6. DATE OF BIRTH: Aug 29, 1860 (Month) (Day) (Year)

7. AGE: 61 Yrs. Mos. ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer): At Home

9. BIRTHPLACE (State or Country): Ind

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Iris York

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jerome J. Dyer
(Address) Lacleede, Ida.

15. Filed Nov 8 1921 Floyd Wendle Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct 17, (Month) (Day) 19 21 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 8 1921, to Oct 17 1921, that I last saw h.. alive on Oct 16 1921, and that death occurred on the date stated above, at 4 A.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

(Duration) 2 Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Floyd Wendle M. D.

Nov 1921 (Address) Idaho Falls, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lacleede, Ida — DATE OF BURIAL: Oct 20 1921

20. UNDERTAKER: B. Kruger — ADDRESS: Idaho Falls Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED NOV 30 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35861
Registered No.

1. PLACE OF DEATH
County of Bonner Registration District No. 78
Primary Registration District No. 2155
City of Sandpoint (No.) Colburn, Idaho St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Isaac Bud Tinblin

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6. DATE OF BIRTH: July 5, (Month) (Day) 1890 (Year)

7. AGE: 31 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Lumber Worker
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wis

10. NAME OF FATHER: Ed Tinblin

11. BIRTHPLACE OF FATHER (State or Country): Penna

12. MAIDEN NAME OF MOTHER: Abi Thomas

13. BIRTHPLACE OF MOTHER (State or Country): Penna

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Jainey
(Address) Almira, Ida

15. Filed Nov 8 1921 Floyd Wardle Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct 13 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h.... alive on Oct 11, 1921; and that death occurred on the date stated above, at 1:30 P.M.

The CAUSE OF DEATH* was as follows:
Gunshot in Thoracic region by unknown party. Death due to shock, and internal hemorrhage.
(Duration) Yrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) B. V. Pugh Deputy Coroner
Oct 18 1921 (Address) Sandpoint, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Sandpoint, Ida — DATE OF BURIAL: Oct 18, 1921

20. UNDERTAKER: B. V. Pugh — ADDRESS: Sandpoint, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

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FORM V. S. No. 5-25 M. 1-19.

RECEIVED NOV 30 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35862

Registered No.

1. PLACE OF DEATH

County of Bonner Registration District No. 78

Primary Registration District No. 2155

City of Sand Point (If outside limits of city or village, give township) Cedar St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Daniel Nelson McDonald

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Jan (Month) 12 (Day) 1915 (Year)

7. AGE: 6 Yrs. Mos. ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: School Boy
(b) General nature of industry, business or establishment in which employed (or employer): at Home

9. BIRTHPLACE (State or Country): Ida

10. NAME OF FATHER: Matt McDonald

11. BIRTHPLACE OF FATHER (State or Country): Ida

12. MAIDEN NAME OF MOTHER: Sadie Nelson

13. BIRTHPLACE OF MOTHER (State or Country): Miss

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. E. Nelson
(Address) Sand Point, Ida.

15. Filed Nov 8 1921 Floyd Wendle Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 3 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 30 1921, to Oct 3 1921, that I last saw h[illegible] alive on Oct 3 1921, and that death occurred on the date stated above, at 4:20 P.M.

The CAUSE OF DEATH* was as follows:

Laryngeal Diphtheria

(Duration) # Yrs. # mos. 3 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) E. T. Anderson M. D.

1921 (Address) Sand Point, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Sand Point Ida. DATE OF BURIAL: Oct 5, 1921.

20. UNDERTAKER: E. E. Fuqua ADDRESS: Sand Point, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-23 Rev. 1-19.

RECEIVED NOV 30 1921 BUREAU OF VITAL STATISTICS STATE OF IDAHO

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35863
Registered No.

1. PLACE OF DEATH
Registration District No. 78
Primary Registration District No. 2155
County of Shoshone
City of Sand Point (If outside limits, give township) Original Mines Inc (St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lester E. Ashby

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: June (Month) 30 (Day) 1889 (Year)

7. AGE: 32 Yrs. Mos. ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry, business or establishment in which employed (or employer): Foreman

9. BIRTHPLACE (State or Country): Ill.

10. NAME OF FATHER: Tom Ashby

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Hannah Pascoe

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Fred Ashby
(Address) Coeur D'Alene, Ida

15. Filed Nov 8 1921 Floyd Wendle Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 25 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Mine Accident - Skull crushed in
R. side crushed, Neck broken
other bones broken
(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. F. Shearer M. D.
(Address) Sand Point, Ida. Nov 4 1921.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Coeur D'Alene, Idaho — DATE OF BURIAL: Nov 28 1921.
20. UNDERTAKER: B. F. Vaughn — ADDRESS: Sand Point Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED DEC 1 1921 BUREAU OF VITAL STATISTICS

Registration District No. 85
Primary Registration District No. 2185
File No. 35864
Registered No.

1. PLACE OF DEATH

County of Bonner
City of Priest River, (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Walter Luce Jr.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Oct (Month) 22 (Day) 1921 (Year)

7. AGE: ... Yrs. ... Mos. 27 ds.

IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Walter Luce

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Deborah Maag

13. BIRTHPLACE OF MOTHER (State or Country): Mich.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Walter L. Luce

(Address) Priest River

15. Filed Dec 1 1921

C P Gehloff
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 16 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 22 1921 to Nov, 16 1921, that I last saw him alive on Nov 15 1921, and that death occurred on the date stated above, at 4 A. M.

The CAUSE OF DEATH* was as follows:

Premature birth 7Mo.
Child failed to take proper nourishment

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) C. J. Gehloff M. D.

Nov 16 21 (Address) Priest River, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Priest River

DATE OF BURIAL: Dec 17 1921

20. UNDERTAKER: Walter Luce

ADDRESS: Priest River

FORM V. S. No. 5-25 M. 1-16-13 RECEIVED DEC 8 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH.

35867
3586

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 81
Primary Registration District No. 2155
File No. 2
County of Bonner
City of Laclede, Ida (No. ..... St.)
Registered No. 37

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Harold Robt Christenson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): child

6. DATE OF BIRTH. Oct (Month) 29 (Day) 1921 (Year)

7. AGE ..... Yrs. ..... Mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work... Infant
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Laclede, Idaho

10. NAME OF FATHER Peter C. Christenson

11. BIRTHPLACE OF FATHER (State or Country) minnesota

12. MAIDEN NAME OF MOTHER Pearl Irene Peterson

13. BIRTHPLACE OF MOTHER (State or Country) wisconsin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Peter C. Christenson
(Address) Laclede Idaho

15.
Filed Nov 7 1921 F. W. Didier Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Nov. (Month) 6 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 29 1921, to Nov 6, 1921, that I last saw him alive on Nov 6, 1921, and that death occured on the date stated above, at 5:00 P M.

The CAUSE OF DEATH* was as follows:
asthenia (due to being a premature birth)

(Duration) ..... Yrs. ..... mos. 6 ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

11/6 1921 (Signed) F. W. Didier M. D.
(Address) Laclede, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Laclede Ida. DATE OF BURIAL: Nov. 7 1921

20. UNDERTAKER: None ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

BYRNS - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-19.

RECEIVED DEC

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 81

Primary Registration District No.

File No. 35868

Registered No.

County of Bonner

City of Sandpoint (If outside limits, give township) No. Laclede, Idaho. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Henry Peterson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M.	White	Married

6. DATE OF BIRTH

(Month) (Day) 1868 (Year)

7. AGE

53 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Rancher

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Denmark

10. NAME OF FATHER Peter Peterson

11. BIRTHPLACE OF FATHER (State or Country) Denmark

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (State or Country) Denmark.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Sanford Peterson.

(Address) Laclede, Idaho.

15. Filed Nov 20 1921 H W Dicken Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov. (Month) 16 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 16 1921, to Nov 16 1921 that I last saw him alive on Nov 16 1921, and that death occurred on the date stated above, at 11 00 A M.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(Duration) 1 Yrs. 1 mos. 1 ds.

Contributory (Secondary) Edema Lungs

(Duration) yrs. mos. 10 ds.

(Signed) H W Dicken M. D.

Nov 20 1921 (Address) Laclede, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL ~~OR REMOVAL~~	DATE OF BURIAL
Laclede, Ida.	Nov. 18 1921
20. UNDERTAKER	**ADDRESS**
B. N. Pugh	Sandpoint, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED DEC 6 1921 BUREAU OF VITAL STATISTICS

16,342

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35869
Registered No.

1. PLACE OF DEATH
Registration District No. 76
Primary Registration District No. 2155
County of Bonner
City of Sand Point (No. Lalache, Ida. St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Henry A. Van Buskirk

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Male	White	WIDOWED

6. DATE OF BIRTH
Nov. 15, (Month) (Day) 1865 (Year)

7. AGE
53 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Miner
(b) General nature of industry, business or establishment in which employed (or employer) Employed

9. BIRTHPLACE (State or Country) Mich

10. NAME OF FATHER Van Buskirk

11. BIRTHPLACE OF FATHER (State or Country) Unknown

12. MAIDEN NAME OF MOTHER "

13. BIRTHPLACE OF MOTHER (State or Country) "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs T. S. Davies
(Address) Kitsoty, Alta.

15.
Filed Dec 6 1921 Floyd Wendle
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Nov. 25, (Month) (Day) 1921. (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....19...., to ....19....,
that I last saw h.... alive on ....19....,
and that death occurred on the date stated above, at ....M.
The CAUSE OF DEATH* was as follows:
Accident - Mine - Buried under muck drawn from chute.
....(Duration) ....Yrs. ....mos. ....ds.
Contributory (Secondary)
....(Duration) ....yrs. ....mos. ....ds.
(Signed) C. P. Stylecraynes M. D.
12-6 1921 (Address) Sand Point, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Sand Point, Ida	Nov. 30 1921

20. UNDERTAKER	ADDRESS
E. A. Cusick	Sand Point, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35870

Registered No.

1. PLACE OF DEATH

Registration District No. 18

Primary Registration District No. 2155

County of Bonner

City of Sandpoint (No. 710 N. 6-th St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Maude Jane Aman.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: April 1 1919 (Month) (Day) (Year)

7. AGE: 2 Yrs. 6 Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Idaho.

10. NAME OF FATHER Carl N. Aman

11. BIRTHPLACE OF FATHER (State or Country) Sweden

12. MAIDEN NAME OF MOTHER Anna Edlund

13. BIRTHPLACE OF MOTHER (State or Country) Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Carl N. Aman

(Address) Sandpoint, Ida.

15. Filed Dec 6 1921 Floyd Wendle Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 19 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 15 1921, to Nov 19 1921, that I last saw her alive on Nov 19 19..., and that death occurred on the date stated above, at 7.30 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia - Lobar.

(Duration) Yrs. mos. 3 ds.

Contributory (Secondary) Abdominal Complication Probably Intestinal Influenza

(Duration) yrs. mos. 5 ds.

(Signed) C. P. Stackhouse M. D.

19... (Address) Sandpoint, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ...yrs...mos...days. In the State ...yrs...mos...days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Sandpoint, Ida. DATE OF BURIAL: 11-22 1921

20. UNDERTAKER: B. N. Pugh, Sandpoint, Ida. ADDRESS

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bonner

City of Sandpoint.

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 78

Primary Registration District No. 2155

(No. Ranch, near Kootenai St.)

File No. 35871

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME M. H. Bryans

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Jan. (Month) 28 (Day) 1874 (Year)

7. AGE: 47 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Rancher

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ill.

10. NAME OF FATHER: James Bryans

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Anna Nellie

13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. M. H. Bryans

(Address) Kootenai, Ida.

15. Filed Dec 6 1921 Floyd Weadle Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 21 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 10 1921, to Nov 21 1921 that I last saw him alive on Nov 21 1921 and that death occurred on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(Duration) Yrs. 6 mos. ds.

Contributory (Secondary) Tonsils - and infected teeth.

(Duration) yrs. mos. ds.

(Signed) C. P. Stackhouse M. D.

19 (Address) Sandpoint, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Sandpoint Ida. DATE OF BURIAL: Nov. 27, 1921.

20. UNDERTAKER: B. W. Pugh, Sandpoint, Ida. ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED DEC 8 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35872
Registered No.

1. PLACE OF DEATH
County of Bonner Registration District No. 76
City of Sandpoint Primary Registration District No. 2155
(No. Hope St.) Idaho.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Wm. M. Knapp.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Jan. (Month) 20 (Day) 1847 (Year)

7. AGE: 74 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: M. D. (Retired)
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER: Wm Knapp

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Eliza Osborn

13. BIRTHPLACE OF MOTHER (State or Country): New York.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Knapp
(Address) Hope, Idaho

15. Filed Dec 6 1921 Floyd Wendle Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 16 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1917 to Nov 16 1921
that I last saw him alive on Nov 1921
and that death occurred on the date stated above, at 6 a. M.
The CAUSE OF DEATH* was as follows:
Angina pectoris.

(Duration) Yrs. mos. ds.
Contributory (Secondary) Arterio Sclerosis
(Duration) 5 yrs. mos. ds.
(Signed) C. P. Stackhouse M. D.
12/5 1921 (Address) Sandpoint Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR ~~REMOVAL~~: Hope, Idaho. DATE OF BURIAL: Nov. 19 1921

20. UNDERTAKER: B. N. Pugh, Sandpoint, Idaho. ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED DEC 8 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7C
Primary Registration District No. 2135
File No. 35873
Registered No.

1. PLACE OF DEATH

County of Bonner
City of Sand Point (No. 316 Pine St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Stanley A. Springer

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH: Nov 27 (Month) (Day) 1921 (Year)

7. AGE: ..... Yrs. ..... Mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Ida

10. NAME OF FATHER W. F. Springer

11. BIRTHPLACE OF FATHER (State or Country) Mich

12. MAIDEN NAME OF MOTHER Lillian Ridley

13. BIRTHPLACE OF MOTHER (State or Country) Mich

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. F. Springer
(Address) Sand Point, Ida.

15. Filed Dec 6 1921 Floyd Wendle
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov 29 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 27 1921, to Nov 29 1921, that I last saw h[illegible] alive on Nov 28 1921, and that death occurred on the date stated above, at 7P M.

The CAUSE OF DEATH* was as follows:

Pernt Pneumonia Croupous,

..... (Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) B O Wakefield M. D.

..... 19..... (Address) Sand Point, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Sand Point, Ida	Nov 30 1921.
20. UNDERTAKER	**ADDRESS**
J. K. Kruger	Sand Point

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED DEC 8 1921

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35874
Registered No.

1. PLACE OF DEATH

County of Bonneville Registration District No. 78

City of Idaho Falls (No. in Hospital (Usual Residence) St.) Primary Registration District No. 255

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Francis Robinson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH Jan 9, 1900 (Month) (Day) (Year)

7. AGE 21 Yrs. Mos. ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Saw Setter
(b) General nature of industry, business or establishment in which employed (or employer) Employed

9. BIRTHPLACE (State or Country) Wyo

10. NAME OF FATHER C. A. Robinson

11. BIRTHPLACE OF FATHER (State or Country) Ill

12. MAIDEN NAME OF MOTHER Maud Orr

13. BIRTHPLACE OF MOTHER (State or Country) Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. A. Robinson
(Address) Colburn, Ida.

15. Filed Dec 6 1921 Hoyd Wendle Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov 19, 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....,
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at 5 P.M.
The CAUSE OF DEATH* was as follows:

Exposure

Lost in mts, Father present at death (Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Floyd Wendle M. D.
12-6-1921 (Address) Idaho Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Colburn, Ida. DATE OF BURIAL Nov. 24, 1921.

20. UNDERTAKER D. A. Leigh ADDRESS Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35865

1. **PLACE OF DEATH**
County of Bonner
City of Sandpoint (No. St. James Hotel St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 78
Primary Registration District No. 2155

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. **FULL NAME** Olive Osborne

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F.	White	Divorced

6. **DATE OF BIRTH** Nov. (Month) 9 (Day) 1900 (Year)

7. **AGE** 17 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. **OCCUPATION**
(a) Trade, profession or particular kind of work: Chamber maid
(b) General nature of industry, business or establishment in which employed (or employer):

9. **BIRTHPLACE** (State or Country) Idaho.

10. **NAME OF FATHER** Orrie P. Osborne

11. **BIRTHPLACE OF FATHER** (State or Country) Calif

12. **MAIDEN NAME OF MOTHER** Lilly McHarter

13. **BIRTHPLACE OF MOTHER** (State or Country) Minn.

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**
(Informant) Orrie P. Osborne
(Address) Bayle. Idaho.

15. Filed Dec 6 1921 Hoyd Wendle
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH** Nov. (Month) 5 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 24 1921, to Nov 5 1921
that I last saw her alive on Nov 5 1921,
and that death occurred on the date stated above, at 1045a M.
The CAUSE OF DEATH* was as follows:
Intestinal Influenza

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) C. F. Stackhouse M. D.
12-3 1921 (Address) Sandpoint, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Westmond, Ida.	11/7 1921
20. UNDERTAKER	**ADDRESS**
B. W. Pugh	Sandpoint Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 78
Primary Registration District No. 2155
File No. 35876
Registered No.

1. PLACE OF DEATH
County of Bonner
City of Sandpoint (No. Lakeview, Ida. St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ernest P. Knight
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M.	White	Married

6. DATE OF BIRTH: November (Month) 10 (Day) 1897 (Year)

7. AGE: 24 Yrs. Mos. ds. — IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer (Woods)
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: — Knight

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chas. W. Halsey,
(Address) Lakeview, Ida.

15. Filed Dec 6 1921 Hoyd Wendle Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 8 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....; that I last saw h.... alive on ....., 19....., and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:
Mitral Regurgitation
(Duration) Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) B. Pugh Dep Coroner M. D.
Nov. 8, 1921. (Address) Sandpoint, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Ritzville, Wash. — DATE OF BURIAL: Nov. 12, 1921.

20. UNDERTAKER: E. N. Pugh, Sandpoint, Ida. — ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35877

Registered No.

1. PLACE OF DEATH

County of Boundary

City of Sandpoint

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 78

Primary Registration District No. 2155

(No. On Road, near Granite, Ida. St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Jens R. H. Myrthue

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: June (Month) 2 (Day) 1875 (Year)

7. AGE: 46 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Rancher

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Denmark

10. NAME OF FATHER: Iverman Hansen

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Christ Christenson

(Address) Standard Alta

15. Filed Dec 6 1921 Floyd Wendell Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 7. (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....,

that I last saw h..... alive on ..... 19.....,

and that death occurred on the date stated above, at 11 P. M.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) B. H. Pugh Dep Coroner M. D.

Nov 10 1921 (Address) Sandpoint, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Standard Alta — DATE OF BURIAL: Nov. 15, 1921.

20. UNDERTAKER: B. H. Pugh — ADDRESS: Sandpoint, Ida.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35878
Registered No. 112

1. PLACE OF DEATH
County of Bannock
City of Ida Falls
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

RECEIVED
NOV 30 1921
BUREAU OF VITAL STATISTICS

Civil Division District No. 73
Primary Registration District No. 21V-0

2. FULL NAME Charles Victor Thornton

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: married (Write the word.)

6. DATE OF BIRTH: Oct (Month) 7 (Day) 1887 (Year)

7. AGE: 34 Yrs. 0 Mos. 18 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Real Estate & Loan
(b) General nature of industry, business or establishment in which employed (or employer): Business

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: David Thornton

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Harriet Sharp

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. N. Thornton
(Address) Idaho Falls

15. Filed Oct 21 1921 C. W. Turnbull Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 20 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Injuries from auto accident - Death instant.

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. C. Dennewoody M.D.
10/21 1921 (Address) Ida Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Salt Lake City Ut. | DATE OF BURIAL: 10/24 1921

20. UNDERTAKER: C. C. Dennewoody | ADDRESS: Ida Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35879

Registered No. 111

RECEIVED
NOV 30 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 73

Primary Registration District No. 2107

County of Bonneville

City of Idaho Falls, Ward Hospital St.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Gilbert A Westergard

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Apr (Month) 23 (Day) 1909 (Year)

7. AGE: 12 Yrs. 6 Mos. 1 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iona, Ida.

10. NAME OF FATHER: Peter Westergard

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Sarah Denning

13. BIRTHPLACE OF MOTHER (State or Country): Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) G Westergard

(Address) Iona, Ida

15. Filed Oct 24 1921 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 24 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 15 1921 to Oct 24 1921 that I last saw him alive on Oct 24 1921, and that death occurred on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:

Embolism.

(Duration) ..... Yrs. Instant mos. ..... ds.

Contributory (Secondary) Strangulation of bowel

(Duration) ..... yrs. ..... mos. ..... ds.

Operation Oct 15 1921

(Signed) [illegible] M. D.

10/25/1921 (Address) Idaho Falls, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Iona, Ida — DATE OF BURIAL: 10/26/1921

20. UNDERTAKER: B Edmundsen — ADDRESS: Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35880

Registered No. 110

RECEIVED
NOV 30 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 73

Primary Registration District No. 21V-0

County of Bonneville

City of Ida Falls (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ira Gardner

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH: Sep (Month) 8 (Day) 1880 (Year)

7. AGE: 41 Yrs. 1 Mos. 16 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farming
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Charles Gardner

11. BIRTHPLACE OF FATHER (State or Country): ?

12. MAIDEN NAME OF MOTHER: Susanna Rigby

13. BIRTHPLACE OF MOTHER (State or Country): Ill

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Geo A Gardner
(Address) Idaho T Blackfoot

15. Filed Oct 24 1921 W Freeman Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 24 (Day) 19..... (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 22 1921, to Oct 24 1921, that I last saw him alive on Oct 24 1921 and that death occurred on the date stated above, at 8 A. M.

The CAUSE OF DEATH* was as follows: Acute Perforating Gastric Ulcer (Idiopathic)

..... (Duration) ..... Yrs. ..... mos. 13/4 ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H V P Hatch M. D.

Oct 24 1921 (Address) Idaho Falls, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Blackfoot Ida	10/26 1921
20. UNDERTAKER	**ADDRESS**
C C Dunwoody	Ida Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED NOV 30 19[illegible] BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 9881
Registered No. 109

1. PLACE OF DEATH

County of Bannock Registration District No. 23
Primary Registration District No. 2 1 V 0
City of Ida Falls (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Luetta Butters

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Infant

6. DATE OF BIRTH: Sept (Month) 29 (Day) 1921 (Year)

7. AGE: 0 Yrs. 0 Mos. 31 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Iona, Ida

10. NAME OF FATHER: James J Butters

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Agnes E Jardine

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J J Butters
(Address) Iona, Ida

15. Filed Oct 20 19 21 [signature] Local Registrar
Hollister

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 20 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9-29- 1921, to 10-20- 1921 that I last saw her alive on 10-19- 1921 and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Premature Infant

..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) —
..... (Duration) — Yrs. ..... mos. ..... ds.

(Signed) J C Hollister M. D.
Oct 20 1921 (Address) Idaho Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Trenton, Utah
DATE OF BURIAL: Oct 19 21

20. UNDERTAKER: C C Simmonds
ADDRESS: Ida Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
NOV 30 1921
BUREAU OF VITAL STATISTICS

Registration District No. 73
Primary Registration District No. 2170

File No. 35882
Registered No. 102

1. PLACE OF DEATH

County of Bonneville
City of Idaho Falls (If outside limits, give township) St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Melvin Edward Erickson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH: July (Month) 7 (Day) 1921 (Year)

7. AGE: Yrs. 3 Mos. 10 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New Sweden

10. NAME OF FATHER: Edward Erickson

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Amanda Norby

13. BIRTHPLACE OF MOTHER (State or Country): Minnesota

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Edward Erickson
(Address) Idaho Falls Idaho

15. Filed Oct 20 1921 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 17 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Malnutrition

(Duration) ..... Yrs. 3 mos. 10 ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) P. R. Soderquist M. D.
10/20 1921 (Address) Idaho Falls Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: New Sweden Cem. | DATE OF BURIAL: Oct 19 1921

20. UNDERTAKER: Jeff Hagen | ADDRESS: Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

Dr. Soderquist

FORM V. S. No. 5-25 M. 1-19.

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BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 13
Primary Registration District No. 2140
File No. 35885
Registered No. 107

1. PLACE OF DEATH
County of Bonneville
City of Idaho Falls (No. Yellowstone Hosp. St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Margaret Belle Kimball.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Oct 15 1921 (Month) (Day) (Year)

7. AGE: Yrs. Mos. 2 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Nil
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho Falls

10. NAME OF FATHER: J A Kimball

11. BIRTHPLACE OF FATHER (State or Country): Michigan

12. MAIDEN NAME OF MOTHER: Maud Murray

13. BIRTHPLACE OF MOTHER (State or Country): Michigan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Celey Fennard
(Address) Idaho Falls Ida.

15. Filed Oct 20 1921 Celey Fennard Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct 17 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 14 1921 to Oct 17 1921 that I last saw h... alive on Oct 17 1921 and that death occurred on the date stated above, at ... M.
The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ... Yrs. ... mos. ... ds.
Contributory (Secondary) Lung Edema - Toxemia of pregnancy
(Duration) ... yrs. ... mos. ... ds.

(Signed) Celey Fennard M. D.
Oct 20 1921 (Address) Idaho Falls Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rose Hill Cemetery — DATE OF BURIAL: Oct 18 1921

20. UNDERTAKER: Cliff Hayes — ADDRESS: Idaho Falls

Dr. Fennard.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35884

Registered No. 106

RECEIVED
NOV 30 1921
BUREAU OF VITAL STATISTICS

Registration District No. 13

Primary Registration District No. 2170

1. PLACE OF DEATH

County of Bonneville

City of Idaho Falls (If outside limits of city or village, write Ward, Township, Precinct, or Village, and St.) Water Cor

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Seward Albert Cloward

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Jan (Month) 4 (Day) 1 9 2 (Year)

7. AGE: 1 Yrs. 8 Mos. 4 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Dillon Mont

10. NAME OF FATHER: Orson Cloward

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Nancy McPierce

13. BIRTHPLACE OF MOTHER (State or Country): Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Orson Cloward

(Address) Dillon Mont

15. Filed Oct 20 1921 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 8 (Day) 19 21 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 6 19 21, to Oct 8 19 21, that I last saw h[illegible] alive on Oct 8 19 21, and that death occurred on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:

Toxemia

Neo-Orchitis

(Duration) ..... Yrs. ..... mos. 5 ds.

Contributory (Secondary) Abscess

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. D. Hunkin M. D.

OCT 20 1921

(Address) Idaho Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Iona, Ida. | DATE OF BURIAL: Oct 10 1921

20. UNDERTAKER: Cliff Hayes | ADDRESS: Idaho Falls

Dr. Hunkin

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35885
Registered No. 1 0 1 -

1. PLACE OF DEATH

Registration District No. 7 3
Primary Registration District No. 2 1 2 - 0

County of Bonneville
City of Idaho Falls (No. ..... St.)

RECEIVED
NOV 30 1921
BUREAU OF VITAL STATISTICS

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Frances Fern Brockson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: May (Month) 1 (Day) 1908 (Year)

7. AGE: 14 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: School Girl.
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Nebr.

10. NAME OF FATHER: O H Brockson

11. BIRTHPLACE OF FATHER (State or Country): England.

12. MAIDEN NAME OF MOTHER: Mary E Harper.

13. BIRTHPLACE OF MOTHER (State or Country): Iowa.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs J H Kuttor
(Address) Idaho Falls Ida

15. Filed Oct 20 1921 W Jamison
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 13 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 1 1921 to Sept 13 1921
that I last saw her alive on Sept 13 1921
and that death occurred on the date stated above, at 6 P.M.
The CAUSE OF DEATH* was as follows:

Bright's Disease

..... (Duration) ..... Yrs. 8 mos. ..... ds.
Contributory (Secondary) Anemia
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W H Hamm M. D.
OCT 20 1921 (Address) Idaho Falls Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rose Hill Idaho Falls — DATE OF BURIAL: Sept 15 1921

20. UNDERTAKER: C H Hayes — ADDRESS: Idaho Falls

W. Jamison

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35886
Registered No. 104

RECEIVED
NOV 30 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Bonneville
City of Idaho Falls (If outside city limits, give township) Idaho Falls Hospital (St.)
Registration District No. 73
Primary Registration District No. 214-0
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lee Field

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH: Sept. (Month) 16 (Day) 1[illegible]-6 (Year)

7. AGE: 65 Yrs. 1 Mos. 11 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ?
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Texas.

10. NAME OF FATHER ? Fields

11. BIRTHPLACE OF FATHER (State or Country) Texas

12. MAIDEN NAME OF MOTHER Don't Know ?

13. BIRTHPLACE OF MOTHER (State or Country) " " ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Richard Jones
(Address) Idaho Falls

15. Filed Oct 20 1921 A. Tennant Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH September 27 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1 1921 to Sept 27 1921
that I last saw h[illegible] alive on Sept 27 1921
and that death occurred on the date stated above, at 8:15 P.M.
The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) About Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) H. D. Sunkin M. D.
1921 (Address) Idaho Falls Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Salt Lake Utah	1921

20. UNDERTAKER	ADDRESS
Cliff Hayes	Idaho Falls Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35887
Registered No. 103

RECEIVED
NOV 30 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Bonneville
City of Idaho Falls
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 73
Primary Registration District No. 21V-0
Cassia Ward St.)

2. FULL NAME Wm L. Shuck.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH: Aug 30, 1878
(Month) (Day) (Year)

7. AGE: 43 Yrs. 2 Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kansas

10. NAME OF FATHER: James B. Shuck

11. BIRTHPLACE OF FATHER (State or Country): N. C.

12. MAIDEN NAME OF MOTHER: Julia Schafer.

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Henry Shuck
(Address) Arbon Idaho

15. Filed Oct 20 19 21 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct 10 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 25 1921, to Sept 26 1921, that I last saw h[illegible] alive on Sept 26 1921 and that death occurred on the date stated above, at 39. M.
The CAUSE OF DEATH* was as follows:

Multiple Carcinoma of Buccal mucosa.

(Duration) 1 Yrs. mos. ds.
Contributory (Secondary) Metastatic Carcinoma
(Duration) yrs. 6. mos. ds.

(Signed) [illegible] M. D.
(Address) Idaho Falls
OCT 19 1921

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Lorenzo Ranch	19

20. UNDERTAKER	ADDRESS
Cliff Hayes	Idaho Falls

Dr. Jenkins

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED NOV 30 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. ____

Primary Registration District No. 21 V

File No. 35888

Registered No. ____

1. PLACE OF DEATH

County of Bonneville

City of Idaho Falls (No. ____ St.) (Or) Swan Valley

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Johnnie Calderwood

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH Aug. 16. 1921 (Month) (Day) (Year)

7. AGE 9 Yrs. ____ Mos. ____ ds.

IF LESS than 1 day how many ____ hrs. or ____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: School boy

(b) General nature of industry, business or establishment in which employed (or employer): ____

9. BIRTHPLACE (State or Country) Swan Valley

10. NAME OF FATHER Jas Calderwood

11. BIRTHPLACE OF FATHER (State or Country) Wyoming

12. MAIDEN NAME OF MOTHER Martha Peterson

13. BIRTHPLACE OF MOTHER (State or Country) Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Robt Martin

(Address) Irwin Idaho.

15. Filed Dec 2 19 21 ____ Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug. 16. 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 18 1921 to Aug 18 1921 that I last saw h[illegible] alive on Aug 18 1921 and that death occurred on the date stated above, at ____ M.

The CAUSE OF DEATH* was as follows:

Diphtheria

(Duration) ____ Yrs. ____ mos. 5 ds.

Contributory (Secondary) ____

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) H. D. Thurston M. D.

19 ____ (Address) Idaho Falls Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days

Where was disease contracted if not at place of death? ____

Former or usual residence ____

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Irwin Idaho.	Aug 18 1921

20. UNDERTAKER Jeff Hayes — ADDRESS Idaho Falls

Dr Jenkins

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED NOV 30 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bonneville Registration District No. 73

City of Idaho Falls (No. Ben Hospital St.) Primary Registration District No. 2170

File No. 35889

Registered No. 101

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs. Elizabeth Miller

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Dec (Month) 20 (Day) 1874 (Year)

7. AGE: 46 Yrs. ... Mos. ... ds.

IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: House wife.

(b) General nature of industry, business or establishment in which employed (or employer): ...

9. BIRTHPLACE (State or Country): Penn

10. NAME OF FATHER: Simon Wadsheimer

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Elizabeth Schlomp

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Paul Miller

(Address) Shelly Idaho

15. Filed Oct 20 1921 ... Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 16 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 15 1921 to Sept 16 1921 that I last saw h[er] alive on Sept 16 1921 and that death occurred on the date stated above, at 4:30 P.M.

The CAUSE OF DEATH* was as follows:

Hyperthyroidism

(Duration) ? Yrs. 8 mos. ... ds.

Contributory (Secondary) ...

(Duration) ... yrs. ... mos. ... ds.

(Signed) H P Ray M. D.

Oct 19 21 (Address) Idaho Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death? ...

Former or usual residence ...

19. PLACE OF BURIAL OR REMOVAL: Rose Hill — DATE OF BURIAL: Sept 18 1921

20. UNDERTAKER: Cliff Hayes — ADDRESS: Idaho Falls

Dr. Hatch

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

RECEIVED NOV 8 0 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35890

Registered No. 100

1. PLACE OF DEATH

Registration District No. 73

Primary Registration District No. 2150

County of Bonneville

City of Idaho Falls (If outside limits of city or village, write RURAL.)

(No.) Ora Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Infant Poutrine

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Sept (Month) 6, (Day) 1921 (Year)

7. AGE: ....Yrs....Mos....ds. IF LESS than 1 day how many 10 hrs. or....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: no.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho Falls Idaho

10. NAME OF FATHER: A J Poutrine

11. BIRTHPLACE OF FATHER (State or Country): Mich.

12. MAIDEN NAME OF MOTHER: ? Parr.

13. BIRTHPLACE OF MOTHER (State or Country): ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A J Poutrine Jr.
(Address) Idaho Falls.

15. Filed Oct 20 1921 Guy Truman D. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 6. (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 6 1921, to Sept 6 1921 that I last saw h.... alive on ....19...., and that death occurred on the date stated above, at ....M.

The CAUSE OF DEATH* was as follows: ?

....(Duration) ....Yrs....mos....ds.

Contributory (Secondary)....

....(Duration) ....yrs....mos....ds.

(Signed) Geo Clews M. D.

....19.... (Address) Idaho Falls Ida

*State the Disease Causing Death; or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death....yrs....mos....days. In the State....yrs....mos....days

Where was disease contracted if not at place of death?....

Former or usual residence....

19. PLACE OF BURIAL OR REMOVAL: Rose Hill Cemetery | DATE OF BURIAL: Sept 7 1921

20. UNDERTAKER: Cliff Hague | ADDRESS: Idaho Falls

STAR-YORK CO., PRINTERS & BINDERS, BOISE 51088

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

for Sine

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED NOV 30 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 73

Primary Registration District No. 2110

File No. 35891

Registered No. 99

County of Bannock

City of Ida Dale (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Nora Eliza Burton

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Aug (Month) 9 (Day) 1901 (Year)

7. AGE: 20 Yrs. 1 Mos. 24 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Wm Burton

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Eliza Meeks

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm Burton

(Address) Idaho Falls

15. Filed Oct 13 19 21 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 3 (Day) 19 21 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 18 19 21, to Oct 3 19 21

that I last saw h[illegible] alive on Oct 3 19 21

and that death occurred on the date stated above, at 6:20 P.M.

The CAUSE OF DEATH* was as follows: Exophthalmic goitre

..... (Duration) 1 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H B Spencer M. D.

10/6 1921 (Address) Ida Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Idaho Falls	10/6 1921
20. UNDERTAKER	ADDRESS
C E Dunwoody	Ida Falls

Spencer

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35892
Registered No. 98

RECEIVED
NOV 30 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Bonneville Registration District No. 73
City of Ida Falls Primary Registration District No. 21 V-2
No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Francis Marion Janes
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Infant

6. DATE OF BIRTH: Nov (Month) 24 (Day) 1920 (Year)

7. AGE: 0 Yrs. 8 Mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Colo.

10. NAME OF FATHER: J. Janes

11. BIRTHPLACE OF FATHER (State or Country): Mo.

12. MAIDEN NAME OF MOTHER: Marion Beagley

13. BIRTHPLACE OF MOTHER (State or Country): Mass

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. Janes
(Address) Robert Ida

15. Filed Oct 11 1921 C. C. Kinnaird Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 9 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 9 1921, to Aug 9 1921, that I last saw h.r alive on Aug 9 1921, and that death occurred on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

Intussusception

(Duration) ..... Yrs. ..... mos. 4 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. E. Clive M. D.
8/10 1921 (Address) Ida Falls, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Ida Falls — DATE OF BURIAL: 8/10 1921

20. UNDERTAKER: E. E. Dunwoody — ADDRESS: Ida Falls

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

Dr Clive

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED NOV 8 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 73

Primary Registration District No. 214-0

File No. 35893

County of Bannock

City of Ida Falls (If outside limits, give township) St.)

Registered No. 97

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Bertha Ofret

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Aug 29 1890 (Month) (Day) (Year)

7. AGE: 31 Yrs. 1 Mos. 3 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Jno. A. Bates

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Lucina Keller

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A Ofret

(Address) Duncan Ida

15. Filed Oct 11 1921 C Kennaud Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct 7 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 30 1921, to Oct. 7 1921, that I last saw her alive on Oct. 2 1921, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Post-Operative Pulmonia

(Duration) ..... Yrs. ..... mos. 12 days.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Harry L. Wilson M. D.

10/6 1921 (Address) Ida Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Milo, Ida — DATE OF BURIAL: 10/6 1921

20. UNDERTAKER: E E Dunwoody — ADDRESS: Ida Falls

H Wilson

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35894

Registered No. 96

1. PLACE OF DEATH

County of Bannock

City of Pocatello (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
NOV 30 1921
BUREAU OF VITAL STATISTICS

Registration District No. 73

Primary Registration District No. 2170

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Stephen M. Yeamans

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: July (Month) 7 (Day) 1882 (Year)

7. AGE: 38 Yrs. 3 Mos. 9 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Employee Printing Office

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Mo

10. NAME OF FATHER: Stephen M Yeamans

11. BIRTHPLACE OF FATHER (State or Country): Ky

12. MAIDEN NAME OF MOTHER: Alice Brotherton

13. BIRTHPLACE OF MOTHER (State or Country): Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) M B Yeamans

(Address) Ida Falls

15. Filed Oct 13 1921 C Kinnaird Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 11 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....

that I last saw h..... alive on ..... 19.....

and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Gun shot wound
Self inflicted

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C E Dunwoody Coroner

10/17/21 (Address) Ida Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Idaho Falls — DATE OF BURIAL: 10/13 1921

20. UNDERTAKER: C E Dunwoody — ADDRESS: Ida Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35895

Registered No. 116

1. PLACE OF DEATH

County of Bonneville

City of Idaho Falls

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 73

Primary Registration District No. 2150

(No. ..... St.)

2. FULL NAME Stephen A Browning

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Dec 28 1858 (Month) (Day) (Year)

7. AGE: 64 Yrs. 10 Mos. 28 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Merchant

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ogden, Ut

10. NAME OF FATHER: David E Browning

11. BIRTHPLACE OF FATHER (State or Country): Tenn

12. MAIDEN NAME OF MOTHER: Cherilla Abbott

13. BIRTHPLACE OF MOTHER (State or Country): N.Y.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs S A Browning

(Address) Ida Falls

15. Filed Nov 29 1921 W Truman Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov 26 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....

that I last saw h..... alive on ..... 19.....

and that death occurred on the date stated above, at 9.30 P M.

The CAUSE OF DEATH* was as follows:

Gun shot wound — murdered

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C E Dennewoody Coroner M.D.

11/28/1921 (Address) Ida Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence Ohio

19. PLACE OF BURIAL OR REMOVAL: Ogden, Ut

DATE OF ~~BURIAL~~: 11-29 1921

20. UNDERTAKER: C E Dennewoody

ADDRESS: Ida Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 21 V-6
File No. 35896
Registered No. 11 V-

1. PLACE OF DEATH
County of Bannock
City of Ida Falls
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Rawberry
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: June 22 1848 (Month) (Day) (Year)

7. AGE: 73 Yrs. 4 Mos. 27 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Jno Rawberry

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: ?

13. BIRTHPLACE OF MOTHER (State or Country): ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. E. Ekman
(Address) Dawson Ida.

15. Filed Nov 22 1921 Wm Timmons Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov 19 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 1 1920 to Nov. 20, 1921 that I last saw h.... alive on Nov. 19, 1921 and that death occurred on the date stated above, at 12 M.
The CAUSE OF DEATH* was as follows:
Lobar Pneumonia
36 hours.
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) —
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) John O. Mellar M. D.
11/22 1921 (Address) Ida Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence Ship

19. PLACE OF BURIAL OR REMOVAL: Rooelen, Ut
DATE OF BURIAL: 11/22 1921

20. UNDERTAKER: E. E. Linwoodey
ADDRESS: Ida Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 2150
File No. 35897
Registered No. 114

1. PLACE OF DEATH
County of Bonneville
City of Idaho Falls
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Keith Braxton Barnett
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Infant

6. DATE OF BIRTH: June (Month) 7 (Day) 1920 (Year)

7. AGE: 1 Yrs. 4 Mos. 22 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Firth. Ida

10. NAME OF FATHER: M.E. Barnett

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Gladys Spencer

13. BIRTHPLACE OF MOTHER (State or Country): Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) M.E. Barnett
(Address) Firth

15. Filed Nov 12 1921 — Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 29 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 27 1921, to Oct 29 1921, that I last saw h.im alive on Oct 29 1921, and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Empyema
(Duration) ..... Yrs. 6 mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
11/1 1921 (Signed) [illegible] M. D.
(Address) Idaho Falls Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Firth, Ida — DATE OF BURIAL: 10-31 1921

20. UNDERTAKER: C.C. Dunwoody — ADDRESS: Ida Falls

Dr Cline.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 2110
File No. 35898
Registered No. 113

1. PLACE OF DEATH
County of Bannock
City of Ida Falls
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Grant Wright

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: May (Month) 16 (Day) 1903 (Year)

7. AGE: 17 Yrs. 5 Mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: J S Wright

11. BIRTHPLACE OF FATHER (State or Country): Ida

12. MAIDEN NAME OF MOTHER: Amanda Monson

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J S Wright
(Address) Ida Falls, Ida

15. Filed 11/10 1921
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 7 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 31 1921, to Nov 7 1921, that I last saw him alive on Nov 7 1921 and that death occurred on the date stated above, at 1:30 P.M.

The CAUSE OF DEATH* was as follows:

Following operation for tumor of brain

(Duration) ..... Yrs. ..... mos. 1 ds.

Contributory (Secondary) Tumor brain

(Duration) ..... yrs. 8 mos. ..... ds.

(Signed) W P Hutch M. D.

Nov 9 1921 (Address) Idaho Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence: Ship.

19. PLACE OF BURIAL OR REMOVAL: Blackfoot Ida
DATE OF BURIAL: 11/9 1921

20. UNDERTAKER: E C Isenwood
ADDRESS: Ida Falls

FORM V. S. No. 5-25 M. 1-19.

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NOV 30 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35899.
Registered No.

1. PLACE OF DEATH

Registration District No. 79.
County of Boundary
Registration District No. 2156.
City of Bonners Ferry
(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ella M. Fozier

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F	W	Married

6. DATE OF BIRTH
Aug. (Month) 14 (Day) 1862 (Year)

7. AGE
59 Yrs. 1 Mos. 21 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Wisconsin

10. NAME OF FATHER Morris Mantor

11. BIRTHPLACE OF FATHER (State or Country) Penn.

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country) Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. M. Fozier
(Address) Bonners Ferry Ida

15.
Filed Oct. 6th. 1921
E E Fry
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Oct. (Month) 5 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 3rd. 1921, to Oct. 5th. 1921, that I last saw her alive on Oct. 5th. 1921, and that death occurred on the date stated above, at 11 P. M.
The CAUSE OF DEATH* was as follows:

Cerebral - Hemmorhage -

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E E Fry M. D.
Oct. 6 1921 (Address) Bonners Ferry, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Bonners Ferry Ida	10/7 1921
20. UNDERTAKER O Stookey	ADDRESS Bonners Ferry

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED NOV 30 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35900

Registered No.

1. PLACE OF DEATH

Registration District No. 79

Primary Registration District No. 2156

County of Boundary

City of Bonners Ferry (If outside limits, give township.) St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Marie Francis Muhlfeld

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: June (Month) 2 (Day) 1897 (Year)

7. AGE: 24 Yrs. 4 Mos. 11 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Bookkeeper

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: John

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Anna Braun

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Muhlfeld

(Address) Bonners Ferry Ida

15. Filed Oct 14th 1921

E E Fry
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 13 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 1st 1921, to Oct. 13 - 1921, that I last saw h[illegible] alive on Oct. 13 - 1921, and that death occurred on the date stated above, at 1.40 A.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 1 Yrs. 3 mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) E E Fry M. D.

10/14 1921. (Address) Bonners Ferry, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Bonners Ferry Ida — DATE OF BURIAL: Oct 15 1921

20. UNDERTAKER: [illegible] Stookey — ADDRESS: Bonners Ferry Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED NOV 30 1931 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 19
Primary Registration District No. 3956.
File No. 35901
Registered No.

1. PLACE OF DEATH

County of Boundary
City of Bonners Ferry (If outside limits of city or village, give township.)
St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ethel Irene Davis.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH: Aug. (Month) 14 (Day) 1910 (Year)

7. AGE: 11 Yrs. 2 Mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Scholar
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Bonners Ferry Ida.

10. NAME OF FATHER: Frank A. Davis

11. BIRTHPLACE OF FATHER (State or Country): Ill.

12. MAIDEN NAME OF MOTHER: Elizabeth Mc Tinstone

13. BIRTHPLACE OF MOTHER (State or Country): Portland Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant)
(Address) Frank A. Davis

15. Filed Oct. 17 th. 1931
E E Frey
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. (Month) 16th (Day) 1931 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 15th 1931, to Oct. 16th 1931, that I last saw h.. alive on Oct. 16th 1931, and that death occurred on the date stated above, at 1 P. M.

The CAUSE OF DEATH* was as follows:

Cerebro Spinal Meningitis
(Epidemic type)
(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. 3 ds.

(Signed) E E Frey M. D.
10/17 1931 (Address) Bonners Ferry, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Bonners Ferry Ida. DATE OF BURIAL: Oct. 18 1931

20. UNDERTAKER: O K Harvey ADDRESS: Bonners Ferry

BYRNS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERT[illegible] DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35902

Registered No.

1. PLACE OF DEATH

Registration District No. 79

Primary Registration District No. 2156

County of Boundary

City of Bonners Ferry (No. St.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
NOV 30 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME Joseph King.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH: Unknown (Month) (Day) 1 (Year)

7. AGE: about 60 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Carpenter
(b) General nature of industry, business or establishment in which employed (or employer): Mine

9. BIRTHPLACE (State or Country): Unknown

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Geo Fountain
(Address) Bonners Ferry Ida.

15. Filed Oct. 11th 1921 E E Lamb Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 26 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from [illegible] 19[illegible], to [illegible] 19[illegible], that I last saw h[illegible] alive on [illegible] 19[illegible], and that death occurred on the date stated above, at [illegible] M.

The CAUSE OF DEATH* was as follows:

Heart failure

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) E. E. Lamb M. D.

10/26/1921 (Address) Bonners Ferry, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Seattle Wash — DATE OF BURIAL: 10/28 1921

20. UNDERTAKER: R. Stookey — ADDRESS: Bonners Ferry Ida

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED NOV 30 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35903

1. PLACE OF DEATH
County of Boundary Registration District No. 79
Primary Registration District No. 215-6
City of Bonners Ferry (If outside limits, give township.) St.)
Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ruth Mary Lewis

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Aug (Month) 27 (Day) 1914 (Year)

7. AGE: 7 Yrs. 2 Mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Scholar
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mont

10. NAME OF FATHER: Alfred S. Lewis

11. BIRTHPLACE OF FATHER (State or Country): Wisc.

12. MAIDEN NAME OF MOTHER: June A. Niles

13. BIRTHPLACE OF MOTHER (State or Country): Wisc

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A. S. Lewis
(Address) Bonners Ferry Ida

15. Filed Oct. 30 - 1921
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 29 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 28 1921, to Oct. 29 1921, that I last saw h[illegible] alive on Oct 29 1921, and that death occurred on the date stated above, at 4P M.
The CAUSE OF DEATH* was as follows:
Poliomyelitis
(Duration) ..... Yrs. ..... mos. 2 ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Ryle Bonnell M. D.
10/29 1921 (Address) Bonners Ferry Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Bonners Ferry Ida
DATE OF BURIAL: 10/30 1921

20. UNDERTAKER: [illegible] Hookey
ADDRESS:

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

BYRNS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35904
Registered No.

1. PLACE OF DEATH

County of Boundary
Registration District No. 79
Primary Registration District No. 315-6

City of Bonners Ferry (St.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED NOV 30 1921 BUREAU OF VITAL STATISTICS

2. FULL NAME John Bernard Meyers

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1 (Year)

7. AGE: about 55 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Engineer (Steam)
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Wisc.

10. NAME OF FATHER: Bernard Meyer

11. BIRTHPLACE OF FATHER (State or Country): Switzerland

12. MAIDEN NAME OF MOTHER: Maggie Sund

13. BIRTHPLACE OF MOTHER (State or Country): Switzerland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Gus Meyers
(Address) Revillo S. D.

15. Filed Oct. 31 – 1921 ..... Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 30 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 11th 1921, to Oct. 30th 1921, that I last saw h[im] alive on Oct. 24th 1921, and that death occurred on the date stated above, at 7.30 A. M.
The CAUSE OF DEATH* was as follows:

Traumatic myelitis
(accidental)

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E E Fry M. D.

19..... (Address) Bonners Ferry, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Bonners Ferry Ida — DATE OF BURIAL: 11/1 1921

20. UNDERTAKER: O B Sookey — ADDRESS: Bonners Ferry Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

Transportation of Corpse

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35905
Registered No.

1. PLACE OF DEATH
County of Boundary
City of Bonners Ferry
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 79
Primary Registration District No. 218-6

2. FULL NAME Henry Bethune

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Unknown (Write the word.)

6. DATE OF BIRTH: Unknown (Month) (Day) 1 (Year)

7. AGE: Unknown Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Fire Warden
(b) General nature of industry, business or establishment in which employed (or employer): U. S. Govt.

9. BIRTHPLACE (State or Country): Unknown

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant)
(Address)

15. Filed Nov. 8th 1921 — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 4 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 19..., to 19...,
that I last saw h... alive on 19...,
and that death occurred on the date stated above, at ...M.
The CAUSE OF DEATH* was as follows:
Crushed by tree
accidental

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary)
(Duration) ... yrs. ... mos. ... ds.

(Signed) E E Saunders M.D.
Coroner
11/4 1921 (Address) Bonners Ferry Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Forest Cemetery	11/10 1921

20. UNDERTAKER	ADDRESS
R. B. Mooney	Coeur d'Alene

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

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BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 79
Primary Registration District No. 516
File No. 35906
Registered No.

1. PLACE OF DEATH

County of Boundary

City of Bonners Ferry (Name) (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mildred Lenus Hamilton

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F	W	Married

6. DATE OF BIRTH

(Month) (Day) 1 (Year)

7. AGE Adult

42 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Wisc

10. NAME OF FATHER John Handley

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER Peacock

13. BIRTHPLACE OF MOTHER (State or Country) Wisc

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) S.R. Hamilton

(Address) Bonners Ferry Ida

15.

Filed Nov. 8 th. 1921 E E Fry Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

11 (Month) 6 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 4th 1921, to Nov. 6th 1921, that I last saw h[illegible] alive on Nov. 6th 1921, and that death occurred on the date stated above, at 7 A. M.

The CAUSE OF DEATH* was as follows:

Septicaemia

(Duration) Yrs. mos. 3 ds.

Contributory (Secondary) Uterine polypus

(Duration) yrs. mos. ds.

(Signed) E E Fry M. D.

11/8/1921 (Address) Bonners Ferry, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Bonners Ferry	11/9 1921
20. UNDERTAKER C R Tookey	ADDRESS Bonners Ferry

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

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FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35907
Registered No.

1. PLACE OF DEATH
County of Boundary
City of Bonners Ferry
If death occurs away from usual residence, give facts called for under special information.

RECEIVED
Registration District No. 79
Primary Registration District No. 315-6
(No. ..... St.)

2. FULL NAME Alice Hamren

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F	W	Single

6. DATE OF BIRTH: Sept (Month) 1 (Day) 1906 (Year)

7. AGE: 15 Yrs. 2 Mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Scholar
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: J F Hamren

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Huldah Edwards

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. F. Hamren
(Address)

15. Filed Nov. 9th 1921 — E E Fry, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 9 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 6th 1921, to Nov. 9th 1921, that I last saw h-r alive on Nov. 9th 1921, and that death occurred on the date stated above, at 11 A.M.
The CAUSE OF DEATH* was as follows:
Septicaemia.

(Duration) ..... Yrs. ..... mos. 6 ds.
Contributory (Secondary): Wound of face.
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E E Fry M. D.
11/9 1921 (Address) Bonners Ferry, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Bonners Ferry Ida	11/11th 1921
20. UNDERTAKER	ADDRESS
C Mahoney	Bonners Ferry

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 79
Primary Registration District No. 215-6
File No. 35908
Registered No.

1. PLACE OF DEATH
County of Boundary
City of Bonners Ferry
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Helen Ingrid Peterson
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F	W	Infant

6. DATE OF BIRTH: May (Month) 6 (Day) 1920 (Year)

7. AGE: 1 Yrs. 6 Mos. 14 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Sam Peterson

11. BIRTHPLACE OF FATHER (State or Country) Norway

12. MAIDEN NAME OF MOTHER Hanna Hanson

13. BIRTHPLACE OF MOTHER (State or Country) Wisc

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Sam Peterson
(Address) Bonners Ferry Ida

15. Filed Nov. 21 st. 1921 E E Troy Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 20 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 19th 1921, to Nov. 20th 1921, that I last saw h[illegible] alive on Nov. 20th 1921, and that death occurred on the date stated above, at 2 00 P.M.
The CAUSE OF DEATH* was as follows:

Broncho - Pneumonia

(Duration) Yrs. mos. 2 ds.
Contributory (Secondary) Influenza
(Duration) yrs. mos. 4 ds.

(Signed) E E Troy M. D.
11/21 1921 (Address) Bonners Ferry, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Bonners Ferry Ida — DATE OF BURIAL: 11/22 1921

20. UNDERTAKER: C R Stookey — ADDRESS: Bonners Ferry

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

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Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 79

Primary Registration District No. 215-6

File No. 35909

County of Boundary

City of Bonners Ferry (No. ....., ... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Edmer Milan Miller

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	

6. DATE OF BIRTH: June (Month) 17 (Day) 1918 (Year)

7. AGE: 3 yrs. 4 mos. 20 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Bonners Ferry Idaho

10. NAME OF FATHER Steve T. Miller

11. BIRTHPLACE OF FATHER (State or Country) Austria

12. MAIDEN NAME OF MOTHER Bertha Jaup

13. BIRTHPLACE OF MOTHER (State or Country) Bonners Ferry Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Henry Jaup
(Address) Bonners Ferry Ida

15. Filed Nov. 21st. 1931 E E Fry Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Nov. (Month) 20th. (Day) 1931 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 14th 1931, to Nov. 20th 1931, that I last saw h[illegible] alive on Nov. 20th. 1931, and that death occurred on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:

Broncho - Pneumonia -

(Duration) ..... yrs. ..... mos. 3 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E E Fry M. D.

11/21 1931 (Address) Bonners Ferry, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Bonners Ferry Ida | DATE OF BURIAL: 11/23 1931

20. UNDERTAKER: O P Stookey | ADDRESS: Bonners Ferry

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

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FORM V. S. No. 5-25 M. 1-19.

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BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35910
Registered No.

1. PLACE OF DEATH
Registration District No.
County of Butte
Primary Registration District No. 59
City of Arco (No. St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sara Elizabeth Black

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6. DATE OF BIRTH: Oct (Month) 16 (Day) 1921 (Year)

7. AGE: ..... Yrs. ..... Mos. 7 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Carley Pratt Black

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Mary Dean

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C P Black
(Address) Arco

15.
Filed ..... 19 .....
F. M Cannon
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 16 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 10-9- 1921, to 10-16- 1921
that I last saw her alive on 10-16- 1921
and that death occurred on the date stated above, at 1 P M.
The CAUSE OF DEATH* was as follows:
Congenital Pyloric Stenosis
(Duration) ..... Yrs. ..... mos. 7 ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) F M Cannon M. D.
10/16 1921 (Address) Arco, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Arco Ida
DATE OF BURIAL: 10/2 1921

20. UNDERTAKER
ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

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FORM V. S. No. 5-25 M. 1-19.

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NOV 30 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35911
Registered No.

1. PLACE OF DEATH
Registration District No.
County of Butte
Primary Registration District No.
City of Moore (Ward) (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Omer Waddoups

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: May (Month) 31 (Day) 1896 (Year)

7. AGE: 25 Yrs. 4 Mos. 16 ds.
IF LESS than 1 day how many..... hrs. or.....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Thomas Widdoups

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Mary Call

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Clara Waddoups
(Address) Moore, Idaho

15. Filed 10/8/1921 J. M. Cannon Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. (Month) 17 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....19...., to ....19....
that I last saw h..... alive on ....19....,
and that death occurred on the date stated above, at ....M.
The CAUSE OF DEATH* was as follows: Gunshot wound caused by accidental discharge of rifle
(Duration) ....Yrs....mos....ds.
Contributory (Secondary)
(Duration) ....yrs....mos....ds.
(Signed) F. M. Cannon M. D.
10/8 1921 (Address) Arco Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Woods Cross, Utah — DATE OF BURIAL: 10/10 1921

20. UNDERTAKER — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

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NOV 30 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Butte Registration District No.
City of (No. , St.) Primary Registration District No.

File No. 35912
Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Marion Lambert Quist

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
M	W	Single

6. DATE OF BIRTH Sept. 24 1921
(Month) (Day) (Year)

7. AGE Yrs. Mos. 22 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Ida

10. NAME OF FATHER Aaron Quist

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Josephine Brown

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant)
(Address)

15. Filed 10/16 1921
Local Registrar J. M. Cannon

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. 16 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 10-16 1921 to 10-16 1921
that I last saw he alive on 10-16 1921
and that death occurred on the date stated above, at M.
The CAUSE OF DEATH* was as follows:

Duantion

(Duration) Yrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) J. M. Cannon M. D.
19 (Address) Arco Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Arco	10-18 1921
20. UNDERTAKER	ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
DEC 14 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 58th
Primary Registration District No. 2138
File No. 35913
Registered No.

1. PLACE OF DEATH
County of Custer
City of Conrad. (No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James P. Ruby
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widower.

6. DATE OF BIRTH: March (Month) 8th (Day) 1831. (Year)

7. AGE: 90 Yrs. 8 Mos. 19 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio.

10. NAME OF FATHER: — — —

11. BIRTHPLACE OF FATHER (State or Country): U. S.

12. MAIDEN NAME OF MOTHER: — — —

13. BIRTHPLACE OF MOTHER (State or Country): U. S.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Frank R Ruby
(Address) Conrad Idaho

15. Filed Nov. 28th 1921 — L Wilencheck, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 29th (Day) 1921. (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 25th 1921, to Nov 25th 1921, that I last saw him alive on Nov 25th 1921, and that death occurred on the date stated above, at 8:00 P.M.
The CAUSE OF DEATH* was as follows:

Chronic Bronchitis

(Duration) 30 Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) L Wilencheck M. D.
Nov 28th 1921 (Address) Fairfield, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Hill City, Idaho. — DATE OF BURIAL ..... 19.....
20. UNDERTAKER — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35914
Registered No.

RECEIVED
DEC 10 1921
BUREAU OF VITAL STATISTICS

Registration District No. 7
Primary Registration District No. 106

1. PLACE OF DEATH
County of Canyon
City of Nampa (Ward, Hospital, Nampa, St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Carl M. Brunsell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Sept 5th 1863 (Month) (Day) (Year)

7. AGE: 58 Yrs. 2 Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Postmaster
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER: Anders Brunsell

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Maria

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A Froman
(Address) Murphy Ida

15. Filed Dec. 10 1921 Pearle Dodds Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec 5 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1 1921 to Dec 4 1921 that I last saw h alive on Dec 5 1921 and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:
Chronic Nephritis
+ prostatitis.
(Duration) Yrs. 3 mos. ds.
Contributory (Secondary) Acute Anuria
(Duration) yrs. mos. 1 ds.

(Signed) J O A Kellogg M. D.
Dec 6 1921 (Address) Nampa Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Murphy Ida — DATE OF BURIAL: 12/6 1921

20. UNDERTAKER: Fred K Robinson — ADDRESS: Nampa Ida

J. Kellogg

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35915
Registered No.

RECEIVED
DEC 10 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Canyon Registration District No. 7
Primary Registration District No. 1506
City of Nampa (or Village or Township) St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jack Gibson
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.):

6. DATE OF BIRTH: Oct (Month) 19 (Day) 1913 (Year)

7. AGE: 8 Yrs. — Mos. 15 ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Jr School
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: C. A. Gibson

11. BIRTHPLACE OF FATHER (State or Country): Texas

12. MAIDEN NAME OF MOTHER: Ella Isteworth

13. BIRTHPLACE OF MOTHER (State or Country): Ark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. A. Gibson
(Address) Nampa R. F. D.

15. Filed Dec 12 1921 Pearle Drake
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 4 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 28 1921, to Dec 4 1921, that I last saw h... alive on Nov 30 1921, and that death occurred on the date stated above, at 8 A M.
The CAUSE OF DEATH* was as follows: Diabetes Mellitus
(Duration) ... Yrs. ? mos. ... ds.
Contributory (Secondary)
(Duration) ... yrs. ... mos. ... ds.
(Signed) Geo. R. Proctor M. D.
Dec 8, 1921. (Address) Nampa Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: K. L. Nampa Ida | DATE OF BURIAL: 12-6 1921

20. UNDERTAKER: Fred K Robinson | ADDRESS: Nampa Ida

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

RECEIVED
DEC 10 1921
BUREAU OF VITAL STATISTICS

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 1082
File No. 35916
Registered No.

1. PLACE OF DEATH

County of Canyon
City of Nampa (No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Doris A Huntley

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): S

6. DATE OF BIRTH: Feb (Month) 9 (Day) 1921 (Year)

7. AGE: Yrs. 9 Mos. 19 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: 1
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Edmond A. Huntley

11. BIRTHPLACE OF FATHER (State or Country): Kansas

12. MAIDEN NAME OF MOTHER: Flossie Wolf

13. BIRTHPLACE OF MOTHER (State or Country): Nebr

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Edmond A Huntley.
(Address) Nampa Idaho

15.
Filed Dec 16 1921 Pearle Proctor
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 25 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 27 1921, to Nov 25 1921, that I last saw h.e.r. alive on Nov 25 1921, and that death occurred on the date stated above, at 10 A. M.

The CAUSE OF DEATH* was as follows:
Broncho Pneumonia

Do not know (Duration) Yrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) J. H. Murray M. D.
12/1/1921 (Address) Nampa Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Nampa Idaho	12-1 1921
20. UNDERTAKER	**ADDRESS**
F. K. Robinson	Nampa

Proctor

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED DEC 10 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35917

1. PLACE OF DEATH
Registration District No. 7
County of Canyon
Primary Registration District No. 1006
City of Nampa (No. ....., St.)
Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Infant Parsons

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.):

6. DATE OF BIRTH: Nov (Month) 12 (Day) 1921 (Year)

7. AGE: ....Yrs. Mos. 2 ds. IF LESS than 1 day how many ....hrs. or ....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Wm. D. Parsons

11. BIRTHPLACE OF FATHER (State or Country): Ill.

12. MAIDEN NAME OF MOTHER: Jennie M. Jack

13. BIRTHPLACE OF MOTHER (State or Country): Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wm. D. Parsons
(Address) Nampa

15. Filed Dec. 10 1921 Pearle Dodds Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) - 14 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov - 12 - 1921, to Nov - 14th 1921 that I last saw h.... alive on ....19.... and that death occurred on the date stated above, at 7 A. M.

The CAUSE OF DEATH* was as follows:
Mitral Insufficiency
(Duration) ....Yrs. ....mos. ....ds.
Contributory (Secondary)
(Duration) ....yrs. ....mos. ....ds.

(Signed) Thos. E. Mangum M. D.
Dec 30
Nov 1921 (Address) Nampa Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs. ....mos. ....days. In the State ....yrs. ....mos. ....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Kohlenmann — DATE OF BURIAL: 11/15 1921

20. UNDERTAKER: F K Kohlenmann — ADDRESS: Nampa Ida

Mangum

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35918

Registered No.

RECEIVED
DEC 10 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Canyon Registration District No. 7

Primary Registration District No. 1006

City of Nampa (Or Village) (If outside city limits, give township.) Gaitland Hotel 1st St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sulovan Jordon Jr.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH: Sept (Month) 30 (Day) 1920 (Year)

7. AGE: Yrs. 13 Mos. 13 ds.

IF LESS than 1 day how many..... hrs. or.....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work /

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Sulovan Jordon

11. BIRTHPLACE OF FATHER (State or Country) Ino

12. MAIDEN NAME OF MOTHER Flora Russell

13. BIRTHPLACE OF MOTHER (State or Country) Ky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Sulovan Jordon Sr

(Address) Nampa Ida

15.

Filed Nov 17 1921 Pearle Dodds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 13 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 9th 1921, to Nov 13th 1921, that I last saw him alive on Nov 13th 1921, and that death occurred on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:

Acute Gastro-Enteritis

(Duration) ..... Yrs..... mos. 12 ds.

Contributory (Secondary)

(Duration) ..... yrs..... mos..... ds.

(Signed) Leo W. Chilton M. D.

11/14 1921 (Address) Nampa, Idaho,

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Caldwell Ida — DATE OF BURIAL .....19.....

20. UNDERTAKER: Fred H. Robinson — ADDRESS: Nampa Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

Chilton

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35919
Registered No.

RECEIVED DEC 10 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Canyon Registration District No. 7
Primary Registration District No. 1006
City of Nampa (If outside limits of city or village, write RURAL.) St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Marvin H Stone

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH
(Month) (Day) 1 (Year)

7. AGE: 57 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Millwright
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Y Dok

10. NAME OF FATHER: James E. Stone

11. BIRTHPLACE OF FATHER (State or Country): Canada

12. MAIDEN NAME OF MOTHER: unknown

13. BIRTHPLACE OF MOTHER (State or Country): unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) O E Stone
(Address) McCall Ida

15.
Filed Nov 26 1921 Chas Smith
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. (Month) – 19/20 (Day) – 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 18 1921, to Oct 19 1921, that I last saw him alive on Oct 18 1921, and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:
Mitral Insufficiency.

(Duration) Yrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) Thos F. Mangum M. D.
Oct 20 1921 (Address) Nampa Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Nampa Idaho — DATE OF BURIAL: 10/22/1921

20. UNDERTAKER: Fred L Robinson — ADDRESS: Nampa Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED DEC 10 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35921
Registered No.

1. PLACE OF DEATH
County of Canyon
City of Nampa
(No. 14 Thaw 2nd St N St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 7
Primary Registration District No. 1806

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Frederick L. Bader

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Feb (Month) 11 (Day) 1880 (Year)

7. AGE: 41 Yrs. 8 Mos. — ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Cement Contractor
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Nevada

10. NAME OF FATHER: W. F. Bader

11. BIRTHPLACE OF FATHER (State or Country): N Y

12. MAIDEN NAME OF MOTHER: Martha Radford

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs F L Bader
(Address) Nampa Ida

15. Filed Dec 10 1921 Pearl Wright Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 10 (Month) 8 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 10-5 1921, to 10-8 1921 that I last saw h~~im~~ alive on 10-8 1921 and that death occurred on the date stated above, at about 3 ~~P~~ A.M.

The CAUSE OF DEATH* was as follows:
Acute indigestion

(Duration) ... Yrs. ... mos. 4 ds.

Contributory (Secondary)
(Duration) ... yrs. ... mos. ... ds.

(Signed) H. C. Robinson M. D.
12-10 1921 (Address) Nampa Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rockerlawn — DATE OF BURIAL: 10-13 1921

20. UNDERTAKER: Frank Robinson — ADDRESS: Nampa Ida

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
DEC 10 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Canyon — Registration District No. 7

City of Melba — Subdivision Registration District No. 2 1st — File No. 35922

(No. ..... St.) — Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Thomas Tomlinson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Male	White	married (Write the word.)

6. DATE OF BIRTH: October (Month) 5 (Day) 1855 (Year)

7. AGE: 66 Yrs. 2 Mos. 3 ds. — IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer.
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Elkhart Co., Indiana

10. NAME OF FATHER: A. Tomlinson

11. BIRTHPLACE OF FATHER (State or Country): Indiana

12. MAIDEN NAME OF MOTHER: L

13. BIRTHPLACE OF MOTHER (State or Country): L

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Izora Stafford
(Address) .....

15. Filed Dec. 10 1921 — Pearl Smith, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. (Month) 8 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from October 16 1921, to Dec. 8 1921, that I last saw him alive on Dec. 4 1921, and that death occurred on the date stated above, at 4:15 A.M.

The CAUSE OF DEATH* was as follows:

Pyelitis, Carcinoma of rectum, Cardiac decompensation.

(Duration) — Yrs. 3 mos. — ds.

Contributory (Secondary) Arterio sclerosis, nephritis (Duration) 4 yrs. — mos. — ds.

(Signed) Samuel A Swayne M. D.

Dec 8 1921 (Address) Melba, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Kahlotus Cem	12-9 1921

20. UNDERTAKER	ADDRESS
Fred K Robinson	Nampa Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35923
Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

RECEIVED
DEC 10 1921
BUREAU OF VITAL STATISTICS

Registration District No. 7
Primary Registration District No. 2006

1. PLACE OF DEATH.
County of Canyon
City of Nampa (or Town) (If outside limits, write Sanitarium, Asylum, Prison, Camp, etc.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Thomas Jefferson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Unknown

6. DATE OF BIRTH. Unknown (Month) ..... 1 (Day) ..... (Year)

7. AGE: Unknown Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Unknown

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) D. O. Poynter
(Address) Nampa Idaho

15. Filed Dec 10 1921 Pearl Davis Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 29 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mch 20 1920, to Nov 29 1921, that I last saw h[illegible] alive on Nov 29 1921, and that death occured on the date stated above, at 7.30 A.M.

The CAUSE OF DEATH* was as follows:
Carcinoma of the Liver

(Duration) Unknown Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) D. O. Poynter M. D.
19..... (Address) Nampa Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 1 yrs. 8 mos. 9 days. In the State Unknown yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? Unknown
Former or usual residence Came to this country from Europe

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Nampa Idaho	11/30 1921
20. UNDERTAKER	ADDRESS
Fred E Robinson	Nampa Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35924

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

RECEIVED DEC 10 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH.

Registration District No. 7

Primary Registration District No. 2006

County of Canyon

City of Nampa (or Town) ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Irene Frantz

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Nov (Month) 15 (Day) 1912 (Year)

7. AGE: 9 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Oregon

10. NAME OF FATHER: —

11. BIRTHPLACE OF FATHER (State or Country): Pueblo Col

12. MAIDEN NAME OF MOTHER: Rose J Rowson

13. BIRTHPLACE OF MOTHER (State or Country): Elgin Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) O'Connor Boyne

(Address) Nampa Idaho

15.

Filed DEC. 10 1921 Pearle Stocker Local Registrar

SYMS - YORK CO., PTRS. & STRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 21 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 29 1921, to Nov 21 1921, that I last saw her alive on Nov 21 1921, and that death occured on the date stated above, at 7:30 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

.....(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Hydro Cephalus

(Duration 2 mos. 1 yrs. ..... mos. ..... ds.

(Signed) O'Connor Boyne M. D.

11/22 1921 (Address) Nampa Idaho

State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. 3 mos. 23 days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? Mt Anthony Idaho

Former or usual residence Mt Anthony Idaho

19. PLACE OF BURIAL OR REMOVAL: Nampa Idaho — DATE OF BURIAL: 11/23 1921

20. UNDERTAKER: Ford K Robinson — ADDRESS: Nampa Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35925

Registered No. ____

1. PLACE OF DEATH. RECEIVED DEC 10 1921 BUREAU OF VITAL STATISTICS

Registration District No. ____

Primary Registration District No. 2056

County of Canyon

City of Nampa (Street Sanitarium St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Harold Matthews

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Nov (Month) 14 (Day) 1912 (Year)

7. AGE: 8 Yrs. ____ Mos. ____ ds.

IF LESS than 1 day how many ____ hrs. or ____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): ____

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: B. H. Matthews

11. BIRTHPLACE OF FATHER (State or Country): Russia

12. MAIDEN NAME OF MOTHER: Bauman

13. BIRTHPLACE OF MOTHER (State or Country): Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) D. A. Paynter

(Address) Nampa, Ida.

15. Filed DEC 16 1921 Pearle Dodds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 26 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 2 1921, to Nov 26 1921, that I last saw him alive on Nov 26 1921, and that death occured on the date stated above, at 9 45a M.

The CAUSE OF DEATH* was as follows:

Malignant Epilepticus

(Duration) ____ Yrs. ____ mos. ____ ds.

Contributory (Secondary) ____

(Duration ____ yrs. ____ mos. ____ ds.

(Signed) D. A. Paynter M. D.

11/26/1921 (Address) Nampa Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ____ yrs. 10 mos. 24 days. In the State ____ yrs. ____ mos. ____ days

Where was disease contracted if not at place of death? Aberdeen Idaho

Former or usual residence Aberdeen Ida Co

19. PLACE OF BURIAL OR REMOVAL: Aberdeen Idaho — DATE OF BURIAL ____ 191

20. UNDERTAKER: Ford & Robinson — ADDRESS Nampa Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35926
Registered No. .....

1. PLACE OF DEATH.

Registration District No. 7

Primary Registration District No. 2221

County of Canyon

City of Nampa (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
1921
VITAL STATISTICS

2. FULL NAME Alice C. Garrett

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE: Probably 68 or 70 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: House Wife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Tom Garrett

(Address) Nampa Idaho

15.

Filed Nov 17 1921

Pearle Davis
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 12 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 20 1921, to Nov 12 1921, that I last saw her alive on Nov 12 1921, and that death occured on the date stated above, at 3 P M.

The CAUSE OF DEATH* was as follows:

Exhaustion, Chronic Mania

(Duration) 6 Yrs. ..... mos. ..... ds.

Contributory (Secondary) Chronic Bronchitis

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Tom Garrett M. D.

11/12 1921 (Address) Nampa Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 1 yrs. 2 mos. 22 days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence Risin Idaho

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Risin Idaho	Nov 1921
20. UNDERTAKER	ADDRESS
Fred T. Robinson	Nampa

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35927

Registered No.

RECEIVED DEC 10 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Canyon

City of Nampa (No. , St.)

Registration District No.

Primary Registration District No. 2006

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary F Harrell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widow

6. DATE OF BIRTH: May (Month) 20 (Day) 1921 (Year)

7. AGE: Yrs. 7 Mos. 22 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work:

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Fred I Harrell

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Ada F Sandy

13. BIRTHPLACE OF MOTHER (State or Country): Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Fred I Harrell

(Address) Meridian Ida

15. Filed Nov 17 1921 Pearle Evans Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 12 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 10 1921 to Nov 12 1921 that I last saw her alive on Nov 11 1921 and that death occurred on the date stated above, at 5:30 PM.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

Acute Bronchitis

Gastro Enteritis

(Duration) Yrs. mos. 7 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Marion P. Fink M. D.

Nov 12 1921 (Address) Nampa Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Boise Valley Cem — DATE OF BURIAL: 11-13 1921

20. UNDERTAKER: Fred H Robinson — ADDRESS: Nampa

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

Fink

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35928

Registered No. 20

RECEIVED
DEC 12 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH.

County of Canyon

City of Parma

Registration District No.

Primary Registration District No. 1007

(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Wilfred Brown

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	W	S

6. DATE OF BIRTH.

Nov. (Month) 10 (Day) 1921 (Year)

7. AGE

..... Yrs. ..... Mos. 7 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country) Canyon Co

10. NAME OF FATHER Lester W Brown

11. BIRTHPLACE OF FATHER

(State or Country) North Carolina

12. MAIDEN NAME OF MOTHER Doris Price

13. BIRTHPLACE OF MOTHER

(State or Country) Colorado

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lester W Brown

(Address) Nampa

15.

Filed 11-18 1921 Mitchell Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov. (Month) 18 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 10 1921; to Nov 18 1921; that I last saw h.... alive on Nov 18 1921; and that death occured on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Uremic Coliths

(Duration) ..... Yrs. ..... mos. 8 ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) W M Mitchell M. D.

19..... (Address) Parma Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL ~~OR REMOVAL~~	DATE OF BURIAL
Parma Idaho	Nov 19 1921
20. UNDERTAKER	ADDRESS
Peckham Fun Co	Parma Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35929
Registered No. 21

1. PLACE OF DEATH.
County of Canyon
City of Parma (No.) St.)
Primary Registration District No. 1007
Registration District No.
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jessie Lynch

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): M

6. DATE OF BIRTH. Oct (Month) 6 (Day) 1879 (Year)

7. AGE 42 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kansas

10. NAME OF FATHER: Nelson Allen

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Sarah Folland

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) James Lynch
(Address) Parma Ida

15. Filed 11-16 1921 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Nov (Month) 15 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from about Jan 1921, to Nov 15 1921, that I last saw h. alive on Died Nov 15 1921 and that death occured on the date stated above, at 8 A.M.

The CAUSE OF DEATH* was as follows:
Carcinoma involving all the Gland of Chest
(Duration) about 1 Yrs. — mos. — ds.
Contributory (Secondary)
(Duration — yrs. — mos. — ds.

(Signed) W. E. Wallace M. D.
Nov 16 1921 (Address) Parma, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL ~~OR REMOVAL~~ Parma Idaho — DATE OF BURIAL Nov 16 1921

20. UNDERTAKER Peckham Fun Co — ADDRESS Parma

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 24853

Form V. S. No. 5. 10M. 6-20-11.

RECEIVED
DEC 12 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
Registration District No. 2 8 7
Primary Registration District No.
File No. 35930
County of Canyon
City of Parma Precinct (No. , St.)
Registered No. 27
If death occurs away from usual residence, give facts called for under special information.
2. FULL NAME Briteser
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single
6. DATE OF BIRTH: Nov. (Month) 20 (Day) 1921 (Year)
7. AGE: ....yrs. ....mos. ....ds. IF LESS than 1 day how many ....hrs. or 15 min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry business or establishment in which employed (or employer): —
9. BIRTHPLACE (State or Country): Canyon Co. Idaho
10. NAME OF FATHER: Daniel B. Briteser
11. BIRTHPLACE OF FATHER (State or Country): Idaho
12. MAIDEN NAME OF MOTHER: V. R. Cooper
13. BIRTHPLACE OF MOTHER (State or Country): California
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Daniel B. Briteser
(Address) Parma, Ida.
15.
Filed 12-21 1921 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 20 (Day) 1921 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Nov. 20 1921, to Nov 20 1921
that I last saw h....alive on Nov. 20 1921,
and that death occurred on the date stated above, at 8:15 a.m.
The CAUSE OF DEATH* was as follows:
Probably strangled from swallowing Amniotic fluid — Was not breathing when Dr. arrived, heart beating faintly — could not be revived —
(Duration) ....yrs. ....mos. —ds.
Contributory (Secondary) —
(Duration) —yrs. —mos. —ds.
(Signed) Chas. B. Allen M. D.
11/22 1921 (Address) Parma, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Parma Cemetery	12 21 1921

20. UNDERTAKER	ADDRESS
Peckham Bros	Parma

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & RINDERS, BOISE 16672

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

RECEIVED DEC 5 1921 BUREAU OF VITAL STATISTICS

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Canyon — Registration District No. 2007

City of Parma — Primary Registration District No. ____

(No. ____ St.)

File No. 35931

Registered No. 23

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Myrtle Stout

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): S

6. DATE OF BIRTH. Nov (Month) 17 (Day) 1921 (Year)

7. AGE: ____ Yrs. ____ Mos. 10 ds.

IF LESS than 1 day how many ____ hrs. or ____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: ____

(b) General nature of industry, business, or establishment in which employed (or employer): ____

9. BIRTHPLACE (State or Country) Canyon Co Ida

10. NAME OF FATHER J.S. Stout

11. BIRTHPLACE OF FATHER (State or Country) Tenn

12. MAIDEN NAME OF MOTHER Mamie Campbell

13. BIRTHPLACE OF MOTHER (State or Country) Tenn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Stanley Stout

(Address) Parma Ida

15. Filed 11-28 1921 Lulu Malchow Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 27 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 12 1921, to Nov 25 1921, that I last saw h[illegible] alive on Nov 25 1921, and that death occured on the date stated above, at between 2 & 4 P. M.

The CAUSE OF DEATH* was as follows:

Premature (7½ months)

(Duration) ____ Yrs. ____ mos. ____ ds.

Contributory (Secondary) ____

(Duration ____ yrs. ____ mos. ____ ds.

(Signed) Chas. B. Allen M. D.

19____ (Address) Parma, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ____ yrs ____ mos ____ days. In the State ____ yrs ____ mos ____ days

Where was disease contracted if not at place of death? ____

Former or usual residence ____

19. PLACE OF BURIAL ~~OR REMOVAL~~: Parma Ida — DATE OF BURIAL: Nov 28 1921

20. UNDERTAKER: Peckham Fun Co — ADDRESS: Parma

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SDRS. 24653

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35932
Registered No.

RECEIVED
DEC 10 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Canyon — Registration District No. 3
Primary Registration District No. 1005
City of Notus (If outside limits, give township.) St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Evariste Talbot
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Oct (Month) 12 (Day) 1856 (Year)

7. AGE: 65 Yrs. 1 Mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Carpenter
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Quebec Canada

10. NAME OF FATHER: Geo. Talbot

11. BIRTHPLACE OF FATHER (State or Country): Quebec Canada

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) G. E. Talbot
(Address) Notus Ida

15. Filed Dec. 9 — 1921 John V. Meyer
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 8 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1921 to Dec 8 1921, that I last saw h.. alive on Dec 7 1921, and that death occurred on the date stated above, at 2 P.M.
The CAUSE OF DEATH* was as follows:
Cancer of Stomach
Contributory (Secondary) Arteriosclerosis
(Duration) ..... Yrs. ..... mos. ..... ds.
(Duration) ..... yrs. 6 mos. ..... ds.
(Signed) W. H. Wilson M. D.
12/5 1921 (Address) Caldwell, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill — DATE OF BURIAL: 12-10-1921

20. UNDERTAKER: Case Furniture Co. — ADDRESS: Caldwell

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED DEC 7 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 2005
File No. 35933
Registered No. 126

1. PLACE OF DEATH
County of Canyon
City of Caldwell (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James Epperson
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	White	Single

6. DATE OF BIRTH
Nov — 1829
(Month) (Day) (Year)

7. AGE
92 Yrs. 11 Mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Carpenter
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Ohio

10. NAME OF FATHER —

11. BIRTHPLACE OF FATHER (State or Country) —

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER (State or Country) —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs T. C. Pearson
(Address) Caldwell

15. Filed Dec. 6 1921 John H. Meyer
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Dec. 7 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 29 1921, to Dec 7 1921, that I last saw him alive on Dec 7 1921, and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
..... (Duration) ..... Yrs. 1 mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) C. M. Daley M. D.
12-8 1921 (Address) Caldwell Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Canyon Hill	12-8 1921

20. UNDERTAKER	ADDRESS
CASE FURNITURE CO.	Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
DEC 10 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 2005
File No. 35934
Registered No. 125

1. PLACE OF DEATH
County of Canyon
City of Caldwell (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ross Wayne Nelson
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.):

6. DATE OF BIRTH: July (Month) 19 (Day) 1920 (Year)

7. AGE: 1 Yrs. 4 Mos. 14 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At home.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: Ira M. Nelson

11. BIRTHPLACE OF FATHER (State or Country): Indiana

12. MAIDEN NAME OF MOTHER: Jessie George

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ira M. Nelson
(Address) Caldwell Ida #1

15. Filed Dec. 5 1921 — John B. Meyer — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 3 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 2 1921, to Dec 3 1921, that I last saw him alive on Dec 3 1921, and that death occurred on the date stated above, at 7-30 P.M.
The CAUSE OF DEATH* was as follows:
Acute Uremia.
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Scald-
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) S B Dudley M. D.
1921 (Address) Caldwell Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Star Cemetery — DATE OF BURIAL: Dec 5 1921
20. UNDERTAKER: E. V. Peckham — ADDRESS: Caldwell

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED DEC 10 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Canyon — Registration District No. 3

City of Caldwell — Primary Registration District No. 2005

(No. ..... St.)

File No. 35935

Registered No. 124

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James Agustus Chevalley

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
male	white	Single

6. DATE OF BIRTH: June (Month) 17 (Day) 1903 (Year)

7. AGE: 18 Yrs. 5 Mos. 15 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At home.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Missouri.

10. NAME OF FATHER: Fred J. Chevalley.

11. BIRTHPLACE OF FATHER (State or Country): Michigan.

12. MAIDEN NAME OF MOTHER: Cora J Robinson

13. BIRTHPLACE OF MOTHER (State or Country): Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Fred J. Chevalley
(Address) Jamestown Colony Apts

15. Filed Dec. 4 1921 — John H. Meyers, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 2 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 19 1921, to Dec 2 1921, that I last saw him alive on Dec 2 1921, and that death occurred on the date stated above, at 2:40 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia ——

(Duration) ..... Yrs. ..... mos. 17 ds.

Contributory (Secondary) Ruptured Appendix

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. S. Forney M. D.

12/3 1921 (Address) Caldwell Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill — DATE OF BURIAL: Dec 4 1921

20. UNDERTAKER: E. V. Peckham — ADDRESS: Caldwell

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

RECEIVED DEC 10 19[illegible] BUREAU OF VITAL STATISTICS

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35936

Registered No. 123

1. PLACE OF DEATH

Registration District No. 9

Primary Registration District No. 2005

County of Canyon

City of Nampa (If outside limits of city or village, give township) No. [illegible] St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Otis Heckman Marsh

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Nov (Month) 27 (Day) 1893 (Year)

7. AGE: 28 Yrs. — Mos. — ds.

IF LESS than 1 day how many..... hrs. or.....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Well Driller

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Jno. James Marsh

11. BIRTHPLACE OF FATHER (State or Country): Ills

12. MAIDEN NAME OF MOTHER: Jennie Bell Grafton

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. J. J. Marsh

(Address) Caldwell Ida

15. Filed Nov. 29 1921 John L. Meyer Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 27 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 21 1921, to Nov 26 1921, that I last saw him alive on Nov 26 1921, and that death occurred on the date stated above, at 6:40 M.

The CAUSE OF DEATH* was as follows:

Shock (Hemorrhage)
Vomited an evening rest & aspirated piece food in Trachea & Strangled

(Duration) — Yrs. — mos. ½ ds.

Contributory (Secondary) Gun shot wound 3rd of Rt hand

(Duration) — yrs. — mos. ½ ds.

(Signed) Horace P Bilbrough M. D.

11/29 1921 (Address) Nampa Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill — DATE OF BURIAL: Nov 29 1921

20. UNDERTAKER: CASE FURNITURE CO. — ADDRESS: Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35937

Registered No. 122

1. PLACE OF DEATH

County of Canyon

City of Caldwell (No. ..... St.)

Registration District No. 3

Primary Registration District No. 1025

RECEIVED DEC 10 1921 BUREAU OF VITAL STATISTICS

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Hardy Nelson Mafey

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): married

6. DATE OF BIRTH: Apr. (Month) 17 (Day) 1 (Year)

7. AGE: 69 Yrs. 7 Mos. 10 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Rancher

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ida

10. NAME OF FATHER: Wm M.A. Mafey

11. BIRTHPLACE OF FATHER (State or Country): Kentucky

12. MAIDEN NAME OF MOTHER: Eddy Owens

13. BIRTHPLACE OF MOTHER (State or Country): Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W.N. Mafey

(Address) Caldwell Ida

15. Filed Nov. 29 1921 John V. Meyers Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 27 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 7 1920 to Nov 27 1921 that I last saw him alive on Nov 27 1921 and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows: Acute Cardiac dilatation

(Duration) ..... Yrs. 1 mos. 1/2 ds.

Contributory (Secondary) Nephritis

(Duration) 1/2 yrs. ..... mos. ..... ds.

(Signed) W.N. Mafey M.D.

11-29 1921 (Address) Caldwell Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill

DATE OF BURIAL: 11-30 1921

20. UNDERTAKER: CASE FURNITURE CO.

ADDRESS: Caldwell

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35938
Registered No. 121

RECEIVED DEC 10 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
Registration District No. 3
Primary Registration District No. 2005
County of Canyon
City of Parma (If outside limits, give township.) St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Velma Almatharshman
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH: 1 (Month) 1 (Day) 1911 (Year)

7. AGE: Yrs. 10 Mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER F M Harshman

11. BIRTHPLACE OF FATHER (State or Country) Ill.

12. MAIDEN NAME OF MOTHER Birtha Rodle

13. BIRTHPLACE OF MOTHER (State or Country) Neb.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) L A Rucker
(Address) Caldwell

15. Filed Nov. 26 1921 John L. Meyers Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 11 (Month) 26 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 23 1921, to Nov. 25 1921
that I last saw h.er alive on Nov. 25 1921,
and that death occurred on the date stated above, at 7 A. M.
The CAUSE OF DEATH* was as follows:

Illeo Colitis

(Duration) ..... Yrs. ..... mos. 8 ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W M Mitchell M. D.
11-26 1921 (Address) Parma Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill — DATE OF BURIAL: 11-27 1921

20. UNDERTAKER: [illegible] FURNITURE CO. — ADDRESS Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
DEC 10 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 3
Primary Registration District No. 2005
File No. 35940
Registered No. 119

County of Canyon
City of Wilder (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Albert Eugene Hudson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Sept (Month) 5 (Day) 1881 (Year)

7. AGE: 40 Yrs. 2 Mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Moving Picture
(b) General nature of industry, business or establishment in which employed (or employer): business.

9. BIRTHPLACE (State or Country): Nebraska

10. NAME OF FATHER: Orlando Hudson

11. BIRTHPLACE OF FATHER (State or Country): Michigan

12. MAIDEN NAME OF MOTHER: Minerva J Gilmore

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A Hudson
(Address) Wilder Idaho

15. Filed Nov 21 1921
John S Meyer
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 20 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 4 1921, to Nov 20 1921
that I last saw h[im] alive on Nov 20 1921,
and that death occurred on the date stated above, at 11-45 M.
The CAUSE OF DEATH* was as follows:
Gonococcus infection

(Duration) Yrs. 2 mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) A A Brandt M. D.
19 (Address) Wilder Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Wilder Cem. | DATE OF BURIAL: 11-2 1921

20. UNDERTAKER: L V Peckham | ADDRESS: Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED
DEC 10 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 8

County of Canyon — Primary Registration District No. 1005 — File No. 35941

City of Caldwell (No. ..... St.) — Registered No. 118

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Betty Plowhead

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
male	White	single

6. DATE OF BIRTH: 11 (Month) 19 (Day) 1921 (Year)

7. AGE: ..... Yrs. ..... Mos. one Ds. — IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER John Plowhead

11. BIRTHPLACE OF FATHER (State or Country) Idaho

12. MAIDEN NAME OF MOTHER Ella Horn

13. BIRTHPLACE OF MOTHER (State or Country) Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wm. J. Plowhead
(Address) Caldwell Idaho

15. Filed Nov. 20 1921 — John L. Meyers, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 11 (Month) 20 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 19 1921, to Nov 19 1921, that I last saw him alive on Nov 19 1921, and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

Pneumonia Lobar

..... (Duration) ..... Yrs. 6 mos. & ds.

Contributory (Secondary) ? Acute Pneumonia

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) S. W. Pendleton M. D.

..... 19..... (Address) Caldwell

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Canyon Hill	Nov 20 1921
20. UNDERTAKER	**ADDRESS**
Base Furn Co	Caldwell

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35942
Registered No. 117

RECEIVED
DEC 10 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Canyon Registration District No. 3
City of Caldwell (No. ..... St.) Primary Registration District No. 2007
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jacob R. Speelman
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Divorced

6. DATE OF BIRTH: Nov. (Month) 11 (Day) 1858 (Year)

7. AGE: 63 Yrs. ..... Mos. 1 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Indiana

10. NAME OF FATHER: R. Speelman

11. BIRTHPLACE OF FATHER (State or Country): Penn

12. MAIDEN NAME OF MOTHER: Fairest

13. BIRTHPLACE OF MOTHER (State or Country): Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. W. Perkins
(Address) Portland Ore.

15. Filed Nov. 14 1921 John S. Meyers Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 12 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 25 1921, to Nov 12 1921, that I last saw him alive on Nov. 12 1921, and that death occurred on the date stated above, at 3 P M.

The CAUSE OF DEATH* was as follows:

Tuberculosis

(Duration) ..... Yrs. 2 mos. ..... ds.
Contributory (Secondary) Pleurisy & other parts tuberculous
(Duration) 10 yrs. 1/2 mos. ..... ds.

(Signed) S. R. Dudley M. D.
19..... (Address) Caldwell Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Portland — DATE OF BURIAL: Nov 16 1921

20. UNDERTAKER: CASE FURNITURE CO. — ADDRESS: Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

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FORM V. S. No. 5-A--25 M. 1-19.

RECEIVED
DEC 10 1921
BUREAU OF VITAL STATISTICS
STATE OF IDAHO

CERTIFICATE OF DEATH

Registration District No. 3
Primary Registration District No. 2005

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35943
Registered No. 116

1. PLACE OF DEATH
County of Canyon
City of Houston Rt 2 (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Fern I. Steenema

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Married

6. DATE OF BIRTH: Apr 26 1898 (Month) (Day) (Year)

7. AGE: 23 Yrs. 6 Mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: J. H. Jones

11. BIRTHPLACE OF FATHER (State or Country): Wales

12. MAIDEN NAME OF MOTHER: Hannah Carter

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) N. P. G. Steenema
(Address) Houston Route No 2

15. Filed Nov. 14 1921 John L. Meyers Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov 11 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 1 1921, to Nov 11 1921 that I last saw h[illegible] alive on Nov 11 1921 and that death occurred on the date stated above, at 11 P. M.

The CAUSE OF DEATH* was as follows:
Femoral hygroma from streptococic infection

(Duration) ..... Yrs. ..... mos. 11 ds.
Contributory (Secondary) Child birth
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. W. Gue M. D.
11/14 1921 (Address) Caldwell Id

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill
DATE OF BURIAL: 11-14 1921

20. UNDERTAKER: CASE FURNITURE CO
ADDRESS: Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 9

Primary Registration District No. 2005

File No. 35944

Registered No. 115

County of Canyon

City of Wilder (If outside limits, give township) St.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
DEC 10 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME Forest Eugene Denton

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH: Oct 8 (Month) (Day) 1918 (Year)

7. AGE: 3 Yrs. 0 Mos. 27 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: C. R. Denton

11. BIRTHPLACE OF FATHER (State or Country): Indiana.

12. MAIDEN NAME OF MOTHER: Florence Mary Macher

13. BIRTHPLACE OF MOTHER (State or Country): Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): C. R. Denton
(Address): Wilder Ida

15. Filed Nov. 6 1921 John S. Meyer Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. 5 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 23 1921, to Nov 4 1921, that I last saw h. alive on Nov 4 1921, and that death occurred on the date stated above, at 4-10 A.M.

The CAUSE OF DEATH* was as follows:

Typhoid fever

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A. M. Banks M. D.

11-6 1921 (Address) Wilder Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Wilder Cem — DATE OF BURIAL: 11-6 1921

20. UNDERTAKER: E. V. Peckham — ADDRESS: Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 1005
File No. 35945
Registered No. 114

1. PLACE OF DEATH

County of Canyon
City of Caldwell (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James Russell Baker

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male

4. COLOR OR RACE White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married (Write the word.)

6. DATE OF BIRTH Dec (Month) 18 (Day) 1843 (Year)

7. AGE 77 Yrs. 10 Mos. 17 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business or establishment in which employed (or employer): ranches

9. BIRTHPLACE (State or Country) Iowa

10. NAME OF FATHER John R. Baker

11. BIRTHPLACE OF FATHER (State or Country) Iowa

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country) Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs A A Brunnell

(Address) Nampa Idaho

15. Filed Nov. 9 1921 John L. Meyer, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. (Month) 5 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1 1921, to Nov 5 1921, that I last saw h~~im~~ alive on Nov 3 1921, and that death occurred on the date stated above, at 9:30 P.M.

The CAUSE OF DEATH* was as follows: Myocarditis

(Duration) Yrs. 2 mos. ds.

Contributory (Secondary) Nephritis

(Duration) yrs. 6 mos. ds.

(Signed) W M Raley M. D.

11-5-1921 (Address) Caldwell Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Canyon Hill — **DATE OF BURIAL** 11-9 1921

20. UNDERTAKER C. V. Jackman — **ADDRESS** Caldwell

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-A—25 M 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35647

Registration District No. 7
Primary Registration District No. 1006

RECEIVED NOV 30 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Canyon
City of Nampa (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jesse Snyder Colvin

Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	white	Widowed

6. DATE OF BIRTH: June (Month) 17 (Day) 1855 (Year)

7. AGE: 66 Yrs. 3 Mos. 24 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Minister
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: John A. Colvin

11. BIRTHPLACE OF FATHER (State or Country): Mass.

12. MAIDEN NAME OF MOTHER: Loveland

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) James Colvin
(Address) Nampa Ida

15. Filed Nov 11 1921 Pearle Bunting Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: October (Month) 11 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1 1921, to Oct 11, 1921, that I last saw h.... alive on Oct 11, 1921, and that death occurred on the date stated above, at 8 A M.
The CAUSE OF DEATH* was as follows:
Pneumonia
.....(Duration) .....Yrs. ..... mos. 11 ..... ds.
Contributory (Secondary) .....
.....(Duration) .....yrs. .....mos. .....ds.
(Signed) Geo. L. Proctor M. D.
11/14 1921 (Address) Nampa, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs. .....mos. .....days. In the State .....yrs. .....mos. .....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Nampa Idaho	10-14 1921
20. UNDERTAKER: Fred K Robinson	ADDRESS: Nampa

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

RECEIVED NOV 30 1921 BUREAU OF VITAL STATISTICS

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No.
Primary Registration District No. 1213
File No. 35918
Registered No.

1. PLACE OF DEATH

County of Canyon
City of Nampa (or Village or Township) (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lew H. Hebedon

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Male	White	Married (write the word.)

6. DATE OF BIRTH

Unknown (Month) 1 (Day) (Year)

7. AGE

27 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Barber

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER J. R. Hebedon

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER Mary A. Whitt

13. BIRTHPLACE OF MOTHER (State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) T. R. Hebedon

(Address) Nampa Idaho

15.

Filed [illegible] 19[illegible]

[illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov 8 19 21
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11-5 19 21, to 11-8 19 21 that I last saw h[illegible] alive on 11-8 19 21 and that death occurred on the date stated above, at 11:30 M.

The CAUSE OF DEATH* was as follows:

Burns of hands, legs and hips

(Duration) — Yrs. — mos. 3 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) A. W. Wilson M. D.

11/8 19 21 (Address) NAMPA, IDAHO

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE ~~OF BURIAL OR~~ REMOVAL Dayton Idaho

DATE OF BURIAL 19

20. UNDERTAKER Fred K Robinson

ADDRESS Nampa Ida.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 1556
File No.
Registered No.

1. PLACE OF DEATH

County of Canyon
City of Nampa
(No. Mercy Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lorenzo D. Hebdon

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	white	Married

6. DATE OF BIRTH Dec (Month) 30 (Day) 1890 (Year)

7. AGE 30 Yrs. 10 Mos. 8 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Barber

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER J. R. Hebdon

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER Mary White

13. BIRTHPLACE OF MOTHER (State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs L. R. Hebdon

(Address) Nahaun N + 8th st

15.

Filed Nov 11 1921 Reuse D. Idle
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 8 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11—5 1921, to 11—8 1921, that I last saw him alive on 11—8 1921, and that death occurred on the date stated above, at 11 30 M.

The CAUSE OF DEATH* was as follows:

Burns of Hands, Legs Hand Ribs

(Duration) — Yrs. mos. 3 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.

11/8 1921. (Address) NAMPA, IDAHO.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF ~~BURIAL OR~~ REMOVAL Rigby Idaho — **DATE OF BURIAL** 19

20. UNDERTAKER Fred K Robinson — **ADDRESS** Nampa Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED NOV 30 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35949
Registered No.

1. PLACE OF DEATH
County of Canyon
Registration District No. 7
Primary Registration District No. 1006
City of Nampa (If outside limits, give township) St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lillie Harding
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: November (Month) 19 (Day) 1907 (Year)

7. AGE: 15 Yrs. 11 Mos. 16 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ark.

10. NAME OF FATHER: Wm Harding

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Amanda Swaner

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Frank Dyer
(Address) Kuna Idaho

15.
Filed Nov. 10 1921 Pearle Dodds
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 5 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1 1921, to Oct 30 1921, that I last saw her alive on Oct 30 1921 and that death occurred on the date stated above, at 4-9 M.

The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis

(Duration) 1 Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. P. Rees M. D.
Nov 6 1921 (Address) Nampa Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (~~For Hospitals, Institutions, Transients or~~ Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. 2 mos. ..... days
Where was disease contracted if not at place of death? Oklahoma
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Riverside Cem Nampa Ida
DATE OF BURIAL: 11-7 1921

20. UNDERTAKER: Fred K. Robinson
ADDRESS: Nampa Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35950
Registered No.

1. PLACE OF DEATH

County of Canyon — Registration District No. 7
City of Nampa — Primary Registration District No. 2006
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

RECEIVED NOV 30 1921 BUREAU OF VITAL STATISTICS

2. FULL NAME Frederick D. Young

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M.	White	Married

6. DATE OF BIRTH: Dec (Month) 28 (Day) 1875 (Year)

7. AGE: 45 Yrs. 10 Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ma.

10. NAME OF FATHER: Talbert P. Young

11. BIRTHPLACE OF FATHER (State or Country): Penn.

12. MAIDEN NAME OF MOTHER: Sarah Walker

13. BIRTHPLACE OF MOTHER (State or Country): Mo

14. THE ~~ABOVE~~ IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs F D Young
(Address) Nampa Ida

15. Filed Oct 21 1921 Pearle Dodds Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 10 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Stomache trouble
a Chiropractor in attendance
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Pearle Dodds Dodds M. D.
Oct 12 1921 (Address) Local Registrar

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Kohler Lawn Cem — DATE OF BURIAL: 10/12 1921

20. UNDERTAKER: Burt K Robinson — ADDRESS: Nampa Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED NOV 5 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 7

Primary Registration District No. 2006

File No. 35952

County of Canyon

City of 2 mi North Nampa (If outside limits, give township) St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John E. Morrison

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: April 2 1870 (Month) (Day) (Year)

7. AGE: 51 Yrs. 7 Mos. 19 ds.

IF LESS than 1 day how many..... hrs. or.....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ida

10. NAME OF FATHER: Andrew Morrison

11. BIRTHPLACE OF FATHER (State or Country): unknown

12. MAIDEN NAME OF MOTHER: Mary A Edwards

13. BIRTHPLACE OF MOTHER (State or Country): unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs E Morrison
(Address) Nampa Ida

15. Filed Nov. 11 1921 Pearle Dodds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 21 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1918, to Oct 1 1921
that I last saw him alive on Oct 1 1921
and that death occurred on the date stated above, at 5 P. M.
The CAUSE OF DEATH* was as follows:
Chronic Valvular Heart Disease
(Duration) 4 Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) H. P. Rose M. D.
Nov 1 1921 (Address) Nampa Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Nampa Idaho	10-23 1921
20. UNDERTAKER	ADDRESS
Fred L Robinson	Nampa Ida

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED NOV 8 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 2006
File No. 35953
Registered No.

1. PLACE OF DEATH
County of Owyhee
City of Homedale (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ira Harris

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Aug (Month) 1 (Day) 1914 (Year)

7. AGE: 5 Yrs. 6 Mos. — ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Canada

10. NAME OF FATHER: Edward W. Harris

11. BIRTHPLACE OF FATHER (State or Country): Ino

12. MAIDEN NAME OF MOTHER: Jessie Mage

13. BIRTHPLACE OF MOTHER (State or Country): Ino.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. W. Harris
(Address) Homedale Ida

15. Filed Nov. 10 1921 Pearl Dodds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 25 (Day) 19 21 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 25 19 21 to Oct 26 19 21
that I last saw h-- alive on Oct 26 19 21
and that death occurred on the date stated above, at 9:30 M.
The CAUSE OF DEATH* was as follows:
Burn of 2nd & third degree neck, Chest, abdomen, thighs and arms
(Duration) — Yrs. — mos. 1 ds.
Contributory (Secondary)
(Duration) — yrs. — mos. — ds.
(Signed) J. Emil Lillian M. D.
19 (Address) NAMPA, IDAHO

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. 1 days. In the State 3 yrs. — mos. — days
Where was disease contracted if not at place of death? at ranch Homedale Ida
Former or usual residence Homedale Ida

19. PLACE OF BURIAL OR REMOVAL: Nampa Ida — DATE OF BURIAL: 10-26 1921

20. UNDERTAKER: Fred Robinson — ADDRESS: Nampa

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

M 2

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED NOV 30 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 7

Primary Registration District No. 2006

File No. 35954

Registered No.

County of Canyon

City of Nampa (No. Idaho, State Sanitarium, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ida Kinnes

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1 (Year)

7. AGE: 52 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: House servant

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Mich

10. NAME OF FATHER: A J Kinnes

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Tom Boyer

(Address) Nampa

15.

Filed Nov. 10 1921 Paid $1.00

Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 13 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 17 1920, to Oct 13 1921

that I last saw h[illegible] alive on Oct 13 1921

and that death occurred on the date stated above, at 3 20 P. M.

The CAUSE OF DEATH* was as follows:

Bronch-Pneumonia

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Influenza

..... (Duration) ..... yrs. ..... mos. 8 ..... ds.

(Signed) Tom Boyer M. D.

10/13 1921 (Address) Nampa Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 1 yrs. 3 mos. 26 days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? Nampa Idaho

Former or usual residence Onslow Idaho

19. PLACE OF BURIAL OR REMOVAL: Rohlman Cem — DATE OF BURIAL: 10/15 192[illegible]

20. UNDERTAKER: Fred R Robinson — ADDRESS: Nampa Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED
NOV 30 [redacted]
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35955
Registered No. 19

1. PLACE OF DEATH
County of Canyon
City of Parma
If death occurs away from usual residence, give facts called for under special information.

Primary Registration District No. 2007
(STATISTICS St.)

2. FULL NAME Mary [redacted] Mollie Mary A. Healy

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: married (Write the word.)

6. DATE OF BIRTH: Dec (Month) 10 (Day) 862 (Year)

7. AGE: 58 Yrs. 10 Mos. 11 ds.
IF LESS than 1 day how many ____ hrs. or ____ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: John Redmond

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: [redacted] McClure

13. BIRTHPLACE OF MOTHER (State or Country): N. Y.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Ed. H. VanHuffa
(Address) Parma Idaho

15. Filed 11-23 1921 Ruby Waldrop Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 21 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 10 1921 to Oct 21 1921, that I last saw h[redacted] alive on Oct 21 1921, and that death occurred on the date stated above, at 11 A. M.

The CAUSE OF DEATH* was as follows:
Rotten pruning
(Duration) — Yrs. — mos. 10 ds.
Contributory (Secondary) Pneumonia
(Duration) — yrs. — mos. 8 ds.

(Signed) W. E. Fulcher M. D.
Oct 23 1921 (Address) Parma Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Parma Cemetery — DATE OF BURIAL: 10-23 1921

20. UNDERTAKER: CASE FURNITURE CO. — ADDRESS: Caldwell Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

RECEIVED NOV 30 1921 BUREAU OF VITAL STATISTICS

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35956
Registered No. 17

1. PLACE OF DEATH.
Registration District No. 9
Primary Registration District No. 1007
County of Canyon
City of Parma St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Maria N Rose

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. ~~SINGLE~~, MARRIED, ~~WIDOWED OR DIVORCED~~. (Write the word.): M

6. DATE OF BIRTH. Dec (Month) 12 (Day) 1856 (Year)

7. AGE: 64 Yrs. 10 Mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Henry C. Cook

11. BIRTHPLACE OF FATHER (State or Country): Do not Know

12. MAIDEN NAME OF MOTHER: Silva J. Risley

13. BIRTHPLACE OF MOTHER (State or Country): N Y

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) L. G. Rose
(Address) Parma

15. Filed Oct 16 1921 Lulu Waldrop Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. (Month) 14 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 7 1921, to Oct. 14 1921, that I last saw h~~er~~ alive on Oct 13 1921, and that death occured on the date stated above, at 5-10a M.

The CAUSE OF DEATH* was as follows:
Influenza
(Duration) — Yrs. — mos. 7 ds.
Contributory (Secondary) Bronchial Asthma
(Duration 30 yrs. — mos. — ds.
(Signed) H. E. Waldrop M. D.
Oct 16 1921 (Address) Parma Idy

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR ~~REMOVAL~~: Parma Ida — DATE OF BURIAL: Oct 16 1921

20. UNDERTAKER: Peckham Fur Co — ADDRESS: Parma

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYNS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-18 RECEIVED NOV 30 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 3 D-

County of Canyon Primary Registration District No. 2007

City of ..... (No. ....., ... St.)

File No. 35957

Registered No. 18

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lester Anderson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	W	S

6. DATE OF BIRTH. Oct (Month) 11 (Day) 1921 (Year)

7. AGE ....Yrs....Mos. 8 ds. IF LESS than 1 day how many ....hrs. or ....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Canyon Co

10. NAME OF FATHER Ben Anderson

11. BIRTHPLACE OF FATHER (State or Country) Minn

12. MAIDEN NAME OF MOTHER Gladys Maw

13. BIRTHPLACE OF MOTHER (State or Country) Minn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Ben A. Anderson
(Address) .....

15. Filed Oct 20 1921 Lulu Waldrop Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. (Month) 19 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 17 1921, to Oct 19 1921, that I last saw him alive on Oct 19 1921, and that death occured on the date stated above, at 5P. M.

The CAUSE OF DEATH* was as follows:

Pupura Hemorrhagica

(Duration) ....Yrs. ....mos. 2 ds.

Contributory (Secondary) .....

(Duration) ....yrs. ....mos. ....ds.

(Signed) W. W. Mitchell M. D.

10/20 1921 (Address) Parma

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL ~~OR REMOVAL~~ Parma — DATE OF BURIAL Oct 20 1921

20. UNDERTAKER Peckham Fun Co — ADDRESS Parma

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24658

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 3

Primary Registration District No. 2005

File No. 35958

County of Canyon

City of Caldwell (If outside limits of city or village, give township) St.)

Registered No. 113

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
NOV 30 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME Baby Steensma

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH: 11 (Month) / (Day) 19.. (Year)

7. AGE: ..... Yrs. ..... Mos. 4 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER N. P. G. Steensma

11. BIRTHPLACE OF FATHER (State or Country) Kansas

12. MAIDEN NAME OF MOTHER Emma Jones

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) N. P. G. Steensma

(Address) Caldwell Ida. Route No. 2.

15. Filed Nov 5 1921 John L. Meyer
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 11 (Month) 5 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 1 1921, to ..... 19.., that I last saw h. alive on Nov 1 1921, and that death occurred on the date stated above, at .....M.

The CAUSE OF DEATH* was as follows:

Premature birth

(7 mos.)

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. W. Lee M. D.

11/5 1921 (Address) Caldwell Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Canyon Hill	11-5 1921

20. UNDERTAKER	ADDRESS
CASE FURNITURE CO.	Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
NOV 30 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 9

Primary Registration District No. 1005

File No. 35959

Registered No. 112

County of Canyon

City of Caldwell (If outside limits, give township) St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Henry Enoch Carter

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH: July (Month) 23 (Day) 1846 (Year)

7. AGE: 75 Yrs. 3 Mos. 8 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Minister
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Maine

10. NAME OF FATHER: Benjamin Carter

11. BIRTHPLACE OF FATHER (State or Country): Maine

12. MAIDEN NAME OF MOTHER: Tavilla Jane

13. BIRTHPLACE OF MOTHER (State or Country): Maine

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs W H Yarnall
(Address) 206 Everett

15. Filed Nov. 2 1921 John L. Meeser Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 31 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 6 1921, to Oct 31 1921
that I last saw him alive on Oct 30 1921
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Influenza

(Duration) ..... Yrs. ..... mos. 10 ds.
Contributory (Secondary) Senile Pneumonia
(Duration) ..... yrs. 4 mos. ..... ds.

(Signed) W. Kaley M. D.
11-1 1921 (Address) Caldwell Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Canyon Hill	11-2-1921
20. UNDERTAKER: Case Furn. Co.	ADDRESS: Caldwell, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. [illegible]-A—25 M. 1-19.

RECEIVED
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BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH — Registration District No. 3
County Canyon — Primary Registration District No. 2005
City of Caldwell (Ward ..... St.)
File No. 35960
Registered No. 111
If death occurs away from usual residence, give facts called for under special information.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ella A. Horn

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: married (Write the word.)

6. DATE OF BIRTH: May (Month) 23 (Day) 1878 (Year)

7. AGE: 43 Yrs. 5 Mos. 7 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kansas

10. NAME OF FATHER: Wm E. Meason

11. BIRTHPLACE OF FATHER (State or Country): Penn

12. MAIDEN NAME OF MOTHER: Rebecca L. Ryan

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. L. Horn
(Address) R. 2.

15. Filed Oct 31 1921 — John V. Meyer — Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 30 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 23 1921 to Oct 30 1921 that I last saw h[illegible] alive on Oct 29 1921, and that death occurred on the date stated above, at 6 A.M.

The CAUSE OF DEATH* was as follows:
Cancer of Liver —
(Duration) 2 Yrs. mos. ds.
Contributory (Secondary) Cancer Breast
(Duration) 2 yrs. mos. ds.

(Signed) T. L. Jones M. D.
10/31 1921 (Address) Caldwell Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill — DATE OF BURIAL: 10/ 1 1921

20. UNDERTAKER: Caldwell Co. — ADDRESS: Caldwell Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
NOV 30 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 9
Primary Registration District No. 2005
File No. 35961
Registered No. 110

County of Canyon
City of Caldwell (or) Village of ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Anna May Northrup

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: married (Write the word.)

6. DATE OF BIRTH: May (Month) 19 (Day) 1 (Year)

7. AGE: 28 Yrs. 5 Mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Washington

10. NAME OF FATHER: C. E. Sliderberg

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Martha Dreher

13. BIRTHPLACE OF MOTHER (State or Country): Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. M. Northrup
(Address)

15. Filed Oct. 25 1921 — John L. Meyer, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 23 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 19 1921, to Oct 23 1921, that I last saw her alive on Oct 22 1921, and that death occurred on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Puerperal septicemia

..... (Duration) ..... Yrs. ..... mos. 4 ds.

Contributory (Secondary) Abortion

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A. B. Bond M. D.

Oct. 1921 (Address) Wilder Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Orchard Walk — DATE OF BURIAL: 10-27 1921

20. UNDERTAKER: CASE FURNITURE CO. — ADDRESS: Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED NOV 30 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Canyon Registration District No. 3
City of Caldwell (or Village or Township) Registration District No. 1005 St.)
File No. 35962
Registered No. 109

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lila Mary Gilbaugh

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6. DATE OF BIRTH: Nov. (Month) 13 (Day) 1895 (Year)

7. AGE: 25 Yrs. 11 Mos. 6 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: John F. Caldwell

11. BIRTHPLACE OF FATHER (State or Country): Utah.

12. MAIDEN NAME OF MOTHER: Hala A. Robins

13. BIRTHPLACE OF MOTHER (State or Country): Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. E. Gilbaugh
(Address) Caldwell Idaho

15. Filed Oct. 21 1921 John C. Meyer. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. (Month) 19 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from October 2 1921, to October 19 1921, that I last saw h[illegible] alive on October 19 1921, and that death occurred on the date stated above, at 9:10 A.M.

The CAUSE OF DEATH* was as follows:

Puerperal septicemia

Serious 17

(Duration) ..... Yrs. ..... mos. 17 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Carl Warner M. D.O.
Oct. 1921 (Address) Caldwell, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill — DATE OF BURIAL: 10-21 1921

20. UNDERTAKER: C. V. Peckham — ADDRESS: Caldwell.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED NOV 30 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 3

Primary Registration District No. 2005

File No. 35963

County of Canyon

City of Wilder (St.)

Registered No. 107

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Samuel Austin Thompson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
male	white	Married

6. DATE OF BIRTH: Nov (Month) 3 (Day) 1868 (Year)

7. AGE: 52 Yrs. 11 Mos. 14 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Nevada

10. NAME OF FATHER: Samuel C. Thompson

11. BIRTHPLACE OF FATHER (State or Country): Tennessee

12. MAIDEN NAME OF MOTHER: Carrie Stems

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Julia K. Thompson (Mrs.)
(Address) Wilder Idaho

15. Filed Oct. 19 1921 Jos. L. Meyer Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 17 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 15 1921, to Oct 17 1921, that I last saw him alive on Oct 17 1921, and that death occurred on the date stated above, at 8 A. M.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Autointoxication

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A. Board M. D.

19..... (Address) Wilder Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Canyon Hill	10-19 1921
20. UNDERTAKER: E. V. Peckham	ADDRESS: Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED
NOV 30 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 2005
File No. 35964
Registered No. 106

1. PLACE OF DEATH
County of Canyon
City of Homedale (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Fred Stanage Wilson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: (Write the word) single

6. DATE OF BIRTH: Nov. 10 (Month) (Day) 1900 (Year)

7. AGE: 20 Yrs. 11 Mos. 6 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Oregon

10. NAME OF FATHER: J. H. Wilson

11. BIRTHPLACE OF FATHER (State or Country): Illinois

12. MAIDEN NAME OF MOTHER: Rachael E. Sullivan

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Morgan H. Wilson
(Address) Homedale, Ida.

15. Filed Oct. 19 1921 — Jos. S. Meyers, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct 16 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 8 1921 to Oct 16 1921, that I last saw h. alive on Oct 16 1921, and that death occurred on the date stated above, at 11:50 P.M.
The CAUSE OF DEATH* was as follows:

Septic Peritonitis

(Duration) ..... Yrs. ..... mos. 10 ds.
Contributory (Secondary) Ruptured Appendix
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) S. B. Dudley M. D.
19..... (Address) Caldwell Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Canyon Hill	10-19 1921

20. UNDERTAKER	ADDRESS
[illegible]	Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
NOV 30 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Canyon Registration District No. 3
Primary Registration District No. 2002
File No. 35965
City of Nampa (If outside limits, give township) St.)
Registered No. 104

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Thelma Martha Halliday

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Married

6. DATE OF BIRTH: March 1st 1902 (Month) (Day) (Year)

7. AGE: 19 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House Wife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): California

10. NAME OF FATHER: Chas. Sulden Simpson

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Hanna L. Johnston

13. BIRTHPLACE OF MOTHER (State or Country): Western Australia North Hampton

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. J. Halliday
(Address) Middleton Idaho

15. Filed Oct. 9 1921 John S. Meyers Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 8 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 20 1921, to Oct 8 1921, that I last saw her alive on Oct 7 1921, and that death occurred on the date stated above, at 2-45a M.
The CAUSE OF DEATH* was as follows:

Epilepsy

(Duration) Yrs. mos. 9 ds.
Contributory (Secondary) Enteritis
(Duration) yrs. mos. ds.

(Signed) A. P. Brock M. D.
Oct 19 21 (Address) Wilder Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Middleton
DATE OF BURIAL: 10-9 1921

20. UNDERTAKER: E. V. Cockham
ADDRESS: Caldwell

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35966
Registered No. 104

RECEIVED
NOV 30 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
Registration District No. 3
Primary Registration District No. 1004
County of Canyon
City of Caldwell (If outside limits, give township) St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ernest Raymond Wagoner

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: 10 (Month) 8 (Day) 1921 (Year)

7. AGE: ....Yrs. ....Mos. 1 ds.
IF LESS than 1 day how many ....hrs. or ....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work:
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Caldwell

10. NAME OF FATHER: R D Dilley

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Fern McCormick

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): [illegible]
(Address): [illegible]

15. Filed Oct. 12 1921 — John S. Meyers — Local Registrar

SUNS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 10 (Month) 8 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 8 1921, to Oct 8 1921, that I last saw ... alive on ... 1921, and that death occurred on the date stated above, at ....M.
The CAUSE OF DEATH* was as follows:

Stillborn

....(Duration) ....Yrs. ....mos. ....ds.
Contributory (Secondary)
....(Duration) ....yrs. ....mos. ....ds.

(Signed) C M Dilley M. D.
10-9 1921 (Address) Caldwell Ida

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs. ....mos. ....days. In the State ....yrs. ....mos. ....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: [illegible] — DATE OF BURIAL: 10-8 1921

20. UNDERTAKER: CASE FURNITURE CO. — ADDRESS: Caldwell

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35967

Registered No. 103

RECEIVED
NOV 30 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 3

Primary Registration District No. 2005

County of Canyon

City of Greenleaf (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Thos Rudolph Potter

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married

6. DATE OF BIRTH: May 1 1852 (Month) (Day) (Year)

7. AGE: 71 Yrs. 2 Mos. 6 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New York.

10. NAME OF FATHER: C. W. Potter.

11. BIRTHPLACE OF FATHER (State or Country): New York.

12. MAIDEN NAME OF MOTHER: Polly Owen

13. BIRTHPLACE OF MOTHER (State or Country): Wisconsin.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Jas L Rapp
(Address): Greenleaf Idaho

15. Filed Oct 9 1921

John S. Meyer
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 7 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 7 1921, to ..... 19....., that I last saw him alive on Oct 7 1921, and that death occurred on the date stated above, at 6.30 A.M.,

The CAUSE OF DEATH* was as follows:

microdyctus

(Duration) ..... Yrs. ..... mos. 1 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A. B. Beach M. D.

..... 19..... (Address) Wilder Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Greenleaf Ida — DATE OF BURIAL: 10-9 1921

20. UNDERTAKER: E. V. Beckham — ADDRESS: Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED NOV 30 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 117
Primary Registration District No. 2196
File No. 35968
Registered No. 342

1. PLACE OF DEATH

County of Cassia
City of Burley (No. of St. Paul Ida. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Henry Feusternmaker

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Jan (Month) 24 (Day) 1898 (Year)

7. AGE: 23 Yrs. 7 Mos. 17 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Fountaineee Utah.

10. NAME OF FATHER: David A. Feusternmaker.

11. BIRTHPLACE OF FATHER (State or Country): Fountaineee Utah.

12. MAIDEN NAME OF MOTHER: Alice A. Lucas.

13. BIRTHPLACE OF MOTHER (State or Country): Salt Lake City Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Alice Feusternmaker.
(Address) Paul Idaho.

15. Filed Sept 8. 11 1921 W. J. Patterson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 10 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 8- 1921, to Sept 10- 1921 that I last saw h[illegible] alive on Sept. 10 - 1921, and that death occurred on the date stated above, at 8 A M.

The CAUSE OF DEATH* was as follows:
Pulmonary Embolism.

..... (Duration) — Yrs. mos. ds.
Contributory (Secondary) Termination Bulbar Paralysis

(Duration) — yrs. — mos. 2 ds.

(Signed) C. S. Soper M. D.
19..... (Address) Burley Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Burley Ida. DATE OF BURIAL: Sept 12 1921

20. UNDERTAKER: L. B. Talloghy. ADDRESS: Burley Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

Franklin

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED NOV 30 1921 BUREAU OF STATISTICS

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 117
County of Cassia Primary Registration District No. 2196
City of Burley (or Village) St.)
File No. 35969
Registered No. 543
If death occurs away from usual residence, give facts called for under special information.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Walter H Coplin

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Aug (Month) 11 (Day) 1875 (Year)

7. AGE: 46 Yrs. 1 Mos. 19 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Samuel Coplin

11. BIRTHPLACE OF FATHER (State or Country): Pa

12. MAIDEN NAME OF MOTHER: Elizabeth Page

13. BIRTHPLACE OF MOTHER (State or Country): Ind

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) James Coplin
(Address) Burley Ida

15. Filed Sept. 30 1921 W. J. C. Patterson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 30 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 28 - 1921, to Sept 30 1921, that I last saw him alive on Sept 28 - 1921, and that death occured on the date stated above, at ____ M.

The CAUSE OF DEATH* was as follows: Carcinoma Stomach

(Duration) ____ Yrs ____ mos. ____ ds.

Contributory (Secondary) Don't know

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) Fremont Peterson M. D.

19..... (Address) Burley Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Pleasant View Cemetery — DATE OF BURIAL: Oct 3 1921

20. UNDERTAKER: Kay Grant — ADDRESS: Burley Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED NOV 30 1921 BUREAU OF STATISTICS

CERTIFICATE OF DEATH.

Cutler

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 117
Primary Registration District No. 2196

File No. 35970
Registered No. 344

1. PLACE OF DEATH.
County of Cassia
City of Burley (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William Murray Guthrie

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE:
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.):

6. DATE OF BIRTH. Oct (Month) 1 (Day) 1918 (Year)

7. AGE: 2 Yrs. 11 Mos. 22 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: .....
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Earl Guthrie

11. BIRTHPLACE OF FATHER (State or Country): Colo

12. MAIDEN NAME OF MOTHER: Eula Quinn

13. BIRTHPLACE OF MOTHER (State or Country): Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Earl Guthrie
(Address) Burley Ida

15.
Filed Sept 24 1921 W. J. Patterson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 23 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 23 1921, to Sept 23 1921, that I last saw him alive on Sept 23 1921, and that death occured on the date stated above, at 6-0 P.M.

The CAUSE OF DEATH* was as follows:

Burned to Death

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) T. H. Cutler M. D.

19 ..... (Address) Burley

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Albion Ida — DATE OF BURIAL: Sept 25 1921

20. UNDERTAKER: Rowan — ADDRESS: Burley Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SORS. 24658

FORM V. S. No. 5-25 M. 1-16-12

RECEIVED
NOV 30 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 117

Primary Registration District No. 2196

File No. 35972

Registered No. 546

County of Cassia

City of Burley (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Robert Paul Booth

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write one word.): Single

6. DATE OF BIRTH. September 7 (Month) (Day) 1920 (Year)

7. AGE: 1 Yrs. 0 Mos. 5 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...

(b) General nature of industry, business, or establishment in which employed (or employer)...

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Geo E Booth

11. BIRTHPLACE OF FATHER (State or Country): New Mex

12. MAIDEN NAME OF MOTHER: Carolyn Worthington

13. BIRTHPLACE OF MOTHER (State or Country): Ut

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo E Booth

(Address) Burley Ida

15. Filed Sept. 7 1921

L. J. C. Parthesius
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 7 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1st 1921, to Sept. 7 1921, that I last saw him alive on Sept. 7 1921 and that death occured on the date stated above, at 2 P M.

The CAUSE OF DEATH* was as follows:

Ileo-Colitis

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

..... (Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) A D Smith M. D.

10/7 1921 (Address) Burley Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Pleasant View Cemetery — DATE OF BURIAL: 191

20. UNDERTAKER: R W Watt — ADDRESS: Burley Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED NOV 30 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35973
Registered No. 341

1. PLACE OF DEATH
County of Cassia — Registration District No. 117
City of Burley — Primary Registration District No. 2196
(If not in city or village give township) 211 E. 2nd St. (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Helen Virginia Boyle

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Single

6. DATE OF BIRTH: June (Month) 12 (Day) 1917 (Year)

7. AGE: 4 Yrs. 3 Mos. 22 ds. — IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Salt Lake City Utah

10. NAME OF FATHER: Jack Boyle

11. BIRTHPLACE OF FATHER (State or Country): Logan Utah

12. MAIDEN NAME OF MOTHER: Lilla McCulloch

13. BIRTHPLACE OF MOTHER (State or Country): Logan Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jack Boyle
(Address) 211 E. 2nd St. Burley Ida.

15. Filed Oct-7 1921 — Dr. J. Patterson, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 6 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 5th 1921, to Oct 6 1921, that I last saw her alive on Oct 6 1921 and that death occurred on the date stated above, at 1:30 P.M.

The CAUSE OF DEATH* was as follows:

Acute Nephritis (Paranchymatous)

Don't Know
(Duration) — Yrs. — mos. — ds.

Contributory (Secondary) Don't Know
(Duration) — yrs. — mos. — ds.

(Signed) C. H. Cooper M. D.

19 (Address) Burley Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Burley Ida.	Oct 6 1921

20. UNDERTAKER	ADDRESS
L. B. Talloyd	Burley Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35974
Registered No. 548
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

RECEIVED
NOV 30 1921
BUREAU OF VITAL STATISTICS

Registration District No. 117
Primary Registration District No. 2196

1. PLACE OF DEATH
County of Cassia
City of Burley
If death occurs away from usual residence, give facts called for under special information.
(Ward, ..., 329 So. Albion Ave. St.)

2. FULL NAME Weston Rolph Snow

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. April 30 1909
(Month) (Day) (Year)

7. AGE: 12 Yrs. 6 Mos. 1 ds.
IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: In School
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Provo Utah

10. NAME OF FATHER: Dominicus R. Snow

11. BIRTHPLACE OF FATHER (State or Country): Provo Utah

12. MAIDEN NAME OF MOTHER: Mary M. Boschardt

13. BIRTHPLACE OF MOTHER (State or Country): Park City Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) D. R. Snow - 329 - So. Albion
(Address) Burley Ida.

15. Filed Nov. 1 1921 Dr. J. C. Patterson
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. 31 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 16 1921 to Oct. 31 1921
that I last saw ~~him~~ alive on Oct. 30 1921
and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:
Pericarditis
(Duration) ..... Yrs. ~~one~~ mos. ..... ds.

Contributory (Secondary)
(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) J. C. Patterson M. D.
Nov. 1 1921 (Address) Burley, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Provo Utah — DATE OF BURIAL: Nov. 3 1921

20. UNDERTAKER: L. B. Colloggy — ADDRESS: Burley Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

35977

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Cassia — Registration District No. 12

City of Oakley — Primary Registration District No. 2199 — 1 — St.)

File No. XVII

Registered No. 22

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
DEC 10 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME ANDY HOGE

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Nov. (Month) 24 (Day) 1878 (Year)

7. AGE: 42 Yrs. 11 Mos. 23 ds.

IF LESS than 1 day how many..... hrs. or.....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Miner

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Germany.

10. NAME OF FATHER: Not obtainable

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jesse L. Rains

(Address) Oakley Ida.

15. Filed Dec 4 19 21 — W. D. Wilson, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 16 (Day) 19 21 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 15 19 21 to Nov. 16 19 21 that I last saw him alive on Nov. 16 19 21, and that death occurred on the date stated above, at 4:30 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Embolism?

.....(Duration) .....Yrs. .....mos. .....ds.

Contributory (Secondary) Acute bronchitis

.....(Duration) .....yrs. .....mos. .....ds.

(Signed) Jesse L. Rains M. D.

11/16 19 21 (Address) Oakley Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Burley Ida — DATE OF BURIAL: Holding body 19

20. UNDERTAKER: L. B. Galloway. — ADDRESS: Burley Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

35978 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 1414
Registered No. 19

Registration District No. 12
Registrar's Registration District No. 3199
No. ... St.)

RECEIVED
DEC 10 1921
BUREAU OF VITAL STATISTICS

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Canyon
City of Caldwell
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lance Bach

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH. Oct. (Month) 24 (Day) 1921 (Year)
7. AGE ... Yrs. ... Mos. ... ds. IF LESS than 1 day how many ... hrs. or 3 min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer): —
9. BIRTHPLACE (State or Country): Idaho
10. NAME OF FATHER: Allen Bach
11. BIRTHPLACE OF FATHER (State or Country): Idaho
12. MAIDEN NAME OF MOTHER: Agnes Colette
13. BIRTHPLACE OF MOTHER (State or Country): Wash
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Allen Bach
(Address) Caldwell Ida
15. Filed Dec 4 1921 W. O. Nelson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 24 (Day) 1921 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Oct 24 1921, to Oct 24 1921, that I last saw h alive on Oct. 24 1921 and that death occured on the date stated above, at 7P M.
The CAUSE OF DEATH* was as follows:
Pneumonia Chl
(Duration) ... Yrs. ... mos. ... ds.
Contributory (Secondary)
(Duration) ... yrs. ... mos. ... ds.
(Signed) W. O. Nelson M. D.
12/25 1921 (Address) Caldwell Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions Transients or Recent Residents.)
At place of death ... yrs ... mos ... days. In the State ... yrs ... mos ... days
Where was disease contracted if not at place of death? ...
Former or usual residence ...

19. PLACE OF BURIAL OR REMOVAL: Caldwell Ida — DATE OF BURIAL: Dec 6 1921
20. UNDERTAKER: Allen Bach — ADDRESS: Caldwell Ida

SYMS - YORK CO., PTRS. & BORS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

35970

Registration District No. 120

Primary Registration District No. 199

File No. XVII

Registered No. 31

1. PLACE OF DEATH.

County of Cassia

City of Oakley (No. St.)

If death occurs away from usual residence, give facts called for under special information.

DEC 10 1917
BUREAU OF VITAL STATISTICS

2. FULL NAME Orlando Lafayette Lee

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): widower

6. DATE OF BIRTH. Dec (Month) 12 (Day) 1839 (Year)

7. AGE: 78 Yrs. 10 Mos. 15 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: Lysander Lee

11. BIRTHPLACE OF FATHER (State or Country): Illinois

12. MAIDEN NAME OF MOTHER: Amanda Sayers

13. BIRTHPLACE OF MOTHER (State or Country): U S

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Emma Lee

(Address)

15. Filed Dec 4 1917

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 2 (Day) 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at 8 A M.

The CAUSE OF DEATH* was as follows:

No Physician

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary)

(Duration ... yrs. ... mos. ... ds.

(Signed): ... M. D.

19... (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Oakley Idaho — DATE OF BURIAL: Dec 4 1917

20. UNDERTAKER: [signature] — ADDRESS: Oakley Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SVMS - YORK CO., PTRS. & SORS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35980

Registered No. .....

1. PLACE OF DEATH.

County of Cassia

City of Burley (If not in incorporated limits, give township.) St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ramnaldo Corsi

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

Registration District No. .....

Primary Registration District No. .....

DEC 1921
BUREAU OF VITAL STATISTICS

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. May (Month) 20 (Day) 1861 (Year)

7. AGE: 60 Yrs. 5 Mos. 20 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Farmer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Italy

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (State or Country) Italy

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (State or Country) Italy

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Minnie Corsi
(Address) Burley Idaho

15. Filed Nov 9 1921 — G. I. Salin, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 9 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 6 1921, to Nov 9 1921, that I last saw h[illegible] alive on Nov 8 1921, and that death occured on the date stated above, at 11:30 A.M.

The CAUSE OF DEATH* was as follows:
Infection due to injury to finger

(Duration) ..... Yrs. ..... mos. 10 ds.

Contributory (Secondary) None

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) G. I. Salin M. D.
11/9 1921 (Address) Malta Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 3 yrs. ..... mos. ..... days. In the State 40 yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? At place of death
Former or usual residence Same

19. PLACE OF BURIAL OR REMOVAL: Malta — DATE OF BURIAL: Nov 11 1921

20. UNDERTAKER: None — ADDRESS: —

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24658

FORM V. S. No. 5-12 M. 6-15-17.

Cooper.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33581
Registered No. 349

RECEIVED
DEC 1 1921
BUREAU OF VITAL STATISTICS

Registration District No. 11.7
Primary Registration District No. 2196

1. PLACE OF DEATH
County of Cassia
City of Burley
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Rosie E. Timm

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. March 5 1883 (Month) (Day) (Year)

7. AGE: 38 Yrs. 7 Mos. 29 ds.
IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Silverton Oregon

10. NAME OF FATHER: Henry Otjen

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Anna Staley

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Henry Timm
(Address) R.F.D. St. Paul Ida.

15. Filed 11-5-21 191.... Dr. J. C. Patterson Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. 3rd 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 26 1921 to Nov. 3 1921
that I last saw h[illegible] alive on Nov. 3 1921
and that death occurred on the date stated above, at 4:00 P.M.

The CAUSE OF DEATH* was as follows:
Pneumonia Lobar
(Duration) Yrs. mos. 4 ds.
Contributory (Secondary)
(Duration) Yrs. mos. ds.
(Signed) C. H. Dopp M. D.
Nov. 5. 1921 (Address) Burley Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mt Angle Oregon. DATE OF BURIAL .... 191...

20. UNDERTAKER: L.D. Talcott ADDRESS: Burley Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-12 M. 6-15-17.

RECEIVED DEC 1 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

35982

Cremated,

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 551
Registered No. 5.5.1
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Cassia

Registration District No. 117

Primary Registration District No. 2196

City of Burley

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Oscar Donald Tiersich

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male.	White.	Single

6. DATE OF BIRTH. Nov. 5 1914
(Month) (Day) (Year)

7. AGE 6 Yrs. 11 Mos. 14 ds.

IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: In School.
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Bountiful Utah.

10. NAME OF FATHER William R. Tiersich.

11. BIRTHPLACE OF FATHER (State or Country) Park City Utah.

12. MAIDEN NAME OF MOTHER Annie Kramer.

13. BIRTHPLACE OF MOTHER (State or Country) Salt Lake City Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) William R. Tiersich

(Address) R.F.D. #3. Burley Ida.

15. Filed Dec. 2 1921 W. J. Patterson Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. 19 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 19 1921 to Oct 19 1921 that I last saw him alive on Oct 19 1921 and that death occurred on the date stated above, at 11:30 P. M.

The CAUSE OF DEATH* was as follows:

Sour Krout

(Duration) — Yrs. — mos. — ds.

Contributory (Secondary)

(Duration) — Yrs. — mos. — ds.

(Signed) J. Fremstad M. D.

19.. (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Cedar Idaho. — **DATE OF BURIAL** Oct. 21 1921.

20. UNDERTAKER L.D. Seeley. — **ADDRESS** Burley Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

35983 Cutler

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. .....
Registered No. 552
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Cassia
City of Burley
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 117
Primary Registration District No. 2196
(No. 256 W. Seventh St. St.)

2. FULL NAME Sherman Devane Jones.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Sing(le)

6. DATE OF BIRTH. Dec. (Month) 27 (Day) 1920. (Year)

7. AGE: Yrs. 10 Mos. 7 ds.
IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION,
(a) Trade, profession or particular kind of work: At Home.
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Burley Ida.

10. NAME OF FATHER: Cyrus Jones.

11. BIRTHPLACE OF FATHER (State or Country): Elba Ida.

12. MAIDEN NAME OF MOTHER: Mattie Hill.

13. BIRTHPLACE OF MOTHER (State or Country): Afton Wyoming.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Cyrus Jones
(Address) Burley Ida.

15. Filed Dec. 2 1921 W. J. Patterson Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. (Month) 3 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 28 1921 to Nov 3 1921 that I last saw him alive on Nov 3 1921 and that death occurred on the date stated above, at 7:30 a. M.

The CAUSE OF DEATH* was as follows:

Enteritis

(Duration) .... Yrs. .... mos. 10 ds.

Contributory (Secondary)

(Duration) .... Yrs. .... mos. .... ds.

(Signed) J. W. Cutler M. D.

19.... (Address) Burley

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs....mos....days. In the State....yrs....mos....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Burley Ida.

DATE OF BURIAL: Nov. 6-1921.

20. UNDERTAKER: L. B. Gallogly.

ADDRESS: Burley Ida.

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

35984 Cooper

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. .....
Registered No. 553
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

Registration District No. 117
Primary Registration District No. 2196
(No. 122 E. Miller St.)

1. PLACE OF DEATH
County of Cassia
City of Burley
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Thos. Colvin Murray.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Dec. (Month) 14 (Day) 1853. (Year)

7. AGE: 67 Yrs. 10 Mos. 21 ds.
IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Lodging House Prop.
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Clinton Mo.

10. NAME OF FATHER George Murray.

11. BIRTHPLACE OF FATHER (State or Country) Unknown.

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country) Va.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Bessie A. Murray.
(Address) Albion Idaho.

15. Filed Dec 2 1921 J. C. Patterson Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. (Month) 4. (Day) 1921. (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 1 1921 to Nov. 4 1921 that I last saw him alive on Nov. 4 1921 and that death occurred on the date stated above, at 10:0 A. M.

The CAUSE OF DEATH* was as follows:
Cancer of Stomach
(Duration) 2 Yrs. — mos. — ds.

Contributory (Secondary)
(Duration) — Yrs. — mos. — ds.

(Signed) [signature] M. D.
19.... (Address) Burley Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Burley Ida.
DATE OF BURIAL: Nov 6. 1921

20. UNDERTAKER: L. B. Gallogly.
ADDRESS: Burley Ida

FORM V. S. No. 5-12 M. 6-15-17.

Cooper. L

CERTIFICATE OF DEATH

35985 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. .....
Registered No. 554

RECEIVED
DEC 1 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Cassia
Registration District No. 117
Primary Registration District No. 2196
City of Burley
If death occurs away from usual residence, give facts called for under special information.
(If not in hospital or institution, give usual residence. If in hospital or institution, give its location. If transient or recent resident, write "Transient" or "Recent Resident," as case may be, and give usual residence. If in hospital or institution, give last residence before entering.)
No. 252 N. Elba St.)
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Arduse Mairian Benson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Aug. 23. 1915
(Month) (Day) (Year)

7. AGE: 6 Yrs. 2 Mos. 15 ds.
IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At School
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Oakley Ida.

10. NAME OF FATHER: John Franklin Benson

11. BIRTHPLACE OF FATHER (State or Country): United States

12. MAIDEN NAME OF MOTHER: Estella May Wilcox

13. BIRTHPLACE OF MOTHER (State or Country): Oakley Ida.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. F. Benson
(Address) 152 N. Elba Ave. Burley

15. Filed Dec. 2 1921
Dr. J. C. Vatthauer
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Nov. 7 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 5 1921 to Nov. 7 1921
that I last saw h.....alive on .....191....
and that death occurred on the date stated above, at 7:00 P. M.

The CAUSE OF DEATH* was as follows:
Embar Pahalyan
(Duration) ..... Yrs. ..... mos. 1.0. ds.
Contributory (Secondary) Appendicitis
(Duration) ..... Yrs. ..... mos. 1.0. ds.

(Signed) C. C. Cooper M. D.
19.... (Address) Burley Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Burley Ida. DATE OF BURIAL: Nov. 9—1921.

20. UNDERTAKER: L. B. Talloyay ADDRESS: Burley Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-12 M. 6-15-17.

RECEIVED DEC 7 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

35986 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. .....
Registered No. 555
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Cassia
Registration District No. 117
Primary Registration District No. 2196
City of Burley
If death occurs away from usual residence, give facts called for under special information.
(No. ....., ... St.)

2. FULL NAME James Henry Satterley

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Oct. (Month) 2 (Day) 1857 (Year)

7. AGE: 70 Yrs. 1 Mos. 11 ds.
IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Common Laborer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Beaver Dam Wisc.

10. NAME OF FATHER: William Satterley

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wm. Satterley
(Address) Box 257 Burley Ida.

15. Filed Dec 7 1921 Dr. J. C. Pattison
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 13 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191.... to .....191...
that I last saw h.....alive on .....191....
and that death occurred on the date stated above, at .....M.
The CAUSE OF DEATH* was as follows:
Old Age & Rheumatism
.....(Duration) ..... Yrs..... mos. ..... ds.
Contributory (Secondary) .....
.....(Duration) ..... Yrs..... mos. ..... ds.
(Signed) L.B. Gallogly = Coroner ~~M. D.~~
11/15/1921. (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the ,State....yrs....mos....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Burley Ida. DATE OF BURIAL: 11/15/1921

20. UNDERTAKER: L.B. Gallogly. ADDRESS: Burley Ida.

Patterson.

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

35987

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. .....
Registered No. 5.5.7.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Cassia
City of Burley.
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 117
Primary Registration District No. 2196
(No. 345 So. Normal St.)

2. FULL NAME Hans C. Christopherson.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. 6. Oct (Month) (Day) 1857 (Year)

7. AGE: 64 Yrs. 1 Mos. 20 ds.
IF LESS than 1 day how many .... hrs. or .....min.?'

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Denmark.

10. NAME OF FATHER: Jones Christopherson

11. BIRTHPLACE OF FATHER (State or Country): Denmark.

12. MAIDEN NAME OF MOTHER: Kedvena. Olsen.

13. BIRTHPLACE OF MOTHER (State or Country): Denmark.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Meredith Christopherson.
(Address): Hazelton Idaho.

15. Filed Dec. 2 1921. Dr. J. C. Patterson Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 26. (Day) 1921. (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 26 1921. to Nov. 26. 1921.
that I last saw h~~e~~ alive on Nov. 26 1921.
and that death occurred on the date stated above, at 2.45 P. M.

The CAUSE OF DEATH* was as follows:
Cirhosis of liver

(Duration) ..... Yrs. Indefinite ds.

Contributory (Secondary)

(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

11-27-1921. (Address) J. C. Patterson

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Burley Idaho. DATE OF BURIAL: 11/29/1921.

20. UNDERTAKER: L. D. Toevsey. ADDRESS: Burley Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-12 M. 6-15-17.

35988 Part 1.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 117
Primary Registration District No. 2196
(No. ....., ... St.)

File No. .....
Registered No. 556.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Cassia
City of Decks
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James Sidney Cooley

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Feb (Month) 14 (Day) 1872 (Year)

7. AGE: 49 Yrs. 8 Mos. 19 ds.
IF LESS than 1 day how many .... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Grantsville Utah

10. NAME OF FATHER: John William Cooley

11. BIRTHPLACE OF FATHER (State or Country): New York City

12. MAIDEN NAME OF MOTHER: Nancy J. Hunt

13. BIRTHPLACE OF MOTHER (State or Country): Tenn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Minnie Cooley
(Address) Decks Ida.

15. Filed Dec. 2 1921 Dr. J. C. Patterson Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 5 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 15 1921 to Nov. 5 1921 that I last saw h.. alive on Nov. 4 1921 and that death occurred on the date stated above, at 5:30 a. M.

The CAUSE OF DEATH* was as follows:
Cancer R. Stomach
(Duration) ..... Yrs. several mos. ..... ds.

Contributory (Secondary)
(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) J. C. Patterson M. D.
11-6 1921 (Address) Burley Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the ,State....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Decks Idaho — DATE OF BURIAL: Nov. 7 1921

20. UNDERTAKER: L. B. Talleggy — ADDRESS: Burley Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35989
Registered No. .....

RECEIVED
NOV 30 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH.
Registration District No. 119
County of Cassia
Primary Registration District No. .....
City of Albion St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Eliza H Peck

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH.
Dec (Month) 22 (Day) 1880 (Year)

7. AGE
40 Yrs. 11 Mos. 23 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Dress Maker
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Salt Lake Cy Utah

10. NAME OF FATHER: Jacob Hunter

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Mary Shafer

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Edith Coates
(Address) Rockland Idaho

15.
Filed Nov 30 1921 C J Salter
Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Nov (Month) 29 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 27 1921 to Nov 29 1921, that I last saw her alive on Nov 28 1921 and that death occured on the date stated above, at 12:20 P.M.
The CAUSE OF DEATH* was as follows:
Chronic Brights disease
.....
.....
(Duration) ..... Yrs. 8 mos. ..... ds.
Contributory (Secondary) Gastric ulcer
(Duration) 2 yrs. ..... mos. ..... ds.
(Signed) C. J. Salter M. D.
11/30 1921 (Address) Malta Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death. 4 yrs. ..... mos. ..... days. In the State 12 yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? At place of death
Former or usual residence Albion Idaho

19. PLACE OF BURIAL OR REMOVAL: Albion Idaho
DATE OF BURIAL: 12/1 1921

20. UNDERTAKER: None
ADDRESS: —

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

RECEIVED
NOV 30 1921
BUREAU OF VITAL STATISTICS

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 119
Primary Registration District No.
File No. 35990
Registered No.

1. PLACE OF DEATH.
County of Cassia
City of Standrod (No. St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Maggie May Barnes

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. May (Month) 20 (Day) 1921 (Year)

7. AGE: Yrs. 4 Mos. 28 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Standrod Utah

10. NAME OF FATHER: May Curtis Barnes

11. BIRTHPLACE OF FATHER (State or Country): Salt Lake Utah

12. MAIDEN NAME OF MOTHER: Rosetta Amelia Hempton

13. BIRTHPLACE OF MOTHER (State or Country): Kelton Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant)
(Address)

15. Filed ..... 191.....
C. I. Bates
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 17 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 12 1921, to Oct 17 1921, that I last saw h. alive on Oct. 15 1921, and that death occured on the date stated above, at 4 P M.

The CAUSE OF DEATH* was as follows:
Cholera Infantum

(Duration) ..... Yrs. ..... mos. 5 ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. I. Bates M. D.
Oct 18 1921 (Address) Malta Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. 4 mos. 28 days. In the State ..... yrs. 4 mos. 28 days.
Where was disease contracted if not at place of death? At place of death.
Former or usual residence Same

19. PLACE OF BURIAL OR REMOVAL: Standrod Idaho — DATE OF BURIAL: Oct. 18 1921

20. UNDERTAKER: None — ADDRESS

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35991
Registered No. .....

RECEIVED
NOV 30 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH. Registration District No. .....
County of Cassia Primary Registration District No. .....
City of Almo ..... St.)
If death occure away from usual residence, give facts called for under special information.

2. FULL NAME Izene Belnap

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White American
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: March 20 (Month) 1910 (Day) (Year)

7. AGE: 11 Yrs. 6 Mos. 23 ds. IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work... None, at home
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Millville Cache Co, Utah

10. NAME OF FATHER Henry Belnap

11. BIRTHPLACE OF FATHER (State or Country) Hooper Utah

12. MAIDEN NAME OF MOTHER Ida Loveland

13. BIRTHPLACE OF MOTHER (State or Country) Brigham City Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Henry Belnap
(Address) Almo Idaho

15. Filed Dec 1 1921 C. P. Sales Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 13 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 5 1911, to Oct 13 1921, that I last saw h[illegible] alive on Oct 14 1921, and that death occured on the date stated above, at 10 15 A.M.

The CAUSE OF DEATH* was as follows: Valvular heart disease

(Duration) 7 Yrs. ..... mos. ..... ds.
Contributory (Secondary) None
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) ..... M. D.
19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death? At place of death
Former or usual residence Same

19. PLACE OF BURIAL OR REMOVAL: Almo Idaho — DATE OF BURIAL: Oct 16 1921

20. UNDERTAKER: Glogoly Body Idaho — ADDRESS:

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

STAR - YORK CO., PTRS. & STRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35992
Registered No. .....

RECEIVED
NOV 30 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH.
County of Cassia Registration District No. .....
City of Almo Primary Registration District No. .....
No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Thomas Owen King

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed
6. DATE OF BIRTH. April (Month) 27 (Day) 1840 (Year)
7. AGE: 81 Yrs. 6 Mos. 20 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work... Rancher
(b) General nature of industry, business, or establishment in which employed (or employer).....
9. BIRTHPLACE (State or Country) Cambridgeshire, England
10. NAME OF FATHER Thomas King
11. BIRTHPLACE OF FATHER (State or Country) Cambridgeshire, England
12. MAIDEN NAME OF MOTHER Hannah Tapfield
13. BIRTHPLACE OF MOTHER (State or Country) Cambridge England
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) T. Owen King Jr.
(Address) Almo, Idaho
15. Filed Dec 1 1921 C. F. Sater Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Nov. (Month) 16 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 2 1921, to Nov 16 1921, that I last saw h.... alive on Nov 2 1921, and that death occured on the date stated above, at 2:15 P.M.

The CAUSE OF DEATH* was as follows:
Bronchitis (acute)
(Duration) ..... Yrs. 1 mos. ..... ds.
Contributory (Secondary) None
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) C. F. Sater M. D.
11/7 1921 (Address) Hailey Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death? Almo Idaho
Former or usual residence Almo

19. PLACE OF BURIAL OR REMOVAL: Almo Idaho — DATE OF BURIAL: Nov. 20 1921
20. UNDERTAKER — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & SOBS. 24653

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35993
Registered No. 52

RECEIVED
NOV 30 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH. Registration District No. 90
County of Clearwater Primary Registration District No. 2168
City of Orofino (If not in a city give the village or township.) (If in a city, Ward, Idaho Street St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME J. C. Newberry

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed
6. DATE OF BIRTH: July (Month) 16th (Day) 1841 (Year)
7. AGE: 80 yrs. 2 mos. 16 ds. IF LESS than 1 day how many ..... hrs. or ..... min?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired Lawyer
(b) General nature of industry business or establishment in which employed (or employer): Practicing Law
9. BIRTHPLACE (State or Country): Pennsylvania,
10. NAME OF FATHER: Unknown
11. BIRTHPLACE OF FATHER (State or Country): Unknown
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (State or Country): Unknown
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. C. Atteberry
(Address) Orofino, Idaho.
15. Filed Nov 1 1921 J. M. Hawley Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: October (Month) 1st (Day) 1921 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Nov. 17th ~~1921~~, to Oct. 1st 1921 ~~191~~
that I last saw h[im] alive on October 1st 1921
and that death occurred on the date stated above, at 1:45 P. M.
The CAUSE OF DEATH* was as follows:
Arteriosclerosis

..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Insanity,
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) John W. Stevens M. D.
Oct. 1, 1921 (Address) Orofino, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.) about
At place of death ..... yrs. 10 mos. 15 ds. In the State 1 yrs. 7 mos. ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence: Near Moscow, Idaho.

19. PLACE OF BURIAL OR REMOVAL: Moscow Ida — DATE OF BURIAL: Oct 4 1921
20. UNDERTAKER: W. A. Shaw — ADDRESS: Orofino

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35994
Registered No. 53

RECEIVED NOV 30 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH Registration District No. 60
County of Clearwater Primary Registration District No. 2168
City of Orofino (No. North Idaho Sanitarium St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Frank Hurt

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Unknown

6. DATE OF BIRTH: About (Month) (Day) 1852 (Year)

7. AGE: About 69 yrs. mos. ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry business or establishment in which employed (or employer): Mining

9. BIRTHPLACE (State or Country): Wisconsin

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. W. Attebery
(Address) Orofino Idaho

15. Filed Nov 1 1921 Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: October (Month) 3rd (Day) 1921 (Year) ~~191~~

17. I HEREBY CERTIFY, That I attended deceased from Feb. 22nd ~~1910~~ ~~191~~, to Oct 3rd ~~191~~ 1921 that I last saw him alive on Oct. 3rd ~~191~~ 1921 and that death occurred on the date stated above, at 9:05 P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia

..... (Duration) ..... yrs. ..... mos. 10 ds.

Contributory (Secondary) Insanity.

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John W. Stivers M. D.
Oct. 3 1921 (Address) Orofino Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 11 yrs. 7 mos. 12 ds. In the State Over 21 yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence Grangeville, Idaho.

19. PLACE OF BURIAL OR REMOVAL: North Idaho Sanitarium Cem. DATE OF BURIAL: Oct 6 1921

20. UNDERTAKER: J. W. Attebery ADDRESS: Orofino Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5. 12½M.7-24-11

RECEIVED NOV 30 BUREAU

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35995
Registered No. 54

1. PLACE OF DEATH. Registration District No. 60
County of Clearwater Primary Registration District No. 2768
City of Orofino (No. No. Idaho Dane Thies St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Benjiman Jamison

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	~~Single~~

6. DATE OF BIRTH ? (Month) ? (Day) 1890 (Year)

7. AGE 32 yrs. ? mos. ? ds. IF LESS than 1 day how many ? hrs. or ? min?

8. OCCUPATION
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) ?

10. NAME OF FATHER ?

11. BIRTHPLACE OF FATHER (State or Country) ?

12. MAIDEN NAME OF MOTHER ?

13. BIRTHPLACE OF MOTHER (State or Country) ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. W. Attebery
(Address) Orofino Idaho

15. Filed Nov 1 1921 M. Finley Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH October 14 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 5 1920, to October 14 1921 that I last saw h[illegible] alive on October 14 1921 and that death occurred on the date stated above, at 1:30 P. M.

The CAUSE OF DEATH* was as follows:
Pneumonary Tuberculosis

(Duration) ? yrs. mos. ds.
Contributory (Secondary) Insanity
(Duration) ? yrs. mos. ds.

(Signed) J. W. Attebery M. D.
10/14/ 1921 (Address) Orofino Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 1 yrs. 7 mos. 9 ds. In the State ? yrs. mos. ds.
Where was disease contracted, if not at place of death? ?
Former or usual residence Clearwater Co. Ida.

19. PLACE OF ~~BURIAL~~ OR REMOVAL Lapwai Ida DATE OF BURIAL 191

20. UNDERTAKER H. A. Grau ADDRESS Orofino

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

RECEIVED
NOV 30 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35996
Registered No. 67

1. PLACE OF DEATH. Registration District No. 90
County of Clearwater Primary Registration District No. 2468
City of Orofino, (No. Idaho Sanitarium St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME W. D. Burch

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH: About (Month) (Day) 1832 (Year)

7. AGE: About 89 yrs. ~~mos.~~ ~~ds.~~
IF LESS than 1 day how many .....hrs. or .....min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired Farmer
(b) General nature of industry business or establishment in which employed (or employer): Farming, Stock Raising &c

9. BIRTHPLACE (State or Country): Indiana

10. NAME OF FATHER: Burch

11. BIRTHPLACE OF FATHER (State or Country): North Carolina

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. W. Atteberry
(Address) Orofino, Idaho,

15. Filed Nov 1 1921 J. M. Finley Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: October (Month) 20th (Day) 1921 ~~191~~ (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 6, 1921 ~~191~~, to Oct 20, 1921 ~~191~~
that I last saw him alive on Oct 19, 1921 ~~191~~
and that death occurred on the date stated above, at 7:15 A. M.

The CAUSE OF DEATH* was as follows:
Cerebral Hemmorrhage

..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Insanity
..... (Duration) Unknown yrs. ..... mos. ..... ds.

(Signed) John W. Stevens M. D.
Oct 20 1921 (Address) Orofino, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.) about
At place of death ~~yrs.~~ ~~mos.~~ 15 ds. In the State 5 yrs. ~~mos.~~ ~~ds.~~
Where was disease contracted, if not at place of death?
Former or usual residence: Moscow, Idaho,

19. PLACE OF BURIAL OR REMOVAL: Moscow Idaho | DATE OF BURIAL 191

20. UNDERTAKER: Hall & Hall | ADDRESS: Orofino

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

RECEIVED NOV 30 192[illegible] BUREAU

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35997
Registered No. 5-6

1. PLACE OF DEATH. Registration District No. 90
County of Clearwater Primary Registration District No. 2408
City of Orofino (No. No. Idaho Sanitarium St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Henry C Mundt

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: About (Month) 1855 (Year)

7. AGE: About 66 yrs. — mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business or establishment in which employed (or employer): Farming

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: Mundt

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. W. Atteberry
(Address) Orofino, Ida.

15. Filed Nov 1 1921 J. M. Tinsley Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: October (Month) 26th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 28 1921, to Oct 26, 1921
that I last saw h[illegible] alive on Oct 25 1921
and that death occurred on the date stated above, at 2:30 A.M.

The CAUSE OF DEATH* was as follows:

Epilepsy

Unknown (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) Insanity

Unknown (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John M. Givens M. D.

Oct 24 1921 (Address) Orofino, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 1 yrs. 5 mos. 29 ds. In the State about 24 yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence Winona, Idaho

19. PLACE OF BURIAL OR REMOVAL: Kamiah Ida
DATE OF BURIAL: Oct 28 1921

20. UNDERTAKER: [illegible]
ADDRESS: Orofino

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5 20M.1-16-12

RECEIVED DEC 1 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35998

Registered No.

1. PLACE OF DEATH

County of Clearwater Registration District No. 91

City of Elk River (No. , St.) Registration District No. 216

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Hendrickson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH: December (Month) 3 (Day) 1921 (Year)

7. AGE: 65 yrs. 11 mos. 20 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Handling Coumbs
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER: Hendrik Hendrickson

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Britt Bagley
(Address) Elk River

15. Filed Dec 5 1921 Mrs. F. P. McComick Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: December (Month) 3 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 1919., to Nov 27 1921, that I last saw h(e/i)m alive on Nov 27 1921, and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:
Interstitial Nephritis

(Duration) 2 yrs. mos. ds.
Contributory (Secondary) Mitral Insufficiency
(Duration) yrs. mos. ds.

(Signed) F. P. McComick M. D.
Dec 3 1921 (Address) Elk River

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Moscow Idaho | DATE OF BURIAL: Dec 4 1921

20. UNDERTAKER: C. E. Morris Sr. | ADDRESS: Elk River

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-12 M. 6-15-17.

RECEIVED
DEC 1 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35999
Registered No. [redacted]

1. PLACE OF DEATH
County of Clearwater Registration District No. 90
City of Orofino Registered No. 2168
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Harry Casey

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH. About (Month) (Day) 1843 (Year)
AGE About 78 Yrs. 6 Mos. 6 ds.
IF LESS than 1 day how many .... hrs. or .... min.?
7. OCCUPATION
(a) Trade, profession or particular kind of work: Lineman
(b) General nature of industry, business, or establishment in which employed (or employer):
8. BIRTHPLACE (State or Country): Virginia
9. NAME OF FATHER: Casey
10. BIRTHPLACE OF FATHER (State or Country): Virginia
11. MAIDEN NAME OF MOTHER: ?
12. BIRTHPLACE OF MOTHER (State or Country): ?
13. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. M. Tandy
(Address) Orofino Ida
14. Filed Nov. 4 1921. J. M. Tandy Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 4 (Day) 1921 (Year)
17. I HEREBY CERTIFY, That I attended deceased from October 23 1921 to Nov. 4 1921
that I last saw h[illegible] alive on Nov 4 1921
and that death occurred on the date stated above, at 9 30 P.M.
The CAUSE OF DEATH* was as follows:
Valvular Heart Disease
(Duration) ? Yrs. mos. ds.
Contributory (Secondary) Angina Pectoris
(Duration) Yrs. mos. 10 ds.
(Signed) J. M. Tandy M. D.
Nov. 4 1921. (Address) Orofino Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Orofino Ida — DATE OF BURIAL: Nov. 6. 1921.
20. UNDERTAKER: W. E. Shaw — ADDRESS: Orofino Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-12 M. 6-15-17.

36000

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. .....
Registered No. 58
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Owyhee — Registration District No. 90

City of Grasmere — Primary Registration District No. 2168

If death occurs away from usual residence, give facts called for under special information. (No. ..... St.)

2. FULL NAME Geo. W. Moody

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Mar (Month) 8 (Day) 1842 (Year)

7. AGE: 79 Yrs. 7 Mos. 28 ds. IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Stock Keeper
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Ben Moody

11. BIRTHPLACE OF FATHER (State or Country): "

12. MAIDEN NAME OF MOTHER: Campbell

13. BIRTHPLACE OF MOTHER (State or Country): "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Fred L. Raymond
(Address) Owyhee Ida

15. Filed Nov 6 1921 — J. M. Fahy, Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 6 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1919 to Nov 6 1921 that I last saw h— alive on Nov 5 1921 and that death occurred on the date stated above, at 4:30 A. M.

The CAUSE OF DEATH* was as follows:

Progressive Bulbar Paralysis

(Duration) 2 Yrs. 6 mos. ..... ds.

Contributory (Secondary) .....

(Duration) 2 Yrs. 9 mos. ..... ds.

(Signed) J. M. Fahy M. D.

Nov 6 1921 (Address) Owyhee Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs....mos....days. In the ,State....yrs....mos....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Owyhee Ida — DATE OF BURIAL: Nov 7 1921

20. UNDERTAKER: H. A. Shaw — ADDRESS: Owyhee

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

—Every item of information should be carefully supplied. AGE should be stated EXACTLY.

LANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Ex

nt of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

BUREAU OF STATISTICS Registration District No. 2168 File No. 3661

City of Orofino, (No. ....., ... St.) Registered No. 59

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Betsy Roscoe or Roscoe

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED? (Write the word.)

6. DATE OF BIRTH: About (Month) (Day) 1846 (Year)

7. AGE: About 75 yrs. — mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Formerly Housewife
(b) General nature of industry business or establishment in which employed (or employer): House keeping

9. BIRTHPLACE (State or Country): United States

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown,

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. W. Atteberry
(Address) Orofino Idaho.

15. Filed Nov 12 1921 J. M. Tainter Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: November Tenth 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from August Fifteenth 1920, to November Tenth 1921, that I last saw her alive on November Ninth 1921 and that death occurred on the date stated above, at 6:50 A. M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) Insanity

..... (Duration) Unknown yrs. ..... mos. ..... ds.

(Signed) John W. Atteberry M. D.

November 10 1921 (Address) Orofino, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.) About

At place of death 1 yrs. 2 mos. 27 ds.

In the State 6 yrs. — mos. — ds.

Where was disease contracted, if not at place of death?

Former or usual residence Lewiston Idaho,

19. PLACE OF BURIAL OR REMOVAL: Aurora S. Dak. DATE OF BURIAL: Nov 14 1921

20. UNDERTAKER: L. L. Bolo ADDRESS: Orofino, Idg.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M. 7-20-15

RECEIVED DEC 1 1921 STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36002
Registered No. 60

1. PLACE OF DEATH
Registration District No. 90
County of Clearwater Subdistrict No. 2169
City of Orofino, (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Daniel Dill

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH: About (Month) ..... (Day) 1846 (Year)

7. AGE: About 75 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... *hrs.* or ..... *min.*

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry business or establishment in which employed (or employer): General Laboring

9. BIRTHPLACE (State or Country): Ireland

10. NAME OF FATHER: Dill

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. W. Atteberry
(Address) Orofino, Idaho,

15. Filed Nov 15 1921 J. M. Tandy Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: November (Month) 15th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 20, 1916, to November 15th 1921
that I last saw h[illegible] alive on November 15th 1921
and that death occurred on the date stated above, at 4:05 P. M.

The CAUSE OF DEATH* was as follows:
Arteriosclerosis
Unknown
..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory Insanity
(Secondary)
..... (Duration) Unknown yrs. ..... mos. ..... ds.
(Signed) John W. Stevens M. D.
Nov. 15 1921 (Address) Orofino, Idaho,

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.) Over
At place of death 5 yrs. 3 mos. 27 ds.
In the State 44 yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence Lewiston, Idaho.

19. PLACE OF BURIAL OR REMOVAL: Orofino Ida
DATE OF BURIAL: Nov 17 1921

20. UNDERTAKER: [illegible]
ADDRESS: Orofino

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

RECEIVED DEC 1 - 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36003
Registered No. 61

1. PLACE OF DEATH. Registration District No. 90
County of Clearwater Primary Registration District No. 2168
City of Orofino, (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Henry Wineman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: About 1860 (Month) (Day) (Year)

7. AGE: About 61 yrs. ✓ mos. ✓ ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Day Laborer
(b) General nature of industry business or establishment in which employed (or employer): Laboring by the Day

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: Wineman

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. W. Gilbertson
(Address) Orofino Ida.

15. Filed Nov 18 1921 J. R. Faith Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: November 18th 1921 (Month) (Day) (Year) ~~191~~

17. I HEREBY CERTIFY, That I attended deceased from Nov. 11, 1921 ~~191~~, to Nov. 18, 1921 ~~191~~ that I last saw h~~im~~ alive on Nov. 17, 1921 ~~191~~ and that death occurred on the date stated above, at 7:40 A M.

The CAUSE OF DEATH* was as follows:

arterio sclerosis

Unknown (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) Insanity

Unknown (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Thos. W. Stevens M. D.

Nov. 18 1921 (Address) Orofino, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.) about

At place of death ✓ yrs. ✓ mos. 8 ds. In the State 5 yrs. ✓ mos. ✓ ds.

Where was disease contracted, if not at place of death?

Former or usual residence Rathdrum, Idaho,

19. PLACE OF BURIAL OR REMOVAL: N. D. Sanitarium Cemetery — DATE OF BURIAL: 11 21 1921

20. UNDERTAKER: J. M. Johnson — ADDRESS: Orofino Idaho

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED
DEC 1 1921
BUREAU OF VITAL STATISTICS

Form V. S. No. 5. 12½M.7-24-11 **CERTIFICATE OF DEATH**

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36004
Registered No. 62

1. **PLACE OF DEATH.** Registration District No. 90
County of Clearwater Primary Registration District No. 2168
City of Orofino, (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. **FULL NAME** Carl Edward Swanson

PERSONAL AND STATISTICAL PARTICULARS

3. **SEX** Male

4. **COLOR OR RACE** White

5. **SINGLE, MARRIED, WIDOWED OR DIVORCED.** (*Write* the word.)

6. **DATE OF BIRTH** About 1872
(Month) (Day) (Year)

7. **AGE** about 39 yrs. ✓ mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. **OCCUPATION**
(a) Trade, profession or particular kind of work ..... Laborer
(b) General nature of industry business or establishment in which employed (or employer) ..... Laboring by the Day

9. **BIRTHPLACE** (State or Country) Sweden

10. **NAME OF FATHER** Swanson

11. **BIRTHPLACE OF FATHER** (State or Country) Unknown

12. **MAIDEN NAME OF MOTHER** Unknown

13. **BIRTHPLACE OF MOTHER** (State or Country) Unknown

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**
(Informant) J. W. Atteberry
(Address) Orofino Ida

15. Filed Dec 1 1921 J. M. Francis Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. **DATE OF DEATH** November 17th 1921
(Month) (Day) (Year)

17. **I HEREBY CERTIFY,** That I attended deceased from Sept 15, 1911 ~~191~~, to Nov. 17, 1921 ~~191~~.
that I last saw him alive on Nov. 18, 1921 ~~191~~
and that death occurred on the date stated above, at 3:40 A. M.

The **CAUSE OF DEATH*** was as follows:
Endocarditis
about →
..... (Duration) ..... yrs. ..... mos. 5 ds.
Contributory (Secondary) Insanity
..... (Duration) Unknown yrs. ..... mos. ..... ds.
(Signed) John [illegible] M. D.
Nov. 19 1921 (Address) Orofino, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.) about
At place of death 10 yrs. 2 mos. 5 ds. In the State 10 yrs. 2 mos. ✓ ds.
Where was disease contracted, if not at place of death?
Former or usual residence Orofino, Idaho.

19. **PLACE OF BURIAL OR REMOVAL** N. D. Sanitarium Cemetery — **DATE OF BURIAL** 11/23 1921

20. **UNDERTAKER** P. M. Johnson — **ADDRESS** Orofino Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

FORM V. S. No. 5-12 M. 6-15-17. RECEIVED DEC 1 1921 BUREAU OF VITAL STATISTICS STATE OF IDAHO

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36005
Registered No. 63
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Clearwater
City of Lenore
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 90
Primary Registration District No. 2168
(No. ....., ... St.)

2. FULL NAME John C. McKinnie

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH. May (Month) 8 (Day) 1854 (Year)

7. AGE 67 Yrs. 7 Mos. 1 ds. IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Iowa

10. NAME OF FATHER -

11. BIRTHPLACE OF FATHER (State or Country) -

12. MAIDEN NAME OF MOTHER -

13. BIRTHPLACE OF MOTHER (State or Country) -

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. A. Shaw
(Address) Orofino Ida.

15. Filed Dec 1 1921 J. M. Daily Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 19 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191... to ..... 191...
that I last saw h... alive on ..... 191...
and that death occurred on the date stated above, at ....,... M.
The CAUSE OF DEATH* was as follows:

Unknown
Had no physician

(Duration) ... Yrs. ... mos. ... ds.
Contributory (Secondary) ...
(Duration) ... Yrs. ... mos. ... ds.

(Signed) J. C. Bullock Coroner M. D.
11/20 1921 (Address) ...

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death? ...
Former or usual residence ...

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Southwick	Nov 23 1921
20. UNDERTAKER W. A. Shaw	ADDRESS Orofino Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36006
Registered No. 64

Registration District No. 90
Primary Registration District No. 7168

1. PLACE OF DEATH
County of Clearwater
City of Orofino
If death occurs away from usual residence, give facts called for under special information.
(No. ....., ... St.)

2. FULL NAME Helen Myrtle Pratt

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. July (Month) 4 (Day) 1907 (Year)

7. AGE: 14 Yrs. 4 Mos. 18 ds.
IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Oregon

10. NAME OF FATHER: Ross Pratt

11. BIRTHPLACE OF FATHER (State or Country): Ind.

12. MAIDEN NAME OF MOTHER: Emma Templeton

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ernest Pratt
(Address) Orofino

15. Filed Dec. 5 1927 — J. M. Bandy, Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 22 (Day) 1927 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 25 1927 to Nov. 22 1927
that I last saw h— alive on Nov. 22 1927
and that death occurred on the date stated above, at 9:00 P.M.

The CAUSE OF DEATH* was as follows:
Myocarditis
Valvular Heart Disease
(Duration) 1 Yrs. 2 mos. ds.
Contributory (Secondary) Acute Influenza Rheumatism
(Duration) Yrs. 2 mos. ds.

(Signed) J. M. Bandy M. D.
Nov 30 1927 (Address) Orofino Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the State....yrs.....mos....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Gilbert Ida — DATE OF BURIAL: Nov 24 1927

20. UNDERTAKER: W. A. Shaw — ADDRESS: Orofino Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36007
Registered No. 65

1. PLACE OF DEATH. Registration District No. 90
County of Clearwater Primary Registration District No. 2168
City of Orofino, (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Mike Glenn

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: ——— (Month) ——— (Day) 1852 (Year)

7. AGE: 69 yrs. ~ mos. ~ ds. IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry business or establishment in which employed (or employer): Laboring by Day

9. BIRTHPLACE (State or Country): Ireland

10. NAME OF FATHER: Glenn.

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. W. Patterson
(Address) Orofino, Ida.

15. Filed Dec 1 1921 J. M. Faith Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: November 22, 1921 ~~191~~ (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 15 1919, to November 22, 1921 ~~191~~ that I last saw h im alive on November 22 ~~191~~ 1921 and that death occurred on the date stated above, at 5:05 P. M.

The CAUSE OF DEATH* ~~was~~ as follows:
Arteriosclerosis,
? (Duration) 7 yrs. ..... mos. ..... ds.
Contributory Insanity
(Secondary) Unknown (Duration) ~~Unknown~~ yrs. ..... mos. ..... ds.

(Signed) John Simpson M. D.
Nov. 22 1921 (Address) Orofino, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.) about
At place of death 2 yrs. 4 mos. 8 ds. In the State 5 yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence Sandpoint, Idaho.

19. PLACE OF BURIAL OR REMOVAL: P. M. Thurson
DATE OF BURIAL: 11/25 1921

20. UNDERTAKER: Sanitarium Cemetery
ADDRESS: Orofino Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24

RECEIVED DEC 1 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36008
Registered No. 66

1. PLACE OF DEATH. Registration District No. 90
County of Clearwater Subdivision Registration District No. 2168
City of Orofino, (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME George E. Cozier

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Divorced
6. DATE OF BIRTH: ✓ (Month) ✓ (Day) 1862 (Year)
7. AGE: 59 yrs. ✓ mos. ✓ ds. IF LESS than 1 day how many ..... hrs. or ..... min?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Engineer
(b) General nature of industry business or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Ohio
10. NAME OF FATHER: Cozier
11. BIRTHPLACE OF FATHER (State or Country): Pennsylvania
12. MAIDEN NAME OF MOTHER: Unknown,
13. BIRTHPLACE OF MOTHER (State or Country): Michigan
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. W. Patterson
(Address) Orofino Ida.
15. Filed Dec 1 1921 J. M. Smith Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: November (Month) 24 (Day) 1921 (Year) ~~1921~~
17. I HEREBY CERTIFY, That I attended deceased from Sept. 23, 1921 ~~1921~~, to Nov. 24, 1921 ~~1921~~ that I last saw him alive on November 23 ~~1921~~ 1921 and that death occurred on the date stated above, at 3 A. M.
The CAUSE OF DEATH* was as follows:

General Paresis

..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Insanity
..... (Duration) Unknown, yrs. ..... mos. ..... ds.
(Signed) Johnson Greene M. D.
Nov. 24, 1921 (Address) Orofino, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ✓ yrs. 2 mos. 2 ds. In the State 41 ✓ yrs. ✓ mos. ✓ ds.
Where was disease contracted, if not at place of death?
Former or usual residence Bovill, Idaho.

19. PLACE OF BURIAL OR REMOVAL: Moscow Ida. DATE OF BURIAL ..... 191...
20. UNDERTAKER: [illegible] ADDRESS: [illegible]

AYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36009

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

RECEIVED NOV 30 1921 BUREAU OF VITAL STATISTICS

Registration District No. 76

Primary Registration District No. 2153

1. PLACE OF DEATH.

County of Custer

City of Chilly

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Kirsten Johansen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. July 4 - 1848
Oct. 9 1921
(Month) (Day) (Year)

7. AGE: 73 Yrs. 3 Mos. 5 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer) House - Maid

9. BIRTHPLACE (State or Country) Seeland Denmark

10. NAME OF FATHER M. Johansen

11. BIRTHPLACE OF FATHER (State or Country) Denmark

12. MAIDEN NAME OF MOTHER Inger Anderson.

13. BIRTHPLACE OF MOTHER (State or Country) Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Inger B. Childs
(Address) Chilly - Idaho.

15. Filed 12/2 1921 Rose Rowan Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Oct 9 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191.., to Oct 7 1921, that I last saw h.s alive on Oct 7 1921 and that death occured on the date stated above, at was not present M.

The CAUSE OF DEATH* was as follows:
Myocarditis
Endocarditis

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Senility

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) C A Johnson M. D.

19..... (Address) Mackay Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Chilly - Idaho — DATE OF BURIAL ..... 191.....

UNDERTAKER ..... ADDRESS .....

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BORS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36010

Registered No. .....

RECEIVED NOV 30 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH.

Registration District No. 76

Primary Registration District No. 2153

County of Custer

City of Mackay (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William Harrison Millman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Jan (Month) 18 (Day) 1886 (Year)

7. AGE: 35 Yrs. 9 Mos. 12 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer): Mechanic

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: R. H. Millman

11. BIRTHPLACE OF FATHER (State or Country): Wisconsin

12. MAIDEN NAME OF MOTHER: Octavia Jeffries

13. BIRTHPLACE OF MOTHER (State or Country): Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) R. H. Millman

(Address) Langley, Wash.

15. Filed 10/31 1921 Ron Nowack Local Registrar

SYMS - YORK CO., PTRS. & BOOKS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 10 (Month) 30 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 26 1921, to Oct 30 1921, that I last saw him alive on Oct 30 1921, and that death occured on the date stated above, at 1:15 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Abscess

(Duration) Yrs. 1 mos. 4 ds.

Contributory (Secondary) Meningitis

(Duration) yrs. mos. 4 ds.

(Signed) Carl B. Swain M. D.

10/31 1921 (Address) Mackay Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Seattle, Wash. DATE OF BURIAL: ..... 191...

20. UNDERTAKER: E J Rick ADDRESS: Blackfoot Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

RECEIVED
NOV 30 1931
BUREAU OF VITAL STATISTICS
STATE OF IDAHO

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 35
County of Elmore Registration District No. 2021
City of Glenns Ferry (No. ....., ... St.)
File No. 36011
Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Caroline Watkins Mayfield

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: March (Month) 2nd (Day) 1864 (Year)

7. AGE: 57 yrs. 9 mos. 19 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Kansas

10. NAME OF FATHER: Amos Watkins

11. BIRTHPLACE OF FATHER (State or Country): Illinois

12. MAIDEN NAME OF MOTHER: Mary Nance

13. BIRTHPLACE OF MOTHER (State or Country): Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Walker Mayfield
(Address) Glenns Ferry Ida

15.
Filed Nov 24 1931 J. W. Doris Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 21 (Day) 1931 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 1st 1931, to Nov 21 1931 that I last saw her alive on Nov 21 1931 and that death occurred on the date stated above, at 9:30 A.M.

The CAUSE OF DEATH* was as follows:
Mitral insufficiency
.....
.....
..... (Duration) 2 yrs. — mos. — ds.
Contributory (Secondary) Broken compensation
..... (Duration) 5 yrs. 2 mos. — ds.

(Signed) J. J. Pond M. D.
Nov 24 1931 (Address) Glenns Ferry Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and 2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Glenns Ferry Ida
DATE OF BURIAL: Nov 25 1931

20. UNDERTAKER: J. M. Kuebaum
ADDRESS: Glenns Ferry

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16872

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
NOV 30 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 35
Registration District No. 2021
File No. 36012
Registered No.

1. PLACE OF DEATH

County of Elmore
City of
If death occurs away from usual residence, give facts called for under special information.
(No.) 7 Miles Northwest of Gelmo Ferry

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Stanley Elwood Evans

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	White	Single

6. DATE OF BIRTH: Dec 8 (Month) (Day) 1904 (Year)

7. AGE: 16 Yrs. 10 Mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmers
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mo

10. NAME OF FATHER: William H Evans

11. BIRTHPLACE OF FATHER (State or Country): Mo

12. MAIDEN NAME OF MOTHER: Bessie Spencer

13. BIRTHPLACE OF MOTHER (State or Country): Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W H Evans
(Address) Gelmo Ferry

15. Filed Nov. 20 1921 — Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 18 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 14 1921 to Nov. 18 1921 that I last saw him alive on Nov. 18 1921 and that death occurred on the date stated above, at 7:30 P.M.

The CAUSE OF DEATH* was as follows:
Gastro enteritis
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) diabetes
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W L Tapin M. D.
Nov 19 1921 (Address) 615 Overland Bldg Boise Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Nov 21 1921

20. UNDERTAKER: Summers & Kirks — ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

Form V. S. No. 5. 10M. 6-20-11.

RECEIVED NOV 30 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36014
Registered No.

1. PLACE OF DEATH. Registration District No. 35
County of Elmore Primary Registration District No. 2021
City of King Hill (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Mrs Charles Skiffer

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Jan. 24 (Month) (Day) 1850 (Year)

7. AGE: 71 yrs. 9 mos. 4 ds. IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Arminia

10. NAME OF FATHER: Jacob Markell

11. BIRTHPLACE OF FATHER (State or Country): Mississippi

12. MAIDEN NAME OF MOTHER: Emmie Swart

13. BIRTHPLACE OF MOTHER (State or Country): Mississippi

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Chas Skiffer
(Address): King Hill Idaho

15. Filed Oct 29 1921 J. W. Davis Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: October (Month) 28 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 30 1920, to Oct. 28 1921 that I last saw him alive on Oct. 26 1921, and that death occurred on the date stated above, at 12 a. M.

The CAUSE OF DEATH* was as follows:
Locomotor Ataxia

(Duration) 5 yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. W. Davis M. D.
Oct. 30 1921 (Address) Elmore Twp Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Elmore Twp Idaho — DATE OF BURIAL: October 30 1921

20. UNDERTAKER: Joe Rudbaum — ADDRESS: Elmore Twp Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

RECEIVED NOV 30 1921 BUREAU OF VITAL STATISTICS

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
Registration District No.
Primary Registration District No.
File No. 36015
County of Elmore
City of Glenns Ferry (If outside limits, give township.) St.)
Registered No.
If death occurs away from usual residence, give facts called for under special information.
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Cecil Raymond Carrico

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): At Home
6. DATE OF BIRTH: Sept 15th 1919 (Month) (Day) (Year)
7. AGE: 2 yrs. 1 mos. 10 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business or establishment in which employed (or employer) At Home
9. BIRTHPLACE (State or Country): Seattle Wash
10. NAME OF FATHER: Marion Carrico
11. BIRTHPLACE OF FATHER (State or Country): Okla
12. MAIDEN NAME OF MOTHER: Maude Hallum
13. BIRTHPLACE OF MOTHER (State or Country): Oklahoma
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Maude Carrico
(Address) Glenns Ferry
15.
Filed Oct. 28 1921 J. W. Davis Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. 26 1921 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from Oct. 26 1921, to Oct. 26 1921 that I last saw him alive on Oct. 26 1921, and that death occurred on the date stated above, at 9 P M.
The CAUSE OF DEATH* was as follows:
Pneumonia & Laryngitis
(Duration) ..... yrs. ..... mos. 1 ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) J. W. Davis M. D.
Oct. 26 1921 (Address) Glenns Ferry Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and 2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Glenns Ferry Idaho
DATE OF BURIAL: Oct. 28 1921
20. UNDERTAKER: J. W. Buchanan
ADDRESS: Glenns Ferry

185

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MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED NOV 30 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36016
Registered No. 59

1. PLACE OF DEATH
County of Franklin Registration District No. 2119
City of Preston (If outside limits, give township.) Registration District No. 27 St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ray In. Hansen
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Sing
6. DATE OF BIRTH: Oct. (Month) 28 (Day) 1921 (Year)
7. AGE: — Yrs. — Mos. — ds. IF LESS than 1 day how many 2 hrs. or ... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business or establishment in which employed (or employer)
9. BIRTHPLACE (State or Country): Preston Idaho
10. NAME OF FATHER: Peter J Hansen
11. BIRTHPLACE OF FATHER (State or Country): Ellmington Ida
12. MAIDEN NAME OF MOTHER: Nellie Cronson
13. BIRTHPLACE OF MOTHER (State or Country): Preston Ida
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Peter J Hansen
(Address)
15. Filed Oct. 31 1921 D. A. Rudd Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 28 (Day) 1921 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Oct 28 1921, to Oct 28 1921, that I last saw h.i.m. alive on Oct 28 1921, and that death occurred on the date stated above, at 6 P M.
The CAUSE OF DEATH* was as follows:
Asphyxiation due to breech presentation - born dead before help arrived.
(Duration) ... Yrs. ... mos. ... ds.
Contributory (Secondary)
(Duration) ... yrs. ... mos. ... ds.
(Signed) Curtis Bland M. D.
10/29 1921 (Address) Preston Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Preston Ida — DATE OF BURIAL: Oct 30 1921
20. UNDERTAKER: W. A. Skidmore — ADDRESS: Preston Ida

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36017

Registered No. 53

RECEIVED
NOV 30 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH. Registration District No. 2119

County of Franklin Primary Registration District No. 27

City of Weston (If not in city give township) St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Allen O Spencer

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. July (Month) 26 (Day) 1921 (Year)

7. AGE: Yrs. 2 Mos. 5 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... —
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Weston Idaho

10. NAME OF FATHER H G Spencer

11. BIRTHPLACE OF FATHER (State or Country) Miss

12. MAIDEN NAME OF MOTHER Edna Pearl Ogden

13. BIRTHPLACE OF MOTHER (State or Country) Neb

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) H. G. Spencer
(Address) Weston Ida.

15. Filed Oct 26 1921. Dan R Cutler Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 3 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 24 1921, to Oct 3 1921, that I last saw him alive on Oct 3 1921, and that death occured on the date stated above, at 6 P M.

The CAUSE OF DEATH* was as follows:
Dysentary
(Duration) Yrs. mos. 5 ds.
Contributory (Secondary)
(Duration yrs. mos. ds.

(Signed) Thad B Holder M. D.
19 (Address) Weston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Franklin Ida. DATE OF BURIAL: Oct 5 1921

20. UNDERTAKER: none ADDRESS: —

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

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Form V. S. No. 5 20M.1-16-12

RECEIVED NOV 30 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH Registration District No. 2119

County of Franklin Registration District No. 37

City of Riverdale (No. , St.)

File No. 36018

Registered No. 54

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Milford Green

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	W	Single

6. DATE OF BIRTH: July (Month) 4 (Day) 1921 (Year)

7. AGE: ..... yrs. 4 mos. 3 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work —
(b) General nature of industry business, or dstablishment in which employed (or employer) —

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Milton M. Neely

11. BIRTHPLACE OF FATHER (State or Country) Idaho

12. MAIDEN NAME OF MOTHER Eva Green

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Milton Neeley
(Address) Riverdale Ida.

15.
Filed Oct 26 1921 Dr A Ruston
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 10 (Month) 7 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 10-7 1921, to 10-7 1921, that I last saw h— alive on —— 191—, and that death occurred on the date stated above, at 5:00 A.M.

The CAUSE OF DEATH* was as follows:
Probably Pneumonia

(Duration) ..... yrs. ..... mos. 1 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A R Guilty M. D.

10-7 1921 (Address) Preston Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Riverdale - Ida | DATE OF BURIAL: 10-9 1921

20. UNDERTAKER — | ADDRESS —

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

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RI

Form V. S. No. 5. 12½M.7-24-11 RECEIVED CERTIFICATE OF DEATH

NOV 30 1921

BUREAU OF VITAL STATISTICS

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 219
County of Franklin Registration District No. 27
City of Treasureton (No. ....., ... St.)
File No. 36019
Registered No. 56

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charley Smith

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH: Sept. 21 (Month) (Day) 1921 (Year)

7. AGE: ~ yrs. ~ mos. ~ ds. IF LESS than 1 day how many ..... hrs. or 15 min.

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Franklin Co Idaho

10. NAME OF FATHER: Theron Smith

11. BIRTHPLACE OF FATHER (State or Country): Logan Utah

12. MAIDEN NAME OF MOTHER: Lettia Greay

13. BIRTHPLACE OF MOTHER (State or Country): Gentile Valley Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Theron Smith
(Address) Treasureton Idaho

15.
Filed Oct 26 1921 D A Rutter
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Sept. (Month) 21 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 21 - 1921, to Sept 21 - 1921
that I last saw h[illegible] alive on Sept 21 1921
and that death occurred on the date stated above, at 8 45 M.

The CAUSE OF DEATH* was as follows:
Atelectasis from
Premature birth.

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) ~

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G. W. Slater M. D.
Sept 23 1921 (Address) Preston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mound Valley Idaho
DATE OF BURIAL: Sept. 23 1921

20. UNDERTAKER
ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
NOV 30 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH Registration District No. 2119
County of Franklin Primary Registration District No. 37
City of Maplet (St.)
File No. 36020
Registered No. 37
If death occurs away from usual residence, give facts called for under special information.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Devere J. Burbank

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH Sept. (Month) 28 (Day) 1921 (Year)

7. AGE ← Yrs. ← Mos. ← ds. IF LESS than 1 day how many 7 hrs. or ← min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ←
(b) General nature of industry, business or establishment in which employed (or employer) ←

9. BIRTHPLACE (State or Country) Franklin County Idaho

10. NAME OF FATHER B M. Burbank

11. BIRTHPLACE OF FATHER (State or Country) Brigham City Utah

12. MAIDEN NAME OF MOTHER Lettie Gardner

13. BIRTHPLACE OF MOTHER (State or Country) Dewey Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) B. M. Burbank
(Address) Preston R 7 Box 81 Idaho

15.
Filed 19
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. (Month) 28 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 28 1921, to Sept 28 1921, that I last saw h. alive on Sept. 28 1921, and that death occurred on the date stated above, at 9 15 M.
The CAUSE OF DEATH* was as follows:

Ateleatasis

(Duration) ← Yrs. ← mos. 1/4 day
Contributory (Secondary) ←
(Duration) ← yrs. ← mos. ← ds.

(Signed) F W States M. D.
Sept 29 1921 (Address) Preston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.) ←
At place of death ... yrs ... mos ... days. In the State ... yrs ... mos ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Dewey Valley Utah	Sept. 29 1921
20. UNDERTAKER	ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36021
Registered No. 58

1. PLACE OF DEATH

Registration District No. 2119
Primary Registration District No. 21
County of Franklin
City of Dayton (St.)

RECEIVED
NOV 20 1921
BUREAU OF VITAL STATISTICS

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James Page

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Feb. (Month) 12 (Day) 1863 (Year)

7. AGE: 58 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Woods Cross Utah

10. NAME OF FATHER: James Page

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Louisa Graves

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant)
(Address) Dayton, Idaho

15. Filed Oct 31 1921
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 27 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 26 1921, to Oct 27 1921, that I last saw him alive on Oct 26 1921, and that death occurred on the date stated above, at 11 "6 A.M.

The CAUSE OF DEATH* was as follows:
Leakage of Heart

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Thos B Holder M. D.

19 (Address) Preston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Dayton Idaho
DATE OF BURIAL: Oct 29 1921

20. UNDERTAKER: W. A. Steidmon
ADDRESS: Preston Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED DEC 1 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36022
Registered No. 64

1. PLACE OF DEATH
Registration District No. 27
County of Franklin
Registration District No. 2119
City of Weston (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charles M. Hopkins

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Sept (Month) 9 (Day) 1866 (Year)

7. AGE: 56 Yrs. 1 Mos. 28 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Carpenter
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Topek. Kansas

10. NAME OF FATHER: Lyles Hopkins

11. BIRTHPLACE OF FATHER (State or Country): Kansas

12. MAIDEN NAME OF MOTHER: Clive Jane Smith

13. BIRTHPLACE OF MOTHER (State or Country): Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Oscar Wilde
(Address) Mink Creek Idaho

15.
Filed Dec 5 1921 Mrs. Ida Tuppels Local Registrar
Apty

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 6 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 25, 1921 to Nov 6 1921, that I last saw him alive on Nov 6 1921, and that death occurred on the date stated above, at 5 P M.

The CAUSE OF DEATH* was as follows:
Nephritis

(Duration) ..... Yrs. ..... mos. 12 ds.
Contributory (Secondary) Mrennie Parsons
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Thos B Holden M. D.
19..... (Address) Weston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Perry Cem. | DATE OF BURIAL: Nov 8 1921

20. UNDERTAKER: W. G. Shearmore | ADDRESS: Preston Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36023
Registered No. 60

RECEIVED DEC 1 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH.
Registration District No. 27
County of Franklin
Primary Registration District No. 2119
City of Weston (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Hans Christian Hansen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	Widower

6. DATE OF BIRTH. ~~Aug~~ Nov 18 20 1851
(Month) (Day) (Year)

7. AGE 70 Yrs. 4 Mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Farmer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE
(State or Country) Denmark

10. NAME OF FATHER James Hansen

11. BIRTHPLACE OF FATHER
(State or Country) Denmark

12. MAIDEN NAME OF MOTHER Anna Madsen

13. BIRTHPLACE OF MOTHER
(State or Country) Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) James R Hansen.
(Address) Tetonia Idaho.

15.
Filed Dec 6 1921 Mrs. Ida Lizzetta
Local Registrar.
Deputy

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Nov 20 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 23 1921, to Nov 20 1921, that I last saw him alive on Nov 17 1921, and that death occured on the date stated above, at 3:15 A.M.

The CAUSE OF DEATH* was as follows:

Carditis

(Duration) Yrs. 3 mos. 23 ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Thos B Holden M. D.
19..... (Address) Weston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence Weston

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Weston	Nov. 22 1921
20. UNDERTAKER	ADDRESS
G. A. Lundquist	Logan, Utah

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & ENGS. 24658

FORM V. S. No. 5-25 M. 1-19.

RECEIVED DEC 1 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36024
Registered No. 63

1. PLACE OF DEATH
Registration District No. 27
County of Franklin
Registration District No. 2119
City of Preston (St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lars C. Nielson
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Oct (Month) 6 (Day) 1846 (Year)

7. AGE: 75 Yrs. 0 Mos. 27 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Denmark

10. NAME OF FATHER: Hans L. Nielson

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: Carrie Christena Hansen

13. BIRTHPLACE OF MOTHER (State or Country): Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. F. Nielson
(Address) Brigham City Utah

15. Filed Dec 5 1921 Mrs. Ida Lippets Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 2 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 6 1921, to Nov 2 1921, that I last saw h[illegible] alive on Nov 2 1921, and that death occurred on the date stated above, at 11 M.

The CAUSE OF DEATH* was as follows:
Peritonitis purulent.

(Duration) ..... Yrs. ..... mos. 3 ds.
Contributory (Secondary) Perforated duodenal ulcer
(Duration) ..... yrs. ..... mos. 1 ds.

(Signed) A. R. Cutler Jr. M. D.
19..... (Address) Preston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Trunk Creek	Nov. 5 1921
20. UNDERTAKER W. D. Skidmore	ADDRESS Preston Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED DEC 1 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36025

Registered No. 62

1. PLACE OF DEATH

County of Franklin Registration District No. 27

City of Preston Registration District No. 2119 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William Charles Millard

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
M.	W.	Married

6. DATE OF BIRTH: Feb. (Month) 9 (Day) 1857 (Year)

7. AGE: 64 Yrs. 8 Mos. 25 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wales

10. NAME OF FATHER: William Millard

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Betsy Webb

13. BIRTHPLACE OF MOTHER (State or Country): Wales

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John W. Millard
(Address) Ogden Utah

15. Filed Dec 5 1921 Mrs. Ida Lippels Local Registrar
Deputy.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: November (Month) 3 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 27 1921, to Nov 3 1921, that I last saw h.f.M. alive on Nov 3 1921, and that death occurred on the date stated above, at 2:38 M.

The CAUSE OF DEATH* was as follows:
Pneumonia - Hypostatic - due to fracture neck of L. femur due to automobile accident

(Duration) - Yrs. - mos. 5 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Curtis Bland M. D.
11/4/1921 (Address) Preston, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Preston Idaho	Nov. 5 1921
20. UNDERTAKER	ADDRESS
W. A. Skidmore	Preston Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36026

RECEIVED DEC 1 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH. Registration District No. 27
County of Franklin Primary Registration District No. 2119
City of Franklin (If not in limits, give township) (No. St.)
Registered No. 65

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lorenzo Lafayette Hatch

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married

6. DATE OF BIRTH. Dec (Month) 25 (Day) 1851 (Year)

7. AGE: 69 Yrs. 10 Mos. 12 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Lehi Utah

10. NAME OF FATHER: Lorenzo Hill Hatch

11. BIRTHPLACE OF FATHER (State or Country): Vermont

12. MAIDEN NAME OF MOTHER: Cybria Clarrinda Eastman

13. BIRTHPLACE OF MOTHER (State or Country): Vermont

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Rosa C. Hatch
(Address)

15. Filed Dec 5 1921 Mrs. Ida Liggett Local Registrar Dept.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 7 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 1st 1921, to Nov 7th 1921, that I last saw h[e] alive on Nov 3rd 1921, and that death occured on the date stated above, at 1 P M.

The CAUSE OF DEATH* was as follows:
Pernicious Anaemia

(Duration) — Yrs. 18 mos. — ds.

Contributory (Secondary)
(Duration — yrs. — mos. — ds.

(Signed) W O Budge M. D.
11/8 1921 (Address) Logan, Utah

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Franklin Idaho — DATE OF BURIAL: Nov 10 1921

20. UNDERTAKER: J. Guy Benson — ADDRESS: Malad Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYNS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED DEC 1 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 27

County of Franklin — Primary Registration District No. 2119

City of Nelson (St.)

File No. 36027

Registered No. 61

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Edris Nelson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F	W	

6. DATE OF BIRTH: Jan (Month) 8 (Day) 1921 (Year)

7. AGE: Yrs. 10 Mos. 10 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business or establishment in which employed (or employer) —

9. BIRTHPLACE (State or Country) Trunk Creek

10. NAME OF FATHER John Henry Nelson

11. BIRTHPLACE OF FATHER (State or Country) Trunk Creek

12. MAIDEN NAME OF MOTHER Susana Ames

13. BIRTHPLACE OF MOTHER (State or Country) Trenton Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Henry Nelson
(Address) Treasureton

15. Filed Dec 15 1921 — Mrs. Ida Lippert Local Registrar Shoshone

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 18 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 15 1921, to Nov. 18 1921, that I last saw h.r alive on Nov. 15 1921, and that death occurred on the date stated above, at 9 A. M.
The CAUSE OF DEATH* was as follows:

Cerebro-Spinal Meningitis

(Duration) — Yrs. — mos. 11 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. W. States M. D.

Nov 21 1921 (Address) Preston Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Cleveland Ida	Nov 20 1921
20. UNDERTAKER W. A. Hardmon	ADDRESS Preston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Franklin — Registration District No. 27

City of Preston — Primary Registration District No. 2119.

(No. ... St.)

File No. 36028

Registered No. ...

If death occurs away from usual residence, give facts called for under special information.

RECEIVED DEC 1 1921 BUREAU OF VITAL STATISTICS

2. FULL NAME Ellis Riley Cutler

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): married

6. DATE OF BIRTH: Nov (Month) 23 (Day) 1862 ~~1921~~ (Year)

7. AGE: 58 Yrs. 10 Mos. 15 ds. IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Physician & Surgeon
(b) General nature of industry, business or establishment in which employed (or employer): ...

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Martin B Cutler

11. BIRTHPLACE OF FATHER (State or Country): U.S.A.

12. MAIDEN NAME OF MOTHER: Theda A Cutler

13. BIRTHPLACE OF MOTHER (State or Country): U.S.A Mass.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A.R. Cutler Jr
(Address) Preston Idaho

15. Filed Dec 6 1921 — Mrs Ida Lysgaard, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 7 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from — 19—, to — 19—, that I last saw h[illegible] alive on Nov 7 1921, and that death occurred on the date stated above, at 9"0 P.M.

The CAUSE OF DEATH* was as follows:
Fracture of skull, resulting from automobile injury 1st grade. accidental
(Duration) ... Yrs. ... mos. ... ds.
Contributory (Secondary) ...
(Duration) ... yrs. ... mos. ... ds.

(Signed) A.R. Cutler Jr M. D.
Nov 1921 (Address) Preston Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death? ...
Former or usual residence ...

19. PLACE OF BURIAL OR REMOVAL: Preston Ida. — DATE OF BURIAL: 11-10 1921

20. UNDERTAKER: J.T. Anderson — ADDRESS: Preston Ida

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED NOV 30 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36029

Registered No. .....

1. PLACE OF DEATH.

Registration District No. 103

Primary Registration District No. 6

County of Fremont.

City of Marysville (If outside limits of city or village give township) St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Hannah Baron Wood

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. (Month) January (Day) 23 (Year) 1853

7. AGE: 68 Yrs. 10 Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: Thomas Baron

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Brooks

13. BIRTHPLACE OF MOTHER (State or Country): ~~England~~ England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Ethel Sanders

(Address) Pocatello, Idaho.

15. Filed 11-23-1921

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: (Month) November (Day) 23 / 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11-20 1921, to 11-23 1921, that I last saw h[illegible] alive on 11-21 1921, and that death occured on the date stated above, at 8 A. M.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) — Yrs. — mos. 4 ds.

Contributory (Secondary) Arteriosclerosis

(Duration) — yrs. — mos. — ds.

(Signed) C. M. Nelson M. D.

11-23 1921 (Address) Ashton, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Ashton Idaho — DATE OF BURIAL: 11/25/21 191

20. UNDERTAKER: Lewis Kiser — ADDRESS: Ashton Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYNS - YORK CO., PTRS. & BDRS. 24652

FORM V. S. No. 5-25 M. 1-19.

RECEIVED NOV 30 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
Fremont.

Registration District No. 108

County of

Primary Registration District No. 6

City of Ashton (No. , St.)

File No. 36031

Registered No.

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Effie Georgia Strong

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Married

6. DATE OF BIRTH
November 23. 1864
(Month) (Day) (Year)

7. AGE
57 Yrs. — Mos. 4 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE
(State or Country) Vermont

10. NAME OF FATHER
A.A. Prouty

11. BIRTHPLACE OF FATHER
(State or Country) Maine

12. MAIDEN NAME OF MOTHER
[redacted] Dont Know

13. BIRTHPLACE OF MOTHER
(State or Country) Vermont.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
Allie Strong.
(Informant)
(Address) Ashton Idaho

15. Filed 11-24 1921

C. C. Meacham
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
November 27th 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ——— 19..., to Nov 27 1921 that I last saw her alive on Nov 27 1921 and that death occurred on the date stated above, at 9 P.M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis
Apoplexy

(Duration) Yrs. mos. 1 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) E. L. Hagar M. D.

Nov 29 1921 (Address) Ashton Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients or Recent Residents.)

At place of death ...yrs...mos...days. In the State ...yrs...mos...days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Ashton Idaho — DATE OF BURIAL: 11/29/21

20. UNDERTAKER: Lewis Kiser. — ADDRESS: Ashton Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. [illegible]-25 M. 1-16-13

RECEIVED NOV 30 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36032

Registered No. .....

1. PLACE OF DEATH.

Registration District No. 102

County of Fremont

Primary Registration District No. 6

City of Ashton (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Carol Mae. Isenberg

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. November 13 1920 (Month) (Day) (Year)

7. AGE: 1 Yrs. - 13 Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... -

(b) General nature of industry, business, or establishment in which employed (or employer)... -

9. BIRTHPLACE (State or Country) Ashton Idaho

10. NAME OF FATHER Clarence M. Isenberg

11. BIRTHPLACE OF FATHER (State or Country) Emerson NEb

12. MAIDEN NAME OF MOTHER Ruby . Mae, Bryce.

13. BIRTHPLACE OF MOTHER (State or Country) Emerson Neb.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Clarence M. Isenberg

(Address) Ashton Idaho.

15. Filed 11-27-1921 C. C. Emerson Local Registrar

BYNS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: November. 26. 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 1 1921, to Nov 26 1921, that I last saw h[illegible] alive on Nov 26 1921, and that death occured on the date stated above, at 6:30 P.M.

The CAUSE OF DEATH* was as follows:

Summer Complaint

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) S. P. Hagar M. D.

Nov 26 1921 (Address) Ashton Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Ashton Idaho — DATE OF BURIAL: 11/27/21

20. UNDERTAKER: Lewis Kiser . Ashton Idaho. — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of FREMONT.
City of ASHTON.
If death occurs away from usual residence, give facts called for under special information.

RECEIVED NOV 30 1921 BUREAU OF VITAL STATISTICS

Registration District No. 102
Primary Registration District No. 6
No. ..... St.)

File No. 36033
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME HENRY BOYLAN.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: MALE
4. COLOR OR RACE: WHITE
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: MARRIED. (Write the word.)

6. DATE OF BIRTH: APRIL. 17a 1878
(Month) (Day) (Year)

7. AGE: 70 Yrs. 6 Mos. 1 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: RETIRED FARMER
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): WISCONSIN.

10. NAME OF FATHER: CHAUNCY BOYLAN

11. BIRTHPLACE OF FATHER (State or Country): NEW YORK

12. MAIDEN NAME OF MOTHER: SALLIE BOVEE

13. BIRTHPLACE OF MOTHER (State or Country): DONT KNOW

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) MRS HENRY BOYLAN
(Address) ASHTON IDAHO.

15. Filed 11-19-21
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: OCTOBER 18 19 21
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 16 1921, to Oct 18 1921, that I last saw h.[illegible] alive on Oct 18 1921, and that death occurred on the date stated above, at 2 P M.

The CAUSE OF DEATH* was as follows:
Cerebral hemorrhage

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. P. Harper M. D.
Oct 20 1921 (Address) Ashton Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: ASHTON IDAHO
DATE OF BURIAL: 10/20/21.

20. UNDERTAKER: LEWIS KISER.
ADDRESS: ASHTON IDAHO

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
NOV 30 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH. Registration District No. 103
County of Fremont. Primary Registration District No. 6
City of Ashton. (If outside limits, give township) St.)
File No. 36034
Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs Sophia Shafer

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed.
6. DATE OF BIRTH. November (Month) 12 (Day) 1851. (Year)
7. AGE: 59 Yrs. 11 Mos. 23 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife.
(b) General nature of industry, business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Germany
10. NAME OF FATHER: William Shafer
11. BIRTHPLACE OF FATHER (State or Country): Germany
12. MAIDEN NAME OF MOTHER: Louise. Steinmeyer
13. BIRTHPLACE OF MOTHER (State or Country): Germany.
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant): Mrs Chris, Harringt Tat
(Address): Ashton Idaho.
15. Filed 11-7-1921 [signature] Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24858

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: November (Month) 6th (Day) 1921 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Oct 28 1921, to Nov 6 1921, that I last saw h[illegible] alive on Nov 6 1921, and that death occured on the date stated above, at 7 a. M.
The CAUSE OF DEATH* was as follows:
Bright's disease & Uremia
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) E. P. Hanger M. D.
Nov 6 1921 (Address) Ashton Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Squirrel Idaho.
DATE OF BURIAL: Nov. 7 1921
20. UNDERTAKER: Lewis Kiser
ADDRESS: ASHTON Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED NOV 30 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36035

Registered No.

1. PLACE OF DEATH

Registration District No. 103

County of Fremont

Primary Registration District No. 8

City of Ashton (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Harold Davis Dick

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
male	white	

6. DATE OF BIRTH: October (Month) 6th (Day) 1921 (Year)

7. AGE: 1 Yrs. 8 Mos. ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Ashton, Idaho

10. NAME OF FATHER Maurice L. Dick

11. BIRTHPLACE OF FATHER (State or Country) Idaho

12. MAIDEN NAME OF MOTHER Isabelle M. Davis

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Maurice L. [illegible]ick
(Address) Ashton, Idaho

15. Filed 11-15 1921 C. M. Meacham Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: November (Month) 14th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 6th 1921 to Nov. 14th 1921 that I last saw him alive on Nov. 14th 1921 and that death occurred on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:
Erysipelas

(Duration) Yrs. mos. 8 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) E. L. Hargis M. D.
Nov 15 1921 (Address) Ashton Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Pocatello Idaho — DATE OF BURIAL 19

20. UNDERTAKER Lewis Kiser — ADDRESS Ashton Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 102

County of Fremont. RECEIVED NOV 30 1921 BUREAU OF STATISTICS

Primary Registration District No. 6

File No. 36036

City of Ashton. (No. ..... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Martha Cordelia Austin.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: ~~W~~Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married.

6. DATE OF BIRTH. June (Month) Don't know (Day) 1852 (Year)

7. AGE: 69 Yrs. 10 Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Tennessee

10. NAME OF FATHER: Black

11. BIRTHPLACE OF FATHER (State or Country): .....

12. MAIDEN NAME OF MOTHER: McKenzie

13. BIRTHPLACE OF MOTHER (State or Country): .....

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James. B. Colsen

(Address) Chester Idaho

15. Filed 11-19-1921 C. M. Meadows Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: November (Month) 18 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 1 1921, to Nov 18 1921, that I last saw her alive on Nov 18 1921, and that death occured on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Bright disease (Chronic)

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. P. Thompson M. D.

Nov 30 1921 (Address) Ashton Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Ashton Idaho

DATE OF BURIAL: 11/20/21 191...

20. UNDERTAKER: Lewis Kiser

ADDRESS: Ashton Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36037

Registered No.

RECEIVED DEC 8 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Elmore

City of Emmett (No. ..... St.)

Registration District No. .....

Primary Registration District No. 4

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Letah Catlin

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female | 4. COLOR OR RACE: white | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED: married (Write the word.)

6. DATE OF BIRTH: Nov (Month) 29 (Day) 1889 ~~99~~ (Year)

7. AGE: 32 Yrs. — Mos. 1 ds. | IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Kansas

10. NAME OF FATHER: Michael Kelley

11. BIRTHPLACE OF FATHER (State or Country): Indiana

12. MAIDEN NAME OF MOTHER: Emma Polofson

13. BIRTHPLACE OF MOTHER (State or Country): Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W O Latta
(Address) Emmett Ida

15. Filed 12/5 1921 J A Reynolds Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 30 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 17 1921, to Nov 30 1921, that I last saw h-y alive on Nov 28 1921, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(Duration) Several Yrs. ..... mos. ..... ds.

Contributory (Secondary) Tuberculosis Throat & Lungs

(Duration) Several Yrs. ..... mos. ..... ds.

(Signed) J A Reynolds M. D.

12/5 1921 (Address) Emmett Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Emmett Ida | DATE OF BURIAL: 12/2 1921

20. UNDERTAKER: C D Buckenum | ADDRESS: Emmett Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36038
Registered No.

1. PLACE OF DEATH

County of Gem
City of Emmett (Ward) St.)

Registration District No. 6
Primary Registration District No.

RECEIVED DEC 3 1921 BUREAU OF VITAL STATISTICS

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Eliza Anna Brown

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH Feb (Month) 24 (Day) 1863 (Year)

7. AGE 58 Yrs. 7 Mos. 22 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Iowa

10. NAME OF FATHER Hiram Patrick

11. BIRTHPLACE OF FATHER (State or Country) Not Known

12. MAIDEN NAME OF MOTHER Eliza Ann La Gore

13. BIRTHPLACE OF MOTHER (State or Country) Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jason W Kelley
(Address)

15. Filed 10/18 1921 J. C. Reynolds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 16 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 5, 1921, to Oct 16, 1921 that I last saw h[illegible] alive on Oct 16 1921 and that death occurred on the date stated above, at 10 P M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) Yrs. mos. ds.

Contributory (Secondary) Carcinoma

(Duration) yrs. mos. ds.

(Signed) Burton O Clark M. D.

Oct 18 1921 (Address) Emmett Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Emmett Idaho | DATE OF BURIAL 10/19 1921

20. UNDERTAKER O. D. Buckman | ADDRESS Emmett Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36039
Registered No.

1. PLACE OF DEATH
County of Gem
City of Emmett
(No. , St.)
Registration District No.
Primary Registration District No. 6
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Willis Webb

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	white	widowed

6. DATE OF BIRTH: Sept (Month) 29 (Day) 1844 (Year)

7. AGE: 77 Yrs. — Mos. 22 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER: Charles Y. Webb

11. BIRTHPLACE OF FATHER (State or Country): unknown

12. MAIDEN NAME OF MOTHER: Laura Smith

13. BIRTHPLACE OF MOTHER (State or Country): unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. R. Harris
(Address) Emmett Idaho

15. Filed 10/24/1921 J. L. Reynolds Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 21 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 19..., to Oct 21 1921 that I last saw h. [illegible] alive on [illegible] and that death occurred on the date stated above, at 9.30 A.M.
The CAUSE OF DEATH* was as follows:
Apoplexia
Sudden death
(Duration) Yrs. mos. ds.
Contributory (Secondary) Arteria Sclerosis
(Duration) several yrs. mos. ds.
(Signed) J. L. Reynolds M. D.
10/24 1921 (Address) Emmett

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Emmett Idaho	10/24 1921
20. UNDERTAKER: C. D. Buckenum	ADDRESS: Emmett Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36040

RECEIVED DEC 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. .....

Primary Registration District No. 6

County of Gem

City of Emmett, (If outside limits, give township.) .....St.)

If death occurs away from usual residence, give facts called for under special information.

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lewey R. Russell

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): widower

6. DATE OF BIRTH: May (Month) 1 (Day) 1859 (Year)

7. AGE: 62 Yrs. 6 Mos. 17 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Blacksmith
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Horace Russell

11. BIRTHPLACE OF FATHER (State or Country): Not known

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) DeWitt Russell
(Address) Cascade Idaho

15. Filed 11/30 1921 J. L. Reynolds Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 19 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 19 1921, to Nov 19 1921, that I last saw him alive on Nov 19 1921, and that death occurred on the date stated above, at 4 P M.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

D

(Duration) — Yrs. mos. ds.

Contributory (Secondary) Chronic Nephritis

C

(Duration) yrs. mos. ds.

(Signed) R. P. Cummins M. D.

11/20 1921 (Address) Emmett Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Bramwell Ida

DATE OF BURIAL: 11/21 1921

20. UNDERTAKER: C. D. Bucknum

ADDRESS: Emmett Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 6
Primary Registration District No. 6
File No. 36041
Registered No.

1. PLACE OF DEATH
County of Gem
City of Emmett
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Margaret J. Corbin
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
female	white	married

6. DATE OF BIRTH: July (Month) 18 (Day) 1853 (Year)

7. AGE: 68 Yrs. 4 Mos. 9 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Rhoades

11. BIRTHPLACE OF FATHER (State or Country): Not Known

12. MAIDEN NAME OF MOTHER: Mary Tindle

13. BIRTHPLACE OF MOTHER (State or Country): Not Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Lottie Callender
(Address) Cascade Idaho

15. Filed 11/30 1921 J. L. Reynolds Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 27 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 18 1921, to Nov 27 1921, that I last saw her alive on Nov 27 1921, and that death occurred on the date stated above, at 6 P M.

The CAUSE OF DEATH* was as follows:

Lobular Pneumonia

(Duration) Yrs. mos. 40+ ds.

Contributory (Secondary) Influenza

(Duration) yrs. mos. 15 ds.

(Signed) R N Cummings M. D.

11/29 1921 (Address) Emmett Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Emmett Ida — DATE OF BURIAL: 11/29 1921

20. UNDERTAKER: C. E. Buckenum — ADDRESS: Emmett Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36042

Registered No.

Registration District No.

Primary Registration District No.

1. PLACE OF DEATH

County of Gem

City of Emmett

(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Silas Allen Pilant

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.) M

6. DATE OF BIRTH May (Month) 21 (Day) 1873 (Year)

7. AGE 48 Yrs. 5 Mos. 2 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Blacksmith

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Missouri

10. NAME OF FATHER John Pilant

11. BIRTHPLACE OF FATHER (State or Country) Tenn.

12. MAIDEN NAME OF MOTHER Serena Pounds

13. BIRTHPLACE OF MOTHER (State or Country) Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs S A Pilant

(Address) Emmett Idaho

15.

Filed 10/8 1921

W L Symmonds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 4 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 13 1921, to Oct 3 1921, that I last saw him alive on Oct 3 1921, and that death occurred on the date stated above, at 5 9 M.

The CAUSE OF DEATH* was as follows:

Pneumonia following influenza

(Duration) Yrs. mos. 20 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) P M Cummins M. D.

10/5 1921 (Address) Emmett Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Emmett Idaho

DATE OF BURIAL 10/6 1921

20. UNDERTAKER C E Buckenum

ADDRESS Emmett Idaho

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 6
Primary Registration District No.
File No. 36043
Registered No.

1. PLACE OF DEATH
County of Boise
City of Horseshoe Bend
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Betsy Woods
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	married

6. DATE OF BIRTH
not known
(Month) (Day) (Year)

7. AGE
78 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Arkansas

10. NAME OF FATHER Harness

11. BIRTHPLACE OF FATHER (State or Country) Not known

12. MAIDEN NAME OF MOTHER "

13. BIRTHPLACE OF MOTHER (State or Country) "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R B Pearson
(Address) Emmett Idaho

15.
Filed 10/8 1921
J L Reynolds
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Oct 6 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 5 1921, to Oct 5 1921
that I last saw her alive on Oct 5 1921,
and that death occurred on the date stated above, at 5 P M.

The CAUSE OF DEATH* was as follows:
Uraemia - Chronic
Nephritis

(Duration) Yrs. mos. 2 ds.
Contributory (Secondary) Chronic Nephritis
(Duration) Since yrs. mos. ds.

(Signed) R N Cummins M. D.
10/7 1921 (Address) Emmett Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Horseshoe Bend Ida | DATE OF BURIAL 10/8 1921

20. UNDERTAKER C A Buckner | ADDRESS Emmett Idaho

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36044
Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

RECEIVED
NOV 30 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH.
County of Gooding
City of Gooding (No. ..... St.)
Registration District No. 24
Primary Registration District No. .....
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Maria Gorochea

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Feb. (Month) 27 (Day) 1921 (Year)

7. AGE ..... Yrs. 7 Mos. 27 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... None —
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho -

10. NAME OF FATHER Marcenello Gorochea -

11. BIRTHPLACE OF FATHER (State or Country) Spain -

12. MAIDEN NAME OF MOTHER Shuman Lafferde -

13. BIRTHPLACE OF MOTHER (State or Country) Spain

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Marcenello Gorochea -
(Address) Gooding

15. Filed 10-19- 1921 — F. F. Cary M.D. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 19 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5:30PM - 10-18 - 1921, to [redacted] 12:15 Am 10-19- 1921, that I last saw her alive on 10PM. 10-18 — 1921, and that death occured on the date stated above, at 12:15 A M.

The CAUSE OF DEATH* was as follows:

Gastro-enteritis —

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) F. F. Cary — M. D.

10/19/1921 (Address) Gooding, Idaho —

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Gooding Cemetery
DATE OF BURIAL: 10-20 1921

20. UNDERTAKER: A E Thompson
ADDRESS: Gooding, Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BORS. 24658

FORM V. S. No. 5-25 M. 1-19.

RECEIVED DEC 13 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36045

Registered No.

1. PLACE OF DEATH

Registration District No. 24

Primary Registration District No.

County of Gooding

City of Gooding (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Robert Harrison Fales

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: July (Month) 2 (Day) 1911 (Year)

7. AGE: 10 Yrs. 4 Mos. 22 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: school boy
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Gooding Ida

10. NAME OF FATHER: Wm D Fales

11. BIRTHPLACE OF FATHER (State or Country): Mass

12. MAIDEN NAME OF MOTHER: Elizabeth B Fluton

13. BIRTHPLACE OF MOTHER (State or Country): Vermont

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wm D Fales
(Address) Gooding Ida

15. Filed 12-5-1921 J F Caymo
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 24 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....19...., to ....19....,
that I last saw h.... alive on ....19....,
and that death occurred on the date stated above, at ....M.
The CAUSE OF DEATH* was as follows:

Gun shot wound through heart

(Duration) ....Yrs....mos....ds.

Contributory (Secondary)

(Duration) ....yrs....mos....ds.

(Signed) J H Cammell M. D.
10/24/1921 (Address) Gooding Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Gooding Cemetary — DATE OF BURIAL: 11/27/1921

20. UNDERTAKER: A C Thompson — ADDRESS: Gooding

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED
NOV 30 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH.

Registration District No. 9 106
Primary Registration District No. ~~2184~~ 2184

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36047
Registered No. 113

1. PLACE OF DEATH.
County of Idaho
City of near Kamiah
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary Carter

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: Indian
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): widow
6. DATE OF BIRTH. (Month) ? (Day) ? 1825
7. AGE: about 96 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: housework
(b) General nature of industry, business, or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): Idaho
10. NAME OF FATHER: ?
11. BIRTHPLACE OF FATHER (State or Country): Idaho
12. MAIDEN NAME OF MOTHER: ?
13. BIRTHPLACE OF MOTHER (State or Country): Idaho
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) John P Harrod
(Address) Kamiah Idaho
15. Filed 10/27 1921 J M Verbeyst Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Oct 26 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 5 1921, to Oct 26 1921, that I last saw h[er] alive on Oct 19 1921, and that death occured on the date stated above, at 8 p M.

The CAUSE OF DEATH* was as follows:
Chronic Myocarditis
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) General Debility
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) J M Verbeyst M. D.
Oct 27 1921 (Address) Kamiah Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL ..... 191...

20. UNDERTAKER | ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

BYRD - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

RECEIVED
NOV 30 1921
BUREAU OF VITAL STATISTICS

Registration District No. 106
Primary Registration District No. 2184

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36048
Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Idaho
City of Ruu Rooskia (Village, Township or Town) St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Margaret Lee

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Oct (Month) 27 (Day) 1902 (Year)

7. AGE: 18 Yrs. 11 Mos. 27 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Lived at home
(b) General nature of industry, business, or establishment in which employed (or employer): Casper Wyo.

9. BIRTHPLACE (State or Country): Minnesota

10. NAME OF FATHER: John Swantz

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Charlotte Bombreit

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Paul Petrick
(Address) Rooskia

15. Filed Oct 25 1921 J M Weber Kuners Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 19th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 18 1921, to Oct 19 1921, that I last saw h SW alive on Oct 19 1921, and that death occured on the date stated above, at 10a M.

The CAUSE OF DEATH* was as follows:
Uraemic convulsions

(Duration) ..... Yrs. ..... mos. 1 ds.
Contributory (Secondary) Chronic Bright's

(Duration) 4 yrs. ..... mos. ..... ds.
(Signed) H W Wentworth M. D.
Oct 19 1921 (Address) Stites Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence Casper Wyoming

19. PLACE OF BURIAL OR REMOVAL: Rooskia — DATE OF BURIAL: Oct 25 1921

20. UNDERTAKER: Geo Tuman — ADDRESS: Rooskia

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRD - YORK CO., PTRS. & BORS. 24858

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 106
Primary Registration District No. 2184
File No. 36049
Registered No. 114

1. PLACE OF DEATH.
County of Idaho
City of Stites (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

BUREAU OF VITAL STATISTICS

2. FULL NAME ~~Infant Carpenter~~

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Nov (Month) 6th (Day) 1921 (Year)

7. AGE ..... Yrs. ..... Mos. 9 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Infant
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Harry Lee Carpenter

11. BIRTHPLACE OF FATHER (State or Country) Oregon

12. MAIDEN NAME OF MOTHER Carrie Hyson

13. BIRTHPLACE OF MOTHER (State or Country) Wisconsin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Bertha Carpenter
(Address) Stites Idaho

15. Filed Nov 16 1921
J. M. Rebekkus
Local Registrar

SYMS - YORK CO., PTRS. & SONS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 15th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 6th 1921, to Nov 15 1921, that I last saw her alive on Nov 6 1921, and that death occured on the date stated above, at 9a. M.

The CAUSE OF DEATH* was as follows:
Pneumonia Broncho
Seven months plus bronch
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) H W Wentworth M. D.
Nov 19..... (Address) Stites Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Stites
DATE OF BURIAL: Nov 191

20. UNDERTAKER
ADDRESS

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

36050

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Idaho
City of Greencreek (St.)
If death occurs away from usual residence, give facts called for under special information.

RECEIVED
DEC 24 1921
BUREAU OF VITAL STATISTICS

Registration District No. 105
Primary Registration District No. 2183
File No. 13
Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lee Miller

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married
6. DATE OF BIRTH: Nov (Month) 11 (Day) 1840 (Year)
7. AGE: 81 Yrs. Mos. 2 ds. IF LESS than 1 day how many hrs. or min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer)
9. BIRTHPLACE (State or Country): Penn
10. NAME OF FATHER: Lee Miller
11. BIRTHPLACE OF FATHER (State or Country): France
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (State or Country)
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Harry Miller
(Address) Craig Grove
15. Filed Dec 5 1921 W. F. Orr Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 13 (Day) 1921 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Oct 1 1921, to Nov 13 1921, that I last saw h[illegible] alive on Nov 12 1921, and that death occurred on the date stated above, at 3:45 P. M.
The CAUSE OF DEATH* was as follows:
Senile decay
(Duration) Yrs. mos. ds.
Contributory (Secondary) Arterio-sclerosis
(Duration) yrs. mos. ds.
(Signed) G S Stockton M. D.
11/14 1921 (Address) Grangeville Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Denver — DATE OF BURIAL: 11-15 1921
20. UNDERTAKER: Owen — ADDRESS: Cottonwood

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED NOV 30 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 105
Primary Registration District No. 2183.
File No. 13
Registered No. 36052

1. PLACE OF DEATH
County of Idaho
City of Cataldo (St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Edward Ameen
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single
6. DATE OF BIRTH: Nov 4 (Month) (Day) 1876 (Year)
7. AGE: ...Yrs. ...Mos. ...ds. IF LESS than 1 day how many ... hrs. or ... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Bridge Hand on R.R.
(b) General nature of industry, business or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Sweden
10. NAME OF FATHER: John Ameen
11. BIRTHPLACE OF FATHER (State or Country): Sweden
12. MAIDEN NAME OF MOTHER:
13. BIRTHPLACE OF MOTHER (State or Country):
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A Amundson
(Address) 5003 Monroe St Spokane Wash
15. Filed Nov-3 1921 W.F. Orr Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. (Month) 10 (Day) 21 (Year)
17. I HEREBY CERTIFY, That I attended deceased from ... 19..., to ... 19... that I last saw h... alive on ... 19..., and that death occurred on the date stated above, at 8:30 A.M.
The CAUSE OF DEATH* was as follows:
Crushed Skull
Accidental Timber falling from R.R. Bridge.
(Duration) ... Yrs. ... mos. ... ds.
Contributory (Secondary)
(Duration) ... yrs. ... mos. ... ds.
(Signed) A. J. Maugg Coroner
19... (Address) Grangeville

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Spokane Wash
DATE OF BURIAL: ... 19...
20. UNDERTAKER: A. J. Maugg
ADDRESS: Grangeville

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED NOV 30 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

36053

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 105

County of Idaho

Primary Registration District No. 2183

File No. 14

City of Fenn (If outside limits, give township.) St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Rosamond Caroline Spengler

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): single

6. DATE OF BIRTH: May (Month) 18 (Day) 1908 (Year)

7. AGE: ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Chas A. Spengler

11. BIRTHPLACE OF FATHER (State or Country): Kansas

12. MAIDEN NAME OF MOTHER: Annie Wendt

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C C Spengler

(Address) Fenn Idaho

15. Filed Nov 3 1921 T. F. Orr Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 8 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1921, to Oct 1921, that I last saw h[illegible] alive on Oct 6 1921 and that death occurred on the date stated above, at 6 [illegible] M.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia.

[illegible]

(Duration) ..... Yrs. 4 mos. 4 ds.

Contributory (Secondary) Cirrhosis of Liver

(Duration) ..... yrs. 3 mos. ..... ds.

(Signed) J. D. Shinnick M. D.

Oct 8 1921 (Address) Cottonwood Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Denver Colo — DATE OF BURIAL: 10-10 1921

20. UNDERTAKER: [illegible] — ADDRESS: Cottonwood Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED NOV 30 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

36054

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Idaho — Registration District No. 105

City of Greencreek (Ward) (St.) — Primary Registration District No. 2183

File No. 12

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Abram Henry Schmidt

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: single (Write the word.)

6. DATE OF BIRTH: Oct (Month) 21 (Day) 1931 (Year)

7. AGE: ....Yrs....Mos....ds.

IF LESS than 1 day how many 3 hrs. or ....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work....

(b) General nature of industry, business or establishment in which employed (or employer)....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Anton Schmidt

11. BIRTHPLACE OF FATHER (State or Country) Idaho

12. MAIDEN NAME OF MOTHER Josephine Jentges

13. BIRTHPLACE OF MOTHER (State or Country) Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Anton Schmidt

(Address) Grasmere Idaho

15. Filed Nov 3 1921 — W. F. Orr, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 22 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from — 19...., to — 19....,
that I last saw h.— alive on — 19....,
and that death occurred on the date stated above, at 12:20 P.M.
The CAUSE OF DEATH* was as follows:

Unknown
Premature Birth

....(Duration) ....Yrs....mos....ds.

Contributory (Secondary)

....(Duration) ....yrs....mos....ds.

(Signed) Wesley F. Orr M.D.

10/22 1921 (Address) Bellevue Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death....yrs....mos....days. In the State....yrs....mos....days

Where was disease contracted if not at place of death?....

Former or usual residence ....

19. PLACE OF BURIAL OR REMOVAL: Greencreek Idaho — DATE OF BURIAL: 12-22 1921

20. UNDERTAKER: [illegible] — ADDRESS: Cottonwood Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36055

Registered No. 967

RECEIVED NOV 30, 1921 BUREAU OF VITAL STATISTICS

1. **PLACE OF DEATH**

County of Kootenai Registration District No. 30

City of Rathdrum (No. ....., ... St.) Primary Registration District No. 1057

If death occurs away from usual residence, give facts called for under special information.

2. **FULL NAME** Betty Louise Rich

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F	W	S

6. **DATE OF BIRTH** May (Month) 31 (Day) 1915 (Year)

7. **AGE** Yrs. 6 Mos. 3 ds. 6 — IF LESS than 1 day how many ..... hrs. or ..... min.?

8. **OCCUPATION**

(a) Trade, profession or particular kind of work X

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. **BIRTHPLACE** (State or Country) N. Dakota

10. **NAME OF FATHER** Roy H Rich

11. **BIRTHPLACE OF FATHER** (State or Country) Ill

12. **MAIDEN NAME OF MOTHER** Helen Burns

13. **BIRTHPLACE OF MOTHER** (State or Country) Ill

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**

(Informant) Helen Burns Rich

(Address) 726-S-4th Spokane Wash

15. Filed Nov 4 1921 — S D Dresbach Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH** Sept 6. (Month) (Day) 1921 (Year)

17. **I HEREBY CERTIFY, That I attended deceased from** Sept 6. 1921, to Sept 6. 1921, that I last saw b.... alive on Sept 6. 1921, and that death occurred on the date stated above, at 11.45 A.M.

The CAUSE OF DEATH* was as follows: P. Status Lymphaticus

..... (Duration) ..... Yrs. ..... mos. 1 ds.

Contributory (Secondary) Tuberculosis

..... (Duration) ..... yrs. ..... mos. 3 ds.

(Signed) Frank Keys M. D.

7/7 1921 (Address) Rathdrum Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. **PLACE OF BURIAL OR REMOVAL** Spangfield Ill — **DATE OF BURIAL** Sep 9 1921

20. **UNDERTAKER** O. W. Eldam — **ADDRESS** Rathdrum Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36057
Registered No.

1. PLACE OF DEATH

County of Kootenai
City of Coeur d'Alene (If outside city limits, write "Rural") 621 3rd St.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED NOV 30 1921 BUREAU OF VITAL STATISTICS

Registration District No.
Primary Registration District No.

2. FULL NAME Louise Maas

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F.	W.	married

6. DATE OF BIRTH: 3 (Month) - 1 (Day) 1882 (Year)

7. AGE: 39 Yrs. 7 Mos. 6 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wis.

10. NAME OF FATHER: Carl Schultz

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Theo. Maas
(Address): 621 - 3rd St.

15.
Filed 19
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. (Month) 7 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 26 1921 to Oct 6. 1921 that I last saw h.er alive on Oct 6 1921, and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Peritonitis

(Duration) Yrs. mos. ds.
Contributory (Secondary): Perforation of Bowel,
(Duration) yrs. mos. ds.

(Signed) D D Brennan M. D.
9/8 1921 (Address) Coeur d Alene

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Forest-Cem. CdAlene	19
20. UNDERTAKER: C. Cassedy	ADDRESS: CdAlene

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
NOV 30 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 30
Primary Registration District No. 1071
File No. 36058
Registered No. 971

1. PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene (No. 4th St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Louisa Profitt
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: 8 (Month) – 4 (Day) 1851 (Year)

7. AGE: 40 Yrs. – Mos. – ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Virginia

10. NAME OF FATHER: G. M. Venters

11. BIRTHPLACE OF FATHER (State or Country): Virginia

12. MAIDEN NAME OF MOTHER: Susan Clevenger

13. BIRTHPLACE OF MOTHER (State or Country): Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. C. Profitt
(Address) Coeur d'Alene Idaho

15. Filed Nov. 4 1921 C. D. Freeman Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. (Month) 11 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 29 1921, to Oct. 7. 1921, that I last saw h[illegible] alive on Oct. 7 1921 and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Influenza.
..... (Duration) ..... Yrs. ..... mos. 11 ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Wm O Wood M. D.
Oct. 12 1921 (Address) Coeur d'Alene Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Forest-Cem. C D[illegible] | DATE OF BURIAL: 10-12 1921

20. UNDERTAKER: C. Cassedy | ADDRESS: C'Dalene.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED NOV 30 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Kootenai — Registration District No. 98

City of Coeur d'Alene — Primary Registration District No. 1051

No. ..... St.)

File No. 36059

Registered No. 973

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Peter Rahman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: S (Write the word.)

6. DATE OF BIRTH: May (Month) 21 (Day) 1839 (Year)

7. AGE: 82 Yrs. 5 Mos. 24 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: +

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: X

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Gerald Fenlon

(Address) Post Falls R F D # 1

15. Filed Nov 4 1921 — N D Freeman, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sep (Month) 13 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sep 13 1921, to Sept 13 1921, that I last saw him alive on Sep 13 1921 and that death occurred on the date stated above, at 5:00 P.M.

The CAUSE OF DEATH* was as follows:

Acute Dysentery

(Duration) ..... Yrs. ..... mos. 7 ds.

Contributory (Secondary) Old age

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Frank Perry M. D.

9/15 1921. (Address) Rathdrum, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Cathedral Cemetery Trent Wash. — DATE OF BURIAL: Sep 16 1921

20. UNDERTAKER: C W Stone — ADDRESS: Rathdrum Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36060

Registered No. 974

1. PLACE OF DEATH

County of Kootenai

City of Coeur d'Alene (No. 1020, 2nd St.)

Registration District No. 30

Primary Registration District No. 1051

RECEIVED NOV 20

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Agnes Sophia Peterson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: single (Write the word.)

6. DATE OF BIRTH: 6 (Month) — 19 (Day) 1906 (Year)

7. AGE: 15 Yrs. 3 Mos. 24 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Scholar

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Minn.

10. NAME OF FATHER: Paul Peterson

11. BIRTHPLACE OF FATHER (State or Country): Norway

12. MAIDEN NAME OF MOTHER: Annie Olson

13. BIRTHPLACE OF MOTHER (State or Country): Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Paul Peterson

(Address)

15. Filed Nov 4 1921 — D. D. Drenna, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 13 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 9 1921, to Oct 13 1921, that I last saw h[e] alive on Oct 13 1921, and that death occurred on the date stated above, at 4:30 P. M.

The CAUSE OF DEATH* was as follows:

Diffuse Peritonitis

(Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary) Perforated Appendicitis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. O. Mayo M. D.

Oct 13 1921 (Address) Coeur d'Alene Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Forest Cem. CdAlene — DATE OF BURIAL: 10-16 1921

20. UNDERTAKER: C. Cassedy — ADDRESS: CdAlene.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
NOV 30 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Kootenai Registration District No. 30

City of Hayden Lake (No. ..... St.) Primary Registration District No. 1057

File No. 36061

Registered No. 975

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Russell Branson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M.	W.	Married

6. DATE OF BIRTH: 9 (Month) 18 (Day) 1880 (Year)

7. AGE: 41 Yrs. 0 Mos. 29 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Machinest
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mich.

10. NAME OF FATHER: A. E. Branson

11. BIRTHPLACE OF FATHER (State or Country): Mich

12. MAIDEN NAME OF MOTHER: Ella Stanton

13. BIRTHPLACE OF MOTHER (State or Country): Mich.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs A E Branson.
(Address) Coeur d Alene

15. Filed Nov 4 1921 W. D. Duncan Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 17 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1 1921 to June 15 1921 that I last saw h. alive on Sept 1 1921 and that death occurred on the date stated above, at 109 M.

The CAUSE OF DEATH* was as follows:

Hodgkins Disease

(Duration) 3 Yrs. — mos. — ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. H. Hoedemaker M. D.

10/28 1924 (Address) Coeur d Alene Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Forest Cem. C D Alene — DATE OF BURIAL: 10-18 1921

20. UNDERTAKER: C Carsedy — ADDRESS: C D Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
NOV 30 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. **PLACE OF DEATH**

County of Kootenai — Registration District No. 30

City of Rathdrum (St.) — Primary Registration District No. 1031

File No. 36062

Registered No. 976

If death occurs away from usual residence, give facts called for under special information.

2. **FULL NAME** Ida A. Stone

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
F	W	married (Write the word.)

6. **DATE OF BIRTH** April (Month) 2 (Day) 1862 (Year)

7. **AGE** 59 Yrs. 6 Mos. 16 ds. — IF LESS than 1 day how many ..... hrs. or ..... min.?

8. **OCCUPATION**

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer):

9. **BIRTHPLACE** (State or Country) New York

10. **NAME OF FATHER** Runson Kennedy

11. **BIRTHPLACE OF FATHER** (State or Country) New York

12. **MAIDEN NAME OF MOTHER** Rozeta Combs

13. **BIRTHPLACE OF MOTHER** (State or Country) New York

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**

(Informant) O. W. Stone

(Address) Rathdrum, Idaho

15. Filed Nov 3 1921 — L. D. Drema, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH** October (Month) 18 (Day) 1921 (Year)

17. **I HEREBY CERTIFY**, That I attended deceased from August 10 1921, to Oct. 18. 1921, that I last saw h— alive on Oct. 18. 1921, and that death occurred on the date stated above, at 9 P M.

The **CAUSE OF DEATH*** was as follows:

Thyroid adenoma with auto intoxication produced by it

(Duration) about 3 mos.

Contributory (Secondary) Cancerous growth of

Pylorus (Duration) 2 mos.

(Signed) Frank Wm M. D.

10/20 1921 (Address) Rathdrum, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. **PLACE OF ~~BURIAL~~ OR REMOVAL** Spokane, Wash. — **DATE OF ~~BURIAL~~** removal 10-21 1921

20. **UNDERTAKER** C. Cassedy — **ADDRESS** Coeur d'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
NOV 30 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36063
Registered No. 977

1. PLACE OF DEATH
County of Kootenai Registration District No. 30
City of Coeur d'Alene (No. ; St.) Primary Registration District No. 1031 Montana

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Susie F Bedell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Nov (Month) 6 (Day) 1841 (Year)

7. AGE: 79 Yrs. 11 Mos. 12 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmers Wife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mo

10. NAME OF FATHER: Ervin Thomas

11. BIRTHPLACE OF FATHER (State or Country): Ky

12. MAIDEN NAME OF MOTHER: Nancy Kreider

13. BIRTHPLACE OF MOTHER (State or Country): Ky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Ada Tedel
(Address) City

15. Filed Nov. 3. 1921 S D Drenna Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 18 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 15 1921, to Oct 18 1921, that I last saw h[illegible] alive on Oct 18 1921, and that death occurred on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) — Yrs. — mos. — ds.

Contributory (Secondary) Arterio Sclerosis

(Duration) — yrs. — mos. — ds.

(Signed) W H Haeden M. D.

10/20 1921 (Address) Coeur d Alene Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State 18 yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Fort Cemetery	10/20 1921
20. UNDERTAKER	ADDRESS
R B Mooney	Coeur d'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36064
Registered No. 978

RECEIVED
NOV 30 1921
BUREAU OF VITAL STATISTICS

Registration District No. 30
Primary Registration District No. 1057

1. PLACE OF DEATH
County of Kootenai
City of Post Falls (If not in incorporated city or town, give township) St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Annie Ford Patterson
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: July (Month) 16 (Day) 1845 (Year)

7. AGE: 76 Yrs. 3 Mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mo

10. NAME OF FATHER: Harvey Ford

11. BIRTHPLACE OF FATHER (State or Country): unknown

12. MAIDEN NAME OF MOTHER: Elizabeth Shannon

13. BIRTHPLACE OF MOTHER (State or Country): Ken.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Geo M Patterson
(Address) Post Falls Ida

15. Filed Nov 3 1921 D D Greene Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: October (Month) 19 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 17 1921, to October 19 1921, that I last saw her alive on Oct 19 1921, and that death occurred on the date stated above, at 5 A.M.

The CAUSE OF DEATH* was as follows:
Shock from fracture of thigh
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Chronic Gastritis
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F L McCarley M. D.
10/20 1921 (Address) Post Falls, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State 21 yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Post Falls Cemetery
DATE OF BURIAL: 10/20 1921
20. UNDERTAKER: P P B Mooney
ADDRESS: Coeur d'Alene Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36065

Registered No. 979

RECEIVED
NOV 30 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Kootenai Registration District No. 30

City of Coeur d'Alene (If outside limits of city or village, give township) Primary Registration District No. 1057

(Ward) 6 (St.) Lakeside

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Steil

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M.	W.	Widower.

6. DATE OF BIRTH: 4 (Month) 16 (Day) 1845 (Year)

7. AGE: 76 Yrs. 6 Mos. 4 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: Steil

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Katherine S. Trosper.
(Address) 620 Lakeside

15. Filed Nov 24 1921 D. D. Duncan Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. (Month) 20 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 10 1921 to Oct. 20 1921
that I last saw him alive on Oct. 20 1921
and that death occurred on the date stated above, at 9 A. M.
The CAUSE OF DEATH* was as follows:
Chronic lymphoid leukaemia

(Duration) ? Yrs. ? mos. ? ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John Wood M. D.
Oct. 22 1921 (Address) Coeur d'Alene, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
St Thomas. Cem.	10-22 1921

20. UNDERTAKER	ADDRESS
Clarsedy	CdAlene.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
NOV 30 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Kootenai Registration District No. 30

City of Coeur d'Alene (No. Near Hauser Jc. St.) Primary Registration District No. 1051

File No. 36066

Registered No. 980

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Steve Bressan

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Unknown (Month) (Day) 1 (Year)

7. AGE: 50 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: County Charge

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Italy

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Joe Bressan

(Address) Harrison

15. Filed Nov 4 1921 L D Drema Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Found Oct 23 - 1921

Unknown (Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....

that I last saw h..... alive on ..... 19.....

and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Body found near Hauser Jc.

death due to exposure

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) P B Mooney Coroner D.

19..... (Address) Coeur d'Alene, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State 6 yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Harrison Ida

DATE OF BURIAL: 10/25 1921

20. UNDERTAKER: P B Mooney

ADDRESS: Coeur d'Alene Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Kootenai Registration District No. 30

City of Rathdrum Primary Registration District No. 1031

(If outside limits, give township) Near Rathdrum St.)

File No. 36067

Registered No. 981

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Unknown Man

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

RECEIVED
NOV 30 1921
BUREAU OF VITAL STATISTICS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH: Unknown (Month) (Day) 1 (Year)

7. AGE: About 30 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: unknown

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15. Filed Nov 27 1921 D P Brennan Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 20 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....

that I last saw h..... alive on ..... 19.....,

and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Body found near Rathdrum. Gun shot wound in Right Temple

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Suicide

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) P A O'Leary Coroner M. D.

10/22 1921 (Address) Coeur d'Alene, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Wood Cemetery Rathdrum

DATE OF BURIAL: Oct 25 1921

20. UNDERTAKER: E Cassidy

ADDRESS: Coeur d'Alene Ida

FORM V. S. No. 5-25 M. 1-19.

RECEIVED NOV 30 1921 BUREAU OF VITAL STATISTICS STATE OF IDAHO

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 30
Primary Registration District No. 1091
File No. 36068
Registered No. 982

1. PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene (No. 855 Government Way St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lucia A. Branden
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Dec (Month) 24 (Day) 1898 (Year)

7. AGE: 22 Yrs. 10 Mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Home Wife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wis

10. NAME OF FATHER: Frank Stevens

11. BIRTHPLACE OF FATHER (State or Country): Wis

12. MAIDEN NAME OF MOTHER: Lucia Smith

13. BIRTHPLACE OF MOTHER (State or Country): Mich

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Lid A. Branden
(Address) Coeur d'Alene, Ida.

15. Filed Nov. 4 1921 D D Drennan Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 27 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 17 1921, to Oct 27 1921, that I last saw her alive on Oct 26 1921, and that death occurred on the date stated above, at 6 A M.

The CAUSE OF DEATH* was as follows:

Septic Infection

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Neph. Chronic

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D D Drennan M. D.

10/28 1921 (Address) Coeur d'Alene

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State 30 yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetery — DATE OF BURIAL: 10/28 1921

20. UNDERTAKER: R B Mooney — ADDRESS: Coeur d'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 30
Primary Registration District No. 1057
File No. 36069
Registered No. 983

RECEIVED NOV 30 1921 BUREAU

1. PLACE OF DEATH

County of Kootenai
City of Coeur d'Alene (If not in incorporated city or village give township) No. 1052 E. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ole A. Larson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M.	W.	Married

6. DATE OF BIRTH: 1 (Month) 13 (Day) 1866 (Year)

7. AGE: 55 Yrs. 9 Mos. 14 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Common Laborer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER: Lars Larson

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: ———

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs O A Larson
(Address) 1052 E. St.

15. Filed Nov. 4 1921 T. T. Drema Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: October 27 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....
and that death occurred on the date stated above, at 7 P M.
The CAUSE OF DEATH* was as follows: Supposed to be Bright's Disease

..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. H. Hoeden M. D.
10/28 1921 (Address) Coeur d'Alene Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Forest Cem. CD Alene — DATE OF BURIAL: 10-30 1921

20. UNDERTAKER: J. Cassidy — ADDRESS: CD Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

RECEIVED NOV 30 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 30

County of Kootenai

Primary Registration District No. 1051

File No. 36070

City of ... (No. Kidd Island St.)

Registered No. 984

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Stone

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Female	White	Married (or Widowed)

6. DATE OF BIRTH: Oct (Month) 1 (Day) 1857 (Year)

7. AGE: 64 Yrs. 0 Mos. 26 ds. IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Home Wife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER: Kneiberg

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) August Stone
(Address) Kidd Island Coeur d'Alene Ida.

15. Filed Nov. 4 1921 S D Brenna Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 26 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 19 Doctor 19, that I last saw h... alive on ... 19, and that death occurred on the date stated above, at 6 A.M.

The CAUSE OF DEATH* was as follows:

Apoplexy Sudden

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) S D Brenna M. D.

10/27 1921 (Address) Coeur d'Alene

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. 12 mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Forest Cemetery	10/28 1921
20. UNDERTAKER	ADDRESS
R A Toomey	Coeur d'Alene Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36072
Registered No. 986

RECEIVED
DEC 1 1921
BUREAU OF VITAL STATISTICS

Registration District No. 30
Primary Registration District No. 1057

1. PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene (or Township), Foster St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William O'Neal
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Sept (Month) 26 (Day) 1860 (Year)

7. AGE: 61 Yrs. 1 Mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business or establishment in which employed (or employer): Logging Contractor

9. BIRTHPLACE (State or Country): Michigan

10. NAME OF FATHER: Mathews O'Neal

11. BIRTHPLACE OF FATHER (State or Country): Canada

12. MAIDEN NAME OF MOTHER: Katherine Miller

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Wm O'Neal
(Address) Coeur d'Alene Ida

15. Filed Dec 6 1921 D D Drennan Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 30 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1920, to Oct 30 1921, that I last saw him alive on Oct 29 1921, and that death occurred on the date stated above, at 9 A.M.
The CAUSE OF DEATH* was as follows:

Cancer of tongue and throat

(Duration) 2 Yrs. ..... mos. ..... ds.

Contributory (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J O Brown M. D.
Oct 31 1921 (Address) Coeur d'Alene Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State 17 yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: St Thomas Cemetery
DATE OF BURIAL: 11/2 1921

20. UNDERTAKER: [illegible] Denny
ADDRESS: Coeur d'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36073
Registered No. 987

RECEIVED
DEC 1 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
Registration District No. 31
Primary Registration District No. 1067
County of Kootenai
City of Coeur d'Alene (If outside limits, give township.) Kuvell add St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Leslie Acton

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: single (Write the word.)
6. DATE OF BIRTH: 11 (Month) 2 (Day) 1921 (Year)
7. AGE: ....Yrs. ....Mos. 1 ds. IF LESS than 1 day how many.... hrs. or....min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business or establishment in which employed (or employer)
9. BIRTHPLACE (State or Country) Idaho
10. NAME OF FATHER O. H. Acton
11. BIRTHPLACE OF FATHER (State or Country) Missouri
12. MAIDEN NAME OF MOTHER Ellen Davis
13. BIRTHPLACE OF MOTHER (State or Country) Idaho.
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) O. H. Acton
(Address) Coeur d'Alene Ida.
15. Filed Dec 5 1921 D D Dunn
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 3 (Day) 1921 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Nov 2 1921 to Nov 3 1921
that I last saw h.. alive on Nov 3 1921
and that death occurred on the date stated above, at 7 P. M.
The CAUSE OF DEATH* was as follows: —
Ileo Colitis
(Duration) ....Yrs. ....mos. 1 ds.
Contributory (Secondary) Primary Peritonitis
(Duration) ....yrs. ....mos. ....ds.
(Signed) F. H. Haddenham M. D.
11/4 1921 (Address) Coeur d Alene Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetery Ida. | DATE OF BURIAL: 11-5 1921
20. UNDERTAKER: C. Casseedy | ADDRESS: C'Dalene.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED DEC 1 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 30

Primary Registration District No. 1051

File No. 36074

Registered No. 988

County of Kootenai

City of Coeur d'Alene No. 424 Hastings St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Benj. Tisdall

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: single (Write the word.)

6. DATE OF BIRTH: Nov. (Month) 5 (Day) 1821 (Year)

7. AGE: Yrs. Mos. 1 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Oliver Tisdall

11. BIRTHPLACE OF FATHER (State or Country) Iowa.

12. MAIDEN NAME OF MOTHER Julia Sire

13. BIRTHPLACE OF MOTHER (State or Country) Norway.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Oliver Tisdall

(Address)

15. Filed Dec 5 1921 D D Drennan Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 5 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 5. 1921, to 19..., that I last saw h... alive on 19..., and that death occurred on the date stated above, at ...M.

The CAUSE OF DEATH* was as follows:

Premature Birth

Placenta Previa

(Duration) ...Yrs. ...mos. ...ds.

Contributory (Secondary)

(Duration) ...yrs. ...mos. ...ds.

(Signed) D D Drennan M. D.

19... (Address) Coeur d'Alene Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ...yrs. ...mos. ...days. In the State ...yrs. ...mos. ...days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Forest-Cem. C'Alene — DATE OF BURIAL 19...

20. UNDERTAKER: C. Cassedy — ADDRESS C'Alene,

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED DEC 1 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36075
Registered No. 989

1. PLACE OF DEATH
County of Kootenai Registration District No. 30
City of Coeur d'Alene (No. 1406 5th St.) Primary Registration District No. 1051

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John B. Schneider

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: married (Write the word.)
6. DATE OF BIRTH: Feb. (Month) 6 (Day) 1845 (Year)
7. AGE: 76 Yrs. 9 Mos. 0 ds. IF LESS than 1 day how many..... hrs. or.....min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Switzerland
10. NAME OF FATHER: Oscar Schneider
11. BIRTHPLACE OF FATHER (State or Country): Switzerland
12. MAIDEN NAME OF MOTHER: Barbara Baumgarten
13. BIRTHPLACE OF MOTHER (State or Country): Switzerland
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Henry Schneider
(Address).....
15. Filed Dec 5, 1921 D. N. Greenough Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 6 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 16, 1921 to Nov. 6 1921 that I last saw h.. alive on Oct. 30 1921 and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:
Chronic interstitial Nephritis

.....(Duration) .....Yrs. ? mos.....ds.

Contributory (Secondary)
.....(Duration) .....yrs.....mos.....ds.

(Signed) John Allwood M. D.
Nov. 8 1921 (Address) Coeur d'Alene, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Forest-Cem. C'Alene — DATE OF BURIAL: 11-8 1921
20. UNDERTAKER: C. Cassedy — ADDRESS: C'Alene

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED DEC 1 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36076
Registered No. 996

1. PLACE OF DEATH
County of Kootenai
City of ..... (If outside limits of city or village, give township) ..... St.)
Registration District No. 30
Primary Registration District No. 1051

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Peter Anton Gullickson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Sept (Month) 11 (Day) 1877 (Year)

7. AGE: 43 Yrs. 2 Mos. 0 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Norway

10. NAME OF FATHER: Gullick Hanson

11. BIRTHPLACE OF FATHER (State or Country): Norway

12. MAIDEN NAME OF MOTHER: Elsie M Peterson

13. BIRTHPLACE OF MOTHER (State or Country): Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs P. A. Gulbrickson
(Address) Coeur d'Alene Ida

15. Filed Dec 23, 1921 — D. D. Drennan, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 11 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 23 1921, to Nov. 10 1921, that I last saw h. alive on July 5 1921, and that death occurred on the date stated above, at 5 A. M.
The CAUSE OF DEATH* was as follows:
Diabetes Mellitus
(Duration) 2 Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) J. C. Owen M. D.
Nov 12 1921 (Address) Coeur d'Alene Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State 17 yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Forest Cemetery	19.....

20. UNDERTAKER	ADDRESS
R B Mooney	Coeur d'Alene Ida

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED DEC 1 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36077

Registered No. 991

1. PLACE OF DEATH

County of Kootenai Registration District No. 30

City of Coeur d'Alene Primary Registration District No. 1051

If death occurs away from usual residence, give facts called for under special information.

Ward No. 16th & Foster St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Harvey E. Hammond

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M.	W.	single

6. DATE OF BIRTH: Sept. (Month) 11 (Day) 1921 (Year)

7. AGE: — Yrs. 2 Mos. 1 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Earl Hammond

11. BIRTHPLACE OF FATHER (State or Country) Utah - N. D.

12. MAIDEN NAME OF MOTHER Ida Bolleger

13. BIRTHPLACE OF MOTHER (State or Country) Minn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs E. B. Hammond

(Address) 16 and Foster

15. Filed Dec 5 1921 D D Drenna Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 12 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 7 1921 to Nov 12 1921

that I last saw h-- alive on Nov 12 1921

and that death occurred on the date stated above, at 10 M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D D Drenna M. D.

11/13 1921 (Address) Coeur d Alene Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Forest Cem. CDA,	11-13 1921

20. UNDERTAKER	ADDRESS
C. Cassedy	CDAlene

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36078
Registered No. 992

RECEIVED DEC 1 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Kootenai Registration District No. 30
City of Coeur d'Alene Primary Registration District No. 1051
(If outside limits of city or village, give township.) No. 1810 Young ave (St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Catherine H Green
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Dec (Month) 7 (Day) 1920 (Year)

7. AGE: 0 Yrs. 11 Mos. 7 ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Charles J. Green

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Mamie Swofford

13. BIRTHPLACE OF MOTHER (State or Country): Ida.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chas J Green
(Address) Coeur d'Alene

15. Filed Dec 5 1921 — A. D. Greenman, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 14 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 1920 to Nov. 14 1921 that I last saw h[er] alive on Nov. 14 1921, and that death occurred on the date stated above, at 6 P. M.
The CAUSE OF DEATH* was as follows:
Myocarditis
(Duration) ... Yrs. ... mos. ... ds.
Contributory (Secondary)
(Duration) ... yrs. ... mos. ... ds.
(Signed) A D Greenman M. D.
11/14 1921 (Address) R D A

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. 11 mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetery — DATE OF BURIAL: 11/15 1921
20. UNDERTAKER: R B Mooney — ADDRESS: Cda Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36079
Registered No. 993

RECEIVED DEC 1 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene (If outside city limits, write Township) Fancy Ranch (Street and No.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 30
Primary Registration District No. 1057

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Minnie Mary Green

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: June (Month) 29 (Day) 1897 (Year)

7. AGE: 29 Yrs. 5 Mos. 1 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmers Wife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: W. J. Swofford

11. BIRTHPLACE OF FATHER (State or Country): Ill

12. MAIDEN NAME OF MOTHER: Sarah J. Gooden

13. BIRTHPLACE OF MOTHER (State or Country): Ill

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chas Green
(Address) Coeur d'Alene

15. Filed Nov 5 1921 L. D. Drennan Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 11 (Month) 15 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1 1921, to Nov 15 1921, that I last saw h. alive on Nov. 15 1921, and that death occurred on the date stated above, at 9 A M.

The CAUSE OF DEATH* was as follows:
Intussusception of the Bowel
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) L. D. Drennan M. D.
11/16 1921 (Address) Coeur d'Alene Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State 29 yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetery — DATE OF BURIAL: 11— 1921

20. UNDERTAKER: [illegible] — ADDRESS: Coeur d'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36080

Registered No. 994

1. PLACE OF DEATH

Registration District No. 30

Primary Registration District No. 1051

County of Kootenai

City of ..... (No. ....., Foster St.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
DEC 1 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME Agnes Nilson Curley

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Sept (Month) 24 (Day) 1852 ~~1921~~ (Year)

7. AGE: 39 Yrs. 2 Mos. 21 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mich

10. NAME OF FATHER: Alexander Nairn

11. BIRTHPLACE OF FATHER (State or Country): Scotland

12. MAIDEN NAME OF MOTHER: Margaret McCarny

13. BIRTHPLACE OF MOTHER (State or Country): Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. Roy Giles

(Address) Coeur d Alene Ida

15. Filed Dec 5 1921 D D Brennan Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 15 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 15 1921, to Nov 15 1921, that I last saw her alive on Nov 14 1921, and that death occurred on the date stated above, at 4:30 P.M.

The CAUSE OF DEATH* was as follows:

Chronic parenchymatic Nephritis

(Duration) 6 Yrs. ..... mos. ..... ds.

Contributory (Secondary) Myocardial degeneration

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. W. Weyer M. D.

Nov 19 (Address) Coeur d Alene Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. 1 mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetery — DATE OF BURIAL: 11/18 1921

20. UNDERTAKER: [illegible] Dorty — ADDRESS: Coeur d'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED DEC 1 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Kootenai — Registration District No. 30

City of Cidd Island (St.) — Primary Registration District No. 1061

File No. 36081

Registered No. 995

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Greenfield

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F.	W.	single

6. DATE OF BIRTH: 11 (Month) 17 (Day) 1921 (Year)

7. AGE: ....Yrs. ....Mos. 1 ds. — IF LESS than 1 day how many....hrs. or....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Chas. Greenfield

11. BIRTHPLACE OF FATHER (State or Country) Mo.

12. MAIDEN NAME OF MOTHER Laura Hagan

13. BIRTHPLACE OF MOTHER (State or Country) N. D.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Charles Greenfield
(Address)

15. Filed Dec 5 1921 — D. D. Breuna, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 19 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 18 1921 to Nov. 18 1921 that I last saw her alive on Nov. 18 1921 and that death occurred on the date stated above, at 9P M.

The CAUSE OF DEATH* was as follows:
Premature birth. 8 mo.
Convulsions in infant.

(Duration) ....Yrs. ....mos. ....ds.

Contributory (Secondary) Puerperal albuminaria in mother

(Duration) ....yrs. ....mos. ? ds.

(Signed) John Alward M. D.

Nov. 21 1921 (Address) Coeur d'Alene. Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death....yrs....mos....days. In the State....yrs....mos....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Forest Cem. CD'Alene	11-21 1921

20. UNDERTAKER	ADDRESS
C Cassedy	CD'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED DEC 1 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 30

Primary Registration District No. 1057

File No. 36082

County of Kootenai

City of Coeur d'Alene (If outside limits, give township) STATE No. 748 7th St.)

Registered No. 496

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Chloe Stevens

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): widow

6. DATE OF BIRTH: 11 (Month) 3 (Day) 1846 (Year)

7. AGE: 75 Yrs. 0 Mos. 20 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): N. Y.

10. NAME OF FATHER: Innis Surdam

11. BIRTHPLACE OF FATHER (State or Country): Maine

12. MAIDEN NAME OF MOTHER: Mary E. Jones

13. BIRTHPLACE OF MOTHER (State or Country): N. H.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A R Lester
(Address)

15. Filed Dec 5 1921 D D Dremma Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 23 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 12 1921, to Nov 23 1921, that I last saw h.r alive on Nov 22 1921, and that death occurred on the date stated above, at 6a M.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) ..... Yrs. ..... mos. 7 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J D Myers M. D.

Nov 23 21 (Address) Coeur d'Alene Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Forest-Cem. C d'Alene — DATE OF BURIAL: 11-25 1921

20. UNDERTAKER: C. Cassedy — ADDRESS: C d'Alene Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED DEC 1 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 30

Primary Registration District No. 1051

File No. 36083

County of .....

City of ..... (No. ....., ... St.)

Registered No. 997

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Amos A. Green

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	W	M

6. DATE OF BIRTH: Mar (Month) 29 (Day) 1853 (Year)

7. AGE: 68 Yrs. 6 Mos. 26 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: David Green

11. BIRTHPLACE OF FATHER (State or Country): U. S.

12. MAIDEN NAME OF MOTHER: Sarah Blunt

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Edith Green
(Address) Rathdrum R.F.D.

15. Filed Dec 5 1921 — W. D. Freeman, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. (Month) 25 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 25 1921, to Sept 25 1921, that I last saw h.. alive on Sept 24 1921, and that death occurred on the date stated above, at 9 a. M.
The CAUSE OF DEATH* was as follows:

Fracture of skull followed by infection of meninges

(Duration) ..... Yrs. 1 mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. C. [illegible] M. D.

Sept 26 1921 (Address) Coeur d'Alene Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Rathdrum Cemetery	9/27 1921

20. UNDERTAKER: C. Cassedy — ADDRESS: Coeur d'Alene

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36084
Registered No. 998

RECEIVED DEC 1 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 30
Primary Registration District No. 1051

County of Kootenai
City of Rathdrum, (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Bryan M. Green

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M.	W.	Single

6. DATE OF BIRTH: Feb (Month) 3 (Day) 1921 (Year)

7. AGE: Yrs. 9 Mos. 23 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Chas. Green

11. BIRTHPLACE OF FATHER (State or Country) Minn.

12. MAIDEN NAME OF MOTHER Elizabeth Roberts

13. BIRTHPLACE OF MOTHER (State or Country) Minn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Roscoe Scotchmell
(Address)

15. Filed Dec 5 1921 D D Drenna Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Novbr. (Month) 28. (Day) 1921. (Year)

17. I HEREBY CERTIFY, That I attended deceased from Novbr. 27 1921, to Novbr. 28 1921, that I last saw him alive on Novbr. 28 1921, and that death occurred on the date stated above, at 8.00 P. M.

The CAUSE OF DEATH* was as follows:
Diphtheria

(Duration) — Yrs. — mos. 2 ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Frank Wenz M. D.
11/29 1921 (Address) Rathdrum, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rathdrum, Ida. DATE OF BURIAL: 11-29 1921

20. UNDERTAKER: Geo. Medgen, Coeur d'Alene
ADDRESS: Rathdrum

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED DEC 1 19

1. PLACE OF DEATH
County of Kootenai
City of Rathdrum (No. ..... St.)
Registration District No. 30
Primary Registration District No. 1051
File No. 36085
Registered No. 999
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Clair Everett Swanson
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
M.	W.	S (Write the word.)

6. DATE OF BIRTH: May 15th 1920 (Month) (Day) (Year)

7. AGE: 1 Yrs. 6 Mos. 26 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Rathdrum, Idaho

10. NAME OF FATHER E. A. Swanson

11. BIRTHPLACE OF FATHER (State or Country) Kansas

12. MAIDEN NAME OF MOTHER Maud Burnett

13. BIRTHPLACE OF MOTHER (State or Country) Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. E. A. Swanson
(Address) Rathdrum, Idaho

15. Filed Dec 5 1921 D D Simmons Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: November 11th 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 10 1921 to Nov. 11. 1921, that I last saw h... alive on Nov. 11. 1921, and that death occurred on the date stated above, at 1:40 P.M.

The CAUSE OF DEATH* was as follows:
Capillary Bronchitis
with extension of Lungs

(Duration) ... Yrs. ... mos. 3 ds.
Contributory (Secondary) Contributory Cirrhosis

(Duration) ... yrs. ... mos. 6 ds.

(Signed) Frank Voss M. D.
11/12 1921 (Address) Rathdrum, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rathdrum Idaho | DATE OF BURIAL: Nov 13 1921

20. UNDERTAKER: C. W. Stone | ADDRESS: Rathdrum Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

RECEIVED DEC 8 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36087
Registered No. 8

1. PLACE OF DEATH.
Registration District No. 46
Primary Registration District No. 2153
County of Kootenai
City of Worley (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Helene Seidel

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH: Oct 6th 1835 (Month) (Day) (Year)

7. AGE: 86 yrs. 1 mos. 23 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Home Wife
(b) General nature of industry business, or dstablishment in which employed (or employer): "Domestic"

9. BIRTHPLACE (State or Country): Germany.

10. NAME OF FATHER: Lueck.

11. BIRTHPLACE OF FATHER (State or Country): Germany.

12. MAIDEN NAME OF MOTHER: Rabe.

13. BIRTHPLACE OF MOTHER (State or Country): Germany.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) August Seidel
(Address) Worley. Idaho.

15. Filed Oct. 30 1921 H. D. Jaques Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Oct 29th 1921. (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1st 1920, to Oct 29th 1921, that I last saw h[illegible] alive on Oct 8th 1921, and that death occurred on the date stated above, at 8 P M.

The CAUSE OF DEATH* was as follows:
Chronic Rheumatism

(Duration) One yrs. mos. ds.
Contributory (Secondary) Heart-Failure "Heart was very feeble"
(Duration) One yrs. mos. ds.

(Signed) J. J. Herrington M. D.
19..... (Address) Worley. Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Worley, Ida — DATE OF BURIAL: Nov 3 1921

20. UNDERTAKER: H. D. Jaques — ADDRESS: Plummer, Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

RECEIVED DEC 8 1921 BUREAU OF VITAL STATISTICS

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 46
County of Benewah Primary Registration District No. 2123
City of Plummer St.) File No. 36088
Registered No. 7.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Kattie Schumacher

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. July (Month) 9 (Day) 1869 (Year)

7. AGE: 57 Yrs. 3 Mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer Housewife.
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ganaburg. Wisconsin

10. NAME OF FATHER: Schumacher

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Albert J. Nestler
(Address) Plummer. Idaho

15. Filed Oct. 16 1921 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. (Month) 14 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at 6.15 P. M.

The CAUSE OF DEATH* was as follows:
Died very suddenly without medical aid, apparently from natural causes. was working about house when she died.
(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) N. H. Olson Coroner Benewah Co. M. D.
10/14/1921 (Address) St Maries Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Plummer. Ida. DATE OF BURIAL: Oct 16 1921

20. UNDERTAKER: H. J. Jaeger. ADDRESS: Plummer

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24654

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED DEC 5 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 46

Primary Registration District No. 2123

File No. 36089

County of Kootenai

City of Worley (If outside limits of city or village, give township) St.)

Registered No. 6

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Thomas Lamb

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. May (Month) 23 (Day) 1872 (Year)

7. AGE: 49 Yrs. 4 Mos. 3 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Garage Owner

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Cleveland, Ohio

10. NAME OF FATHER: James Lamb

11. BIRTHPLACE OF FATHER (State or Country): Scotland

12. MAIDEN NAME OF MOTHER: Margaret Strang

13. BIRTHPLACE OF MOTHER (State or Country): Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Peter Lamb

(Address) Harrison Idaho.

15. Filed Oct 17 1921. W. L. Jaeger Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24853

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. (Month) 26th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1 1921, to Sept 25 1921, that I last saw him alive on Sept 25 1921, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Pneumonia following Typhoid fever

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) L. Clanton M. D.

19 ..... (Address) Rockford Ill

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Worley, Idaho — DATE OF BURIAL: Sept 28 1921

20. UNDERTAKER: W. L. Jaeger — ADDRESS: Plummer, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Latah

City of Palouse

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 65

Primary Registration District No. 2145.

File No. 36090

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Franklin Monroe Berry.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married.

6. DATE OF BIRTH: April 24 (Month) 1841 (Day) (Year)

7. AGE: 80 Yrs. 7 Mos. ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Tenn

10. NAME OF FATHER: Not Known.

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: Unknown Not known

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Moses L Berry
(Address) Palouse

15. Filed Nov. 3rd 1921 D. Jr. Thompson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 24 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased ~~from~~ on Nov 1 1921 to ..... 19..
that I last saw h~~im~~ alive on Nov 1 1921
and that death occurred on the date stated above, at 2 40 P.M.
The CAUSE OF DEATH* was as follows:

Valvular Heart Disease and Dropsy.

(Duration) ..... Yrs. — mos. — ds.

Contributory (Secondary) — — — —

— (Duration) — yrs. — mos. — ds.

(Signed) E. K. Wolfe M. D.

11-26-1921 (Address) Palouse Wash

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR ~~REMOVAL~~	DATE OF BURIAL
Palouse	Nov 24 1921

20. UNDERTAKER	ADDRESS
E. H. Irwin.	Palouse Wash

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 61
Primary Registration District No. 1011
File No. 36091
Registered No. 62

RECEIVED
NOV 30 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Latah
City of Moscow (If outside limits, give township.) St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Orpha Cochran
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widowed

6. DATE OF BIRTH: Dec 1 1849 (Month) (Day) (Year)

7. AGE: 31 Yrs. 10 Mos. 19 ds.
IF LESS than 1 day how many..... hrs. or.....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Indiana

10. NAME OF FATHER: Samuel Chambers

11. BIRTHPLACE OF FATHER (State or Country): Indiana

12. MAIDEN NAME OF MOTHER: Johanna Bell

13. BIRTHPLACE OF MOTHER (State or Country): Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs George Cochran
(Address) Princeton Idaho

15. Filed ..... 19..... Wm Boardman Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct 20 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 20 1921, to Oct 20 1921, that I last saw her alive on Oct 20 1921, and that death occurred on the date stated above, at 8:00 M.

The CAUSE OF DEATH* was as follows:

Pulmonary Hemorrhage

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas. L. Fortune M. D.
10/31 1921 (Address) Moscow, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Freeze Clem — DATE OF BURIAL: 12/2 1921

20. UNDERTAKER: Glen Price — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 61
Primary Registration District No. 1011
File No. 36092
Registered No. 60

1. PLACE OF DEATH
County of Latah
City of Moscow (If outside limits, give township.) St.)
If death occurs away from usual residence, give facts called for under special information.

RECEIVED
NOV 30 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME Belva Lockwood Dye

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Oct (Month) 4 (Day) 1904 (Year)

7. AGE: 17 Yrs. Mos. 4 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: James H Dye

11. BIRTHPLACE OF FATHER (State or Country): Mo

12. MAIDEN NAME OF MOTHER: Jennie Schooler

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) James H Dye
(Address) Moscow

15. Filed Oct [illegible] 1921 M Chambers Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 18 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 30 1921, to Oct 10 1921, that I last saw h[illegible] alive on Oct 10 1921, and that death occurred on the date stated above, at 3:[illegible] P.M.

The CAUSE OF DEATH* was as follows:

Diffuse suppurative peritonitis

(Duration) Yrs. mos. ds.
Contributory (Secondary): Appendicitis
(Duration) yrs. mos. ds.

(Signed) [illegible] L. Gritman M. D.
10/18/1921 (Address) Moscow Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. 10 days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Moscow | DATE OF BURIAL: Oct 20 1921

20. UNDERTAKER: [illegible] Funeral Home | ADDRESS: Moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED
NOV 30 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 101
Primary Registration District No. 1011
File No. 36093
Registered No. 59

1. PLACE OF DEATH
County of Latah
City of Moscow (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Zora Jean Johnston

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Oct (Month) 19 (Day) 1920 (Year)

7. AGE: Yrs. 11 Mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kooskia Idaho

10. NAME OF FATHER: C. R. Johnston

11. BIRTHPLACE OF FATHER (State or Country): Clearwater Mines

12. MAIDEN NAME OF MOTHER: Ethel McLean

13. BIRTHPLACE OF MOTHER (State or Country): Kooskia Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. R. Johnston
(Address) Kooskia

15. Filed 10/2 1921 M. H. Carothers Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 2 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 15 1921, to Oct 2 1921, that I last saw h.. alive on Oct 2 1921, and that death occurred on the date stated above, at 8.20 A.M.

The CAUSE OF DEATH* was as follows:
Whooping Cough
Complicated with enteric Colitis

(Duration) ..... Yrs. 3 mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F. M. Leitch M. D.
10/2 1921 (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston Ida — DATE OF BURIAL ..... 19.....

20. UNDERTAKER: Glen Grice — ADDRESS: Moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED NOV 30 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 61
Primary Registration District No. 2141
File No. 36094
Registered No. 61

1. PLACE OF DEATH
County of Latah
City of ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charles F. Sutton.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	White	Married

6. DATE OF BIRTH Nov (Month) 2 (Day) 1856 (Year)

7. AGE 56 Yrs. 11 Mos. 13 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Illinois

10. NAME OF FATHER John Sutton

11. BIRTHPLACE OF FATHER (State or Country) Illinois

12. MAIDEN NAME OF MOTHER Sarah McElvain

13. BIRTHPLACE OF MOTHER (State or Country) Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs C Rae Sutton
(Address) Viola Idaho

15. Filed 10/7 1921 M M Matthews Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 15 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased ~~from~~ on Oct 13 1921, to ..... 19....., that I last saw h.... alive on Oct 15 1921, and that death occurred on the date stated above, at 5:20 P. M.
The CAUSE OF DEATH* was as follows:
Acute Intestinal Obstruction
(Duration) ..... Yrs. ..... mos. 3 ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) E. K. Wolfe M. D.
10/17 1921 (Address) Caldwell Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Pleasant View	10/18 1921
20. UNDERTAKER	ADDRESS
Allen Grieg	Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY; PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED
NOV 3 0 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Latah Registration District No. 65
Primary Registration District No. 2145
File No. 36095
City of ..... (No. ..... St.) Registered No. .....
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Alvira A. Stockentagger

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem.
4. COLOR OR RACE: White.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married.

6. DATE OF BIRTH: Aug. 6, 1860
(Month) (Day) (Year)

7. AGE: 61 Yrs. 2 Mos. 17 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife.
(b) General nature of industry, business or establishment in which employed (or employer): /

9. BIRTHPLACE (State or Country): Iowa.

10. NAME OF FATHER: William Hull.

11. BIRTHPLACE OF FATHER (State or Country): Penn.

12. MAIDEN NAME OF MOTHER: Ruth Stinchcomb

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) August A. Stockentagger
(Address) Juliaetta Idaho

15.
Filed Dec 26th 1921 Dr. J. W. Thompson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct 23 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....
and that death occurred on the date stated above, at 11:05 P.M.

The CAUSE OF DEATH* was as follows:
Struck by automobile
accidental
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Ellen Price M. D.
..... 19..... (Address) Moscow

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Juliaetta Cem. | DATE OF BURIAL: 12/28 1921

20. UNDERTAKER: Ellen Price | ADDRESS: Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED NOV 30 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 65

Primary Registration District No. 2145

File No. 36096

Registered No.

1. PLACE OF DEATH

County of Latah

City of Potlatch (If outside limits of city or village, give township.) (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elsie Ellen Williams

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: March 16 1902 (Month) (Day) (Year)

7. AGE: 19 Yrs. 6 Mos. 25 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Washington

10. NAME OF FATHER: Geo W. Humiston

11. BIRTHPLACE OF FATHER (State or Country): Wisconsin

12. MAIDEN NAME OF MOTHER: Rosie B Allen

13. BIRTHPLACE OF MOTHER (State or Country): California

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Rosie B. Humiston

(Address) Potlatch, Latah Co. Idaho

15. Filed Oct. 12 1921

Dr. J. R. Thompson
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct 10 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....

that I last saw h..... alive on ..... 19.....

and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Valvular Insufficiency

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Ellen Price Coroner M. D.

10/10 1921 (Address) Moscow

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Potlatch

DATE OF BURIAL: 10/12 1921

20. UNDERTAKER: Potlatch Undertaking Co.

ADDRESS: Potlatch Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M-1-19.

RECEIVED NOV 3 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 62

County of Latah

Primary Registration District No. 2142

File No. 36097

City of Genesee (No. ..... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Nicholaus John Hasfurther

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Sept (Month) 18 (Day) 1833 (Year)

7. AGE: Yrs. 88 Mos. 1 ds. 16

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: Hasfurther

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: .....

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jas N Hasfurther
(Address) Genesee

15. Filed Oct 27 1921 W N Ellis Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. 26 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 25 1921 to Oct 26 1921 that I last saw h— alive on Oct 26 1921, and that death occurred on the date stated above, at 11:45 P M.

The CAUSE OF DEATH* was as follows:

Uremic Coma

..... (Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W N Ellis M. D.

Oct 27 1921 (Address) Genesee

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Greenwood Cem | DATE OF BURIAL: Oct 28 1921

20. UNDERTAKER: J E Lambert | ADDRESS: Genesee

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH, in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

RECEIVED NOV 22 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 6-2
Primary Registration District No. 2142

File No. 36098
Registered No. 17

1. PLACE OF DEATH

County of Latah

City of Genesee (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lydia Luella Osborn

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. ~~SINGLE~~, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: ~~October 27~~ May 31 1862 (Month) (Day) 1921 (Year)

7. AGE: 59 Yrs. 6 Mos. 27 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House Wife
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Nebraska

10. NAME OF FATHER: John Thomas Hoffe

11. BIRTHPLACE OF FATHER (State or Country): Pennsylvania

12. MAIDEN NAME OF MOTHER: Mary Thomas Hoffe

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. R. Nelson
(Address) Genesee Idaho

15. Filed Oct. 29 1921 C. O. Stevens Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: October 27th 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 10-11- 1921, to 10-27- 1921 that I last saw her alive on 10-26th 1921, and that death occurred on the date stated above, at 10:30 P.M.

The CAUSE OF DEATH* was as follows:
Carcinoma of liver.

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. H. Ponser M. D.

10-28 1921 (Address) Genesee, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Genesee | DATE OF BURIAL: 10-29 1921

20. UNDERTAKER: [illegible] | ADDRESS: [illegible]

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED DEC 1 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Latah, Registration District No. 61
City of Moscow (No. ..... St.) Primary Registration District No. 1011
File No. 36099
Registered No. 67

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Otto Wilbur Eichner

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write this word.)
6. DATE OF BIRTH: Jan (Month) 6 (Day) 1[illegible] (Year)
7. AGE: 14 Yrs. 10 Mos. 17 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry, business or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): Idaho
10. NAME OF FATHER: Claus Eichner
11. BIRTHPLACE OF FATHER (State or Country): Germany
12. MAIDEN NAME OF MOTHER: Bertha Otto
13. BIRTHPLACE OF MOTHER (State or Country): Nebraska
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Claus Eichner
(Address) Kendrick
15. Filed 11/23 19 21 M Hawthorn Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 23 (Day) 21 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Nov 17 1921, to Nov 23 1921, that I last saw h[illegible] alive on Nov 23 1921, and that death occurred on the date stated above, at [illegible].
The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas L Gilliam M. D.
11/23 1921 (Address) Moscow Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. 6 days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence Kendrick Idaho.

19. PLACE OF BURIAL OR REMOVAL: Kendrick — DATE OF BURIAL: 11/25 19 21
UNDERTAKER: [illegible] — ADDRESS: [illegible]

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO. PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. [redacted]

RECEIVED DEC [illegible] BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Adair

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 61

Primary Registration District No. 1011

File No. 36100

Registered No. 66

1. PLACE OF DEATH

County of Latah

City of Moscow (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Nelson Alonzo Vosburgh

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Jan (Month) 19 (Day) 1854 (Year)

7. AGE: 87 Yrs. 10 Mos. [illegible] ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Retired Farmer

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Canada

10. NAME OF FATHER: Vosburgh

11. BIRTHPLACE OF FATHER (State or Country): Canada

12. MAIDEN NAME OF MOTHER: Not known here

13. BIRTHPLACE OF MOTHER (State or Country): [illegible]

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Vosburgh

(Address) .....

15. Filed 11/23 1921 M. S. Hawthorne Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 22 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 16 1921, to Nov 22 1921, that I last saw h[illegible] alive on Nov 22 1921, and that death occurred on the date stated above, at 10 PM.

The CAUSE OF DEATH* was as follows:

Senility

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. R. Adair M. D.

11/23 1921 (Address) Moscow Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Moscow — DATE OF BURIAL: 11/25 1921

20. UNDERTAKER: Glen Green — ADDRESS: Moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 61
Primary Registration District No. 1011
File No. 36101
Registered No. 63

1. PLACE OF DEATH
County of Idaho
City of Moscow
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Amelia J Shoop.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widowed (Write the word.)

6. DATE OF BIRTH: Dec 4 1850 (Month) (Day) (Year)

7. AGE: 70 Yrs. 11 Mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Charlie Niles

11. BIRTHPLACE OF FATHER (State or Country): ?

12. MAIDEN NAME OF MOTHER: ?

13. BIRTHPLACE OF MOTHER (State or Country): ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Hector Shoop
(Address) Moscow Ida

15. Filed 11/19 1921 W M Carothers Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov 17 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 7 1921, to Nov 17 1921 that I last saw h[illegible] alive on Nov 17 1921 and that death occurred on the date stated above, at 10 P M.

The CAUSE OF DEATH* was as follows:
Carcinoma of Intestines

(Duration) 3(?) Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Virgil M. Gilchrist M. D.
11/19 1921 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Moscow | DATE OF BURIAL: 11/19 1921

20. UNDERTAKER: Star Funeral Home | ADDRESS: Moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 61
Primary Registration District No. 1011
(No. ..... St.)

File No. 36102
Registered No. 64

1. PLACE OF DEATH
County of Latah
City of Moscow
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Marion B. James
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: March (Month) 4 (Day) 1857 (Year)

7. AGE: 64 Yrs. 8 Mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Oregon

10. NAME OF FATHER: A J James

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Sarah Surf.

13. BIRTHPLACE OF MOTHER (State or Country): Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mark James.
(Address) Oakesdale, Wn

15. Filed 11/14 1921 W H Carothers Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: November (Month) 14 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 9 1921, to Nov. 14 1921, that I last saw h[illegible] alive on Nov. 14 1921, and that death occurred on the date stated above, at 6: a M.
The CAUSE OF DEATH* was as follows:

Chronic parenchymatous nephritis
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Chas. L. Gettman M. D.
11/14 1921 (Address) Moscow, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. 4 days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Oakesdale Wash. DATE OF BURIAL: 11/15 1921

20. UNDERTAKER: Glen Price ADDRESS: Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

Registration District No. 101

Primary Registration District No. 1011

(No.) 80

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36103

Registered No. 63

1. PLACE OF DEATH

County of Latah

City of Moscow

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Virginia Evelyn Bolding

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fr

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6. DATE OF BIRTH: Apr. 16 (Month) (Day) 1917 (Year)

7. AGE: 14 Yrs. 6 Mos. 21 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Student

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Lamont Colo.

10. NAME OF FATHER: James Bolding

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Eva B. Potter

13. BIRTHPLACE OF MOTHER (State or Country): Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. Bolding

(Address) Moscow Idaho.

15. Filed Jan 8 1921 W. H Carothers Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 6 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 24 1921, to Nov. 6 1921, that I last saw h. Ex. alive on Nov. 6 1921, and that death occurred on the date stated above, at 4:30 P.M.

The CAUSE OF DEATH* was as follows:

Myo Carditis

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Infection

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas. L. Gritman M. D.

11/8 1921 (Address) Moscow, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. 7 days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL ~~OR REMOVAL~~: Moscow Ida — DATE OF BURIAL: Nov 8 1921

20. UNDERTAKER: G. Grice — ADDRESS: Moscow

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

36105

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Latah — Registration District No. 2147

City of Helmer — Primary Registration District No. 67 — File No. 3

(No. ..... St.) — Registered No. 39

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Melva A. McIntyre

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F.	W.	single

6. DATE OF BIRTH: Sept. 27 (Month) (Day) 1918 (Year)

7. AGE: 3 Yrs. 1 Mos. 1 ds. — IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ida.

10. NAME OF FATHER: Geo. W. McIntyre

11. BIRTHPLACE OF FATHER (State or Country): Wis.

12. MAIDEN NAME OF MOTHER: Ethel Vandevanter

13. BIRTHPLACE OF MOTHER (State or Country): Ore.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Geo. W. McIntyre
(Address) Helmer, Ida.

15. Filed Oct. 29 1921 — P. C. Faust — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. 28 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 22 1921, to Oct. 28 1921, that I last saw h[illegible] alive on Oct. 27 1921, and that death occurred on the date stated above, at 10:20 P.M.

The CAUSE OF DEATH* was as follows: Acute Gastro Enteritis

(Duration) 1 Yrs. mos. 7 ds.

Contributory (Secondary) .....

(Duration) yrs. mos. ds.

(Signed) P. C. Faust M. D.

10/29 1921 (Address) Deary

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Pine Crest Cem — DATE OF BURIAL: Oct. 31 1921

20. UNDERTAKER — ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

36106 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2147
Primary Registration District No. 67
File No. 3
Registered No. 40

1. PLACE OF DEATH
County of Latah
City of Helmer
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mildred G. McIntyre
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Sept. 27 (Month) (Day) 1918 (Year)

7. AGE: 3 Yrs. 1 Mos. 12 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Geo. W. McIntyre

11. BIRTHPLACE OF FATHER (State or Country): Wis.

12. MAIDEN NAME OF MOTHER: Ethel Vandevanter

13. BIRTHPLACE OF MOTHER (State or Country): Ore

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Geo. W. McIntyre
(Address) Helmer, Ida.

15. Filed Nov. 9 1921 P. E. Faust Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 8 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 25 1921, to Nov. 8 1921, that I last saw h.e.r. alive on Nov. 8 1921 and that death occurred on the date stated above, at 9 P.M.
The CAUSE OF DEATH* was as follows: Acute Gastro Enteritis

(Duration) 1 Yrs. 1 mos. 13 ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) P. E. Faust M. D.
11/9 1921 (Address) Deary

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Pine Crest Cem. DATE OF BURIAL: 11/10 1921

20. UNDERTAKER: — ADDRESS: —

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
DEC 10 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

36107

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2147
Primary Registration District No. 67
File No. 3
Registered No. 41

1. PLACE OF DEATH
County of Latah
City of Avon
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Walter Eric Anderson
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): single

6. DATE OF BIRTH: Dec. (Month) 7 (Day) 1921 (Year)

7. AGE: 0 Yrs. 0 Mos. 0 ds.
IF LESS than 1 day how many 4 hrs. or 27 min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ida.

10. NAME OF FATHER: Eric Anderson

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Cassie Baker

13. BIRTHPLACE OF MOTHER (State or Country): Wis.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) P. E. Jones
(Address) Deary, Ida.

15. Filed 12/8 1921 P. E. Jones Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. (Month) 7 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 7 1921 to Dec. 7 1921
that I last saw h.im alive on Dec. 7 1921
and that death occurred on the date stated above, at 9:50 A.M.
The CAUSE OF DEATH* was as follows: Delayed & difficult delivery

(Duration) ½ Yrs. ½ mos. ½ ds.
Contributory (Secondary)
(Duration) ½ yrs. ½ mos. ½ ds.
(Signed) P. E. Jones M. D.
12/8 1921 (Address) Deary

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Pine Crest Cem. DATE OF BURIAL: 12/9 1921

20. UNDERTAKER: ADDRESS:

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

RECEIVED NOV 30 1921 BUREAU OF VITAL STATISTICS

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36108

Registered No. .....

1. PLACE OF DEATH.

Registration District No. 41

Primary Registration District No. 2116

County of Lemhi

City of Salmon

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William Jones

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. ..... (Month) ..... (Day) ..... 1 (Year)

7. AGE: about 63 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Lunatic Miner

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Not known

10. NAME OF FATHER: " "

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William Jocelin

(Address) Salmon Idaho

15. Filed 11/30 1921

Clif Bellamy Deputy Local Registrar

SYMS - YORK CO., PTRS. & ADMS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: October 8th 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 4 1921, to Oct. 8 1921, that I last saw him alive on Oct 8 1921 and that death occured on the date stated above, at 9 A. M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) Several Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

10/8 1921 (Signed) A. D. Stratton M. D.

(Address) Salmon, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contfacted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Salmon Cemetery	12-10" 1921
20. UNDERTAKER	**ADDRESS**
Wm C Jocelin	Salmon Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36109

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

RECEIVED NOV 30 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH.

Registration District No. 4

Primary Registration District No. 2116

County of Lemhi

City of Salmon

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Fred H Wartz

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. August 4" (Month) (Day) 1835 (Year)

7. AGE 83 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Farmer

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Germany

10. NAME OF FATHER Not known

11. BIRTHPLACE OF FATHER (State or Country) " "

12. MAIDEN NAME OF MOTHER " "

13. BIRTHPLACE OF MOTHER (State or Country) " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William Jacobs

(Address) Salmon Idaho

15. Filed 11/10 - 1921 Chas Bellamy Local Registrar

Deputy

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH November 7" (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,

that I last saw h... alive on ..... 191...,

and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Old age

due to dropsy

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) William Jacobs Coroner

11-7 1921 (Address) Salmon Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Salmon Cemetery — DATE OF BURIAL: 11-8" 1921

20. UNDERTAKER: William Jacobs — ADDRESS: Salmon Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

BYRNS - YORK CO., PTYS. A 8888. 24653

FORM V. S. No. 5-25 M. 1-16-18

CERTIFICATE OF DEATH. 36110

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED NOV 30 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH.

Registration District No. 47

Primary Registration District No.

File No. 70

County of Lewis

City of Nezperce Idaho (St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information. Route 2

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Elton Gray Osterhout

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
male	white	single

6. DATE OF BIRTH. Nov. (Month) 2 (Day) 1921 (Year)

7. AGE — Yrs. — Mos. 3 ds. IF LESS than 1 day how many ....hrs. or ....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... home
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Forrest S. Osterhout

11. BIRTHPLACE OF FATHER (State or Country) Iowa

12. MAIDEN NAME OF MOTHER Maryle Edgerton

13. BIRTHPLACE OF MOTHER (State or Country) Georgia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Forrest S. Osterhout
(Address) Nezperce, Ida.

15. Filed 11-7 1921 Albert Huff Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. (Month) 5 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 2, 1921, to Nov. 5, 1921, that I last saw him alive on Nov. 3, 1921, and that death occured on the date stated above, at 5:30 A.M.

The CAUSE OF DEATH* was as follows:

Hemorrhagic Disease of Newborn

(Duration) — Yrs. — mos. 3 ds.

Contributory (Secondary)

(Duration ... yrs. ... mos. ... ds.

(Signed) J. J. Darby M. D.

19.... (Address) J. J. Nezperce, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Nezperce, Ida.	Nov. 5, 1921
20. UNDERTAKER	**ADDRESS**
Albert Huff	Nezperce Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BKBS. 24658

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED DEC 8 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36112

Registration District No. 49

Primary Registration District No. 427

1. PLACE OF DEATH.

County of Nez Perce

City of Kamiah (No. ..... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Caleb McCatty

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: Indian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. (Month) 1 (Day) 1 (Year) 1843

7. AGE: About 78 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Oregon

10. NAME OF FATHER: Titus McCatty

11. BIRTHPLACE OF FATHER (State or Country): Oregon

12. MAIDEN NAME OF MOTHER: Deborah

13. BIRTHPLACE OF MOTHER (State or Country): Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Milton S. Frazier

(Address) Status Idaho

15. Filed 12/30 1921

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 30 (Day) 21 (Year) 1921

17. I HEREBY CERTIFY, That I attended deceased from July 1 1921, to Nov 30 1921, that I last saw him alive on Nov 18 1921, and that death occured on the date stated above, at 1 55 A.M.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration 1 yrs. 1 mos. ..... ds.

(Signed) J. W. Herbert Knapp M. D.

19..... (Address) Kamiah Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: ~~Jack Cem~~ Buried on his allotment. DATE OF BURIAL: 12/5 1921

20. UNDERTAKER: C. J. Johnson ADDRESS: Kamiah Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

BYRD - YORK CO., PTRS. & BDRS. 24853

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED NOV 30 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Lincoln — Registration District No. 1076 10/6

City of Dietrich — Primary Registration District No. 1016

(No. ..... St.:)

File No. 36113

Registered No. 17

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Robert Charles La Grange

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. ~~SINGLE, MARRIED, WIDOWED OR DIVORCED~~ (Write the word.)

6. DATE OF BIRTH: Dec (Month) 1 (Day) 1920 (Year)

7. AGE: Yrs. 11 Mos. 6 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Dietrich Ida.

10. NAME OF FATHER: Durgan Joseph La Grange

11. BIRTHPLACE OF FATHER (State or Country): Grinnell Iowa

12. MAIDEN NAME OF MOTHER: Emma Helen Hughes

13. BIRTHPLACE OF MOTHER (State or Country): Mt. Vernon Washington

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Lewis H Foy

(Address) Dietrich Idaho

15. Filed Nov 8 1921

J. L. Fuller Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 7 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 1 1921, to Nov 7 1921, that I last saw h— alive on Nov 7 1921 and that death occurred on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows: Entero-Colitis

(Duration) ..... Yrs. ..... mos. 13 ds.

Contributory (Secondary) Foreign body.

(Duration) ..... yrs. ..... mos. 15 ds.

(Signed) O. K. Dye M. D.

11/8 1921 (Address) Shoshone Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Shoshone — DATE OF BURIAL ..... 19.....

20. UNDERTAKER: O. J. Brennan — ADDRESS: Shoshone

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

36114

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Lincoln

City of Shashone (Ward) (St.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED NOV 30 1921 BUREAU OF VITAL STATISTICS

Registration District No. 16

Primary Registration District No. 1016

File No.

Registered No. 16

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Sam Brothers

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, ~~MARRIED, WIDOWED OR DIVORCED~~: Single (Write the word.)

6. DATE OF BIRTH: unknown (Month) (Day) (Year)

7. AGE: 13 Yrs. — Mos. — ds. —

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farm laborer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Maryland

10. NAME OF FATHER: no information

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: no information

13. BIRTHPLACE OF MOTHER: " " " (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jay Bonner

(Address) Shashone

15. Filed Oct 29 1921 J. L. Fuller Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 29 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 27 1921, to Oct 29 1921 that I last saw h.. alive on Oct 29 1921 and that death occurred on the date stated above, at 9 a M.

The CAUSE OF DEATH* was as follows:

Cerebral Paralysis

(Duration) Yrs. mos. 20 ds.

Contributory (Secondary) Senile Degeneration

(Duration) 3 yrs. mos. ds.

(Signed) C. H. Dietz M. D.

Oct 29 1921 (Address) Shashone Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.) Dec Hospital.

At place of death ..... yrs. ..... mos. 2 days. In the State 20 yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? Near Shashone.

Former or usual residence Shashone.

19. PLACE OF BURIAL OR REMOVAL: Shashone — DATE OF BURIAL ..... 19.....

20. UNDERTAKER: O. J. Brennan — ADDRESS Oct 30 1921

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED
NOV 04 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36115

Registered No.

1. PLACE OF DEATH

Registration District No.

Primary Registration District No.

County of Madison

City of Rexburg (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Blaine R Porter

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	white	Single

6. DATE OF BIRTH: Jan (Month) 19 (Day) 1921 (Year)

7. AGE: — Yrs. 9 Mos. 7 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Charles A. Mikesell

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Minnie J Porter

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Charles A Mikesell
(Address) Ashton Ida R.D. #1

15. Filed 10-27 1921 G E Espe Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 26 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 10-12 1921, to 10-25- 1921 that I last saw him alive on 10-25- 1921, and that death occurred on the date stated above, at 5 A. M.

The CAUSE OF DEATH* was as follows:
Broncho-pneumonia

(Duration) Yrs. mos. 7 ds.

Contributory (Secondary) Eczema

(Duration) for yrs. 1 mos. ds.

(Signed) Lorin A Rich M. D.
10/26 1921 (Address) Rexburg Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL 19
20. UNDERTAKER Rexburg Furn Co by John Phillips	ADDRESS Rexburg Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-12 M. 6-15-17.

Eyem

CERTIFICATE OF DEATH

36116

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. .....
Registered No. 79

1. PLACE OF DEATH
County of Madison
City of Burton
If death occurs away from usual residence, give facts called for under special information.

RECEIVED NOV 30 1921 BUREAU OF VIT STATIST

Registration District No. 100
Primary Registration District No. 3178
No. ..... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Claude A. Bidiman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Bale

6. DATE OF BIRTH: May (Month) 30 (Day) 1919 (Year)

7. AGE: 2 Yrs. 4 Mos. 24 ds. IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Bale
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ruby Idaho

10. NAME OF FATHER: J. W Bidiman

11. BIRTHPLACE OF FATHER (State or Country): Illinois

12. MAIDEN NAME OF MOTHER: Lulla Dorsha

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) G W Bidiman
(Address) R. 1

15. Filed 10/26 1921 G V Eske Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 24 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from October 9, 1921 to Oct. 24, 1921 that I last saw him alive on October 24, 1921 and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Broncho-Pneumonia
(Duration) ..... Yrs. ..... mos. 3 ds.
Contributory (Secondary) Gastro-enteritis
(Duration) ..... Yrs. ..... mos. 14 ds.
(Signed) G. V. Eske M. D.
..... 19.... (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Burton — DATE OF BURIAL: 10/26 1921

20. UNDERTAKER: Wyman — ADDRESS: Ryby

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-12 M. 6-15-17.

82 Ruby

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3617
Registered No. 90

1. PLACE OF DEATH
County of Madison
Registration District No. 100
Primary Registration District No. 2178
City of Rexburg (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Orris P. Wille

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. ~~SINGLE, MARRIED~~, WIDOWED OR ~~DIVORCED~~ (Write the word.)
M	W	

6. DATE OF BIRTH. Oct (Month) 26 (Day) 1839 (Year)

7. AGE 82 Yrs. 2 Mos. — ds. IF LESS than 1 day how many .... hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE Ohio (State or Country)

10. NAME OF FATHER O-B Wolle

11. BIRTHPLACE OF FATHER unknown (State or Country)

12. MAIDEN NAME OF MOTHER H-L. Welch

13. BIRTHPLACE OF MOTHER Unknown (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mary J. Wolle
(Address) Rexburg R.F.D #21

15. Filed Dec 1 1921 G.L. Espe Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 26 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 26 1921 to Nov 26 1921
that I last saw h/M alive on Nov 26 1921
and that death occurred on the date stated above, at 3:30 P M.

The CAUSE OF DEATH* was as follows:
Cerebral haemorrhage
.....
.....
.....(Duration) .... Yrs. ..... mos. 5 ds.
Contributory (Secondary) Pneumonia
.....(Duration) .... Yrs. ..... mos. 2 ds.

(Signed) Lorna L. Rich M. D.
11/28 1921 (Address) Rexburg Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Rexburg — DATE OF BURIAL Dec 2 1921

20. UNDERTAKER Haysoms — ADDRESS Rexburg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-25 M. 1-16-19

RECEIVED DEC 1 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 100
County of Madison Primary Registration District No. 2178
City of Rexburg (No. ..... St.)
File No. 36118
Registered No. 87

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Rosina Wittenbach Miller

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married
6. DATE OF BIRTH. March (Month) 3rd (Day) 1860 (Year)
7. AGE: 61 Yrs. 8 Mos. 19 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Switzerland
10. NAME OF FATHER: Samuel Wittenbach
11. BIRTHPLACE OF FATHER (State or Country): Switzerland
12. MAIDEN NAME OF MOTHER: Anna Schneider
13. BIRTHPLACE OF MOTHER (State or Country): Switzerland
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) George Miller
(Address) Rexburg Idaho
15. Filed 11-29 1921 G. L. Empey Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 22 (Day) 1921 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Jan 1921, to Nov 22 1921, that I last saw her alive on Nov 22 1921, and that death occured on the date stated above, at 5:20 P M.
The CAUSE OF DEATH* was as follows:
Diabetis Mellitus
(Duration) Few Yrs. mos. ds.
Contributory (Secondary) Diabetic Coma
(Duration) yrs. mos. ds.
(Signed) Lorin F. Rich M. D.
11/25 1921 (Address) Rexburg Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rexburg, Ida. DATE OF BURIAL: 11-25 1921
20. UNDERTAKER: DAVID R. YOUNG ADDRESS: REXBURG

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

BYRNE - YORK CO., PTRS. & BDRS. 24654

FORM V. S. No. 5-12 M. 6-17.

CERTIFICATE OF DEATH

36119 Rick

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. .....88.....
Registered No. 88
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Madison
City of Newdale
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 100
Primary Registration District No. 2178
(No. ..... St.)

2. FULL NAME Phyllis Clark

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. July (Month) 23 (Day) 1919 (Year)

7. AGE: 2 Yrs. 3 Mos. 21 ds.
IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Babe
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Teton Idaho

10. NAME OF FATHER: Rhonde Clark

11. BIRTHPLACE OF FATHER (State or Country): Teton Idaho

12. MAIDEN NAME OF MOTHER: Vera Roylance

13. BIRTHPLACE OF MOTHER (State or Country): Utah -

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Edward Edward
(Address) Newdale Idaho

15. Filed 11-15 1921 G. G. Eagle Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 11 (Month) 14 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11-13- 1921 to 11-14- 1921
that I last saw h.....alive on .....191....
and that death occurred on the date stated above, at .....M.
The CAUSE OF DEATH* was as follows:

Marasmus

(Duration) ..... Yrs. Few mos. ..... ds.

Contributory (Secondary)

(Duration) ..... Yrs. ..... mos. ..... ds.

11/19-1921 (Signed) Louis A. Rich M. D.
(Address) Rexburg Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Teton — DATE OF BURIAL: 11/15 1921

20. UNDERTAKER: Wyoming — ADDRESS: Ryley

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

36120

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. .....
Registered No. 87

1. PLACE OF DEATH
County of Madison
City of Rexburg
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 100
Primary Registration District No. 2178
(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Laura Elizabeth Rock

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Married

6. DATE OF BIRTH. August 16 1879
(Month) (Day) (Year)

7. AGE
42 Yrs. 3 Mos. 3 ds.
IF LESS than 1 day how many ...: hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work House wife
(b) General nature of industry, business, or establishment in which employed (or employer) Home

9. BIRTHPLACE
(State or Country) Salt Lake Utah

10. NAME OF FATHER J. L. Evans

11. BIRTHPLACE OF FATHER
(State or Country) Salt Lake Utah

12. MAIDEN NAME OF MOTHER Laura Reed

13. BIRTHPLACE OF MOTHER
(State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. L. Evans
(Address) .....

15.
Filed 11-20 1921
G. G. Ensign
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
11 — 19 — 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11-13-1921 to 11-19-1921 that I last saw her alive on 11-19-1921 and that death occurred on the date stated above, at 2:45 P. M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

.....(Duration) ..... Yrs. ..... mos. 6 ds.

Contributory (Secondary) .....

.....(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) W. O. Martin M. D.

11/19 1921 (Address) Rexburg, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Rexburg — DATE OF BURIAL Nov. 21 1921.

20. UNDERTAKER J. W. Young — ADDRESS Rexburg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED DEC 15 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 100
County of Madison Primary Registration District No. 2178
City of Rexburg (If outside city limits, write township.) St.
File No. 36122
Registered No. 93

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ann Strike Ayton

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. November (Month) 2nd (Day) 1868 (Year)

7. AGE: 53 Yrs. -- Mos. 12 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: Charles Strike

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Ann Richardson

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Ann Ayton
(Address) Rexburg Idaho

15. Filed 11/12 1921
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
11 (Month) 15 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from August 1 1921, to Nov. 14 1921, that I last saw her alive on Nov 1 1921 and that death occured on the date stated above, at 11:20 A.M.

The CAUSE OF DEATH* was as follows:
Chronic Gastritis enteritis

(Duration) Yrs. 5 mos. 15 ds.

Contributory (Secondary)
(Duration ... yrs. ... mos. ... ds.

(Signed) M. G. Parkinson M.D.
19... (Address) Rexburg Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs ... mos ... days In the State ... yrs ... mos ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rexburg Idaho — DATE OF BURIAL: 11-16-1921

20. UNDERTAKER: D R Young — ADDRESS: Rexburg Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

BYRNE - YORK CO., PTRS. & BOOKB. 24654

FORM V. S. No. 5-25 M. 1-16-12

RECEIVED
DEC 1
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36123

Registered No. 84

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH. Registration District No. 100

County of Madison Registration District No. 2178

City of Plano (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Esther Love Alvord

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. July (Month) 29th (Day) 1874 (Year)

7. AGE: 47 Yrs. 3 Mos. 15 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Johnethan Love

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Lydia Bills

13. BIRTHPLACE OF MOTHER (State or Country): New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) E. J. Alvord
(Address) Plano, Idaho

15. Filed 11/15/21 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 13 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 29 1921, to Nov 13 1921, that I last saw her alive on Oct 29 1921 and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows: Carcinoma of Stomach

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) Carley Nelson M. D.

11-15 1921 (Address) Rexburg Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Plano, Ida. DATE OF BURIAL: Nov. 15 1921

20. UNDERTAKER: D R Young ADDRESS: Rexburg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STNRS. 24854

FORM V. S. No. 5-12 M. 6-15-17.

35 36124 1

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH,
County of Madison
City of Rexburg
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 100
Primary Registration District No. 2178
(No. ....., ... St.)
File No. .....
Registered No. 83
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Rosa W. Rowe

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Jan (Month) 31 (Day) 1887 (Year)

7. AGE: 34 Yrs. 10 Mos. 9 ds.
IF LESS than 1 day how many .... hrs. or .....min.?'

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: William L. Windale

11. BIRTHPLACE OF FATHER (State or Country): ~~Utah~~ Scotland

12. MAIDEN NAME OF MOTHER: Alice Wilding

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. W. Windsor
(Address) Rexburg

15. Filed 11/10 1921
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 9 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..... to .....191....
that I last saw h.....alive on .....191....
and that death occurred on the date stated above, at 12 Noon

The CAUSE OF DEATH* was as follows:
Died Crushed by a Wagon load of grain passing over it (Accidental)
(Duration) ..... Yrs..... mos..... ds.

Contributory (Secondary) .....
(Duration) ..... Yrs..... mos..... ds.

(Signed) J. Rymmy - Coroner
19.. (Address) Rexburg

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rexburg — DATE OF BURIAL: 11/11 1921

20. UNDERTAKER: J. Rymmy — ADDRESS: Rexburg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36125
Registered No. 82

1. PLACE OF DEATH.
County of Madison
City of Sugar
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 100
Primary Registration District No. 2178
(No. ....., ... St.)

2. FULL NAME Della Ruth Ricks

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: ~~Female~~
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: September (Month) 8th (Day) 1920 (Year)

7. AGE: 1 yrs. 1 mos. 25 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Sugar, Idaho

10. NAME OF FATHER: Edwin Ricks

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Della Ricks

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Edwin Ricks
(Address) Sugar City, Idaho

15. Filed 11/12 1921 G. G. Capps Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: November (Month) 11th (Day) ~~192~~ 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from November 11 1921, to November 11 1921, that I last saw h.e alive on November 11th 1921 and that death occurred on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:

Infantile Paralysis

(Duration) ..... yrs. ..... mos. 1 day ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. B. Evans M. D.
11-12 1921 (Address) Sugar, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL, OR REMOVAL: Sugar City — DATE OF BURIAL: November 13 1921

20. UNDERTAKER: L. R. Young — ADDRESS:

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-12 M. 6-15-17.

RECEIVED
DEC 1 1921

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36126
Registered No. 81

1. PLACE OF DEATH
County of Fremont
City of Newdale
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 100
Primary Registration District No. 2178
(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lola Elizabeth Bleuers

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Divorced
6. DATE OF BIRTH. Feb. 15 1879 (Month) (Day) (Year)
7. AGE: 42 Yrs. 8 Mos. 10 ds. IF LESS than 1 day how many .... hrs. or .....min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
9. BIRTHPLACE (State or Country) Hardin Co. Ky
10. NAME OF FATHER James Rogan
11. BIRTHPLACE OF FATHER (State or Country) Ky
12. MAIDEN NAME OF MOTHER Lourie Hargen
13. BIRTHPLACE OF MOTHER (State or Country) Ky.
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Burl Bleuers
(Address) 413 E. 14th Ave Pocatello, Idaho.
15. Filed 10/26 1921 C. E. Espe Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 10 (Month) 25 (Day) 1921 (Year)
17. I HEREBY CERTIFY, That I attended deceased from 10-24 1921 to 10-25 1921
that I last saw her alive on 10-25-21 1921
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Diabetes Mellitus
.....
.....
(Duration) few Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... Yrs. ..... mos. ..... ds.
(Signed) Leon J. Rich M. D.
11/3 1921. (Address) Rubgrdale

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the ,State....yrs....mos....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Newdale — DATE OF BURIAL: 10-27 1921
20. UNDERTAKER: Hegsmyer — ADDRESS: Ryckman

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 100

Primary Registration District No. 2178

File No. 36127

County of Madison

City of Ryburg (No. ..... St.)

Registered No. 67

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH: 8 (Month) 4 (Day) 1921 (Year)

7. AGE: ..... Yrs. ..... Mos. 1 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ryburg Idaho.

10. NAME OF FATHER: Lewis George Winter

11. BIRTHPLACE OF FATHER (State or Country): Ryburg Idaho.

12. MAIDEN NAME OF MOTHER: Meda Eames.

13. BIRTHPLACE OF MOTHER (State or Country): Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Lorin F. Rich
(Address) Ryburg Idaho

15. Filed 8/6 1921 G. L. Esper Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August (Month) 5 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 4 1921, to Aug 5 1921, that I last saw h.i.M. alive on Aug 5 1921, and that death occurred on the date stated above, at 7P M.

The CAUSE OF DEATH* was as follows: Premature birth.

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary): Not Viable

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Lorin F. Rich M. D.

8/6 1921 (Address) Ryburg Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL ..... 19 .....
20. UNDERTAKER	ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36128
Registered No. 34

RECEIVED
NOV 30 1921
BUREAU OF VITAL STATISTICS

Registration District No. 19
Primary Registration District No. 2015

1. PLACE OF DEATH
County of Minidoka
City of Rupert (If outside limits, give township.) St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ethel May Rogers
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Child

6. DATE OF BIRTH: Aug (Month) 3 (Day) 1915 (Year)

7. AGE: 6 Yrs. 2 Mos. 17 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Paul M. Rogers

11. BIRTHPLACE OF FATHER (State or Country): Tennessee

12. MAIDEN NAME OF MOTHER: Mossie Cope

13. BIRTHPLACE OF MOTHER (State or Country): Tennessee

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Paul M. Rogers
(Address) Rupert Idaho

15. Filed Nov. 11 1921 Ed Eshmore Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 20 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 8 1921, to Oct 20 1921, that I last saw her alive on Oct. 20 1921, and that death occurred on the date stated above, at 5 P. M.
The CAUSE OF DEATH* was as follows:
General Peritonitis
(Duration) Yrs. mos. 3 ds.
Contributory (Secondary) Acute Appendicitis
(Duration) yrs. mos. 12 ds.
(Signed) Ed Eshmore M. D.
11-10 1921 (Address) Rupert, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rupert Cemetery
DATE OF BURIAL: Oct 22 1921

20. UNDERTAKER: W. G. Goodman
ADDRESS: Rupert Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
NOV 30 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36129

Registered No. 35

1. **PLACE OF DEATH**

Registration District No. 19

Primary Registration District No. 9013

County of Minidoka

City of Rupert (If outside limits, give township) (St.)

If death occurs away from usual residence, give facts called for under special information.

2. **FULL NAME** Ernest Wallace Lock.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. **SEX**: Male

4. **COLOR OR RACE**: White

5. **SINGLE, MARRIED, WIDOWED OR DIVORCED** (Write the word.): Child

6. **DATE OF BIRTH**: Jan. 25 (Month) (Day) 1912 (Year)

7. **AGE**: 9 Yrs. 8 Mos. 13 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. **OCCUPATION**

(a) Trade, profession or particular kind of work: Child.

(b) General nature of industry, business or establishment in which employed (or employer):

9. **BIRTHPLACE** (State or Country): Idaho.

10. **NAME OF FATHER**: Jeptha Wallace Lock.

11. **BIRTHPLACE OF FATHER** (State or Country): Oregon.

12. **MAIDEN NAME OF MOTHER**: Susie Mary Lockhart

13. **BIRTHPLACE OF MOTHER** (State or Country): Idaho.

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**

(Informant) Susie Mary Lock

(Address) Rupert Ida.

15. Filed Nov. 16 1921

Ed. H. Edwards
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH**: Oct 8 (Month) (Day) 1921 (Year)

17. **I HEREBY CERTIFY**, That I attended deceased from Oct. 8 1921, to Oct. 8 1921, that I last saw him alive on Oct. 8 1921, and that death occurred on the date stated above, at 9:30 A.M.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia and Influenza

(Duration) ..... Yrs. ..... mos. 3 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Ed. H. Edwards, M. D.

11-30 1921 (Address) Rupert Idaho

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. **PLACE OF BURIAL OR REMOVAL**: Rupert Cemetery. **DATE OF BURIAL**: Oct 9 1921

20. **UNDERTAKER**: W. A. Gardner **ADDRESS**: Rupert Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED NOV 30 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

36131

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

Registered No. 37

1. PLACE OF DEATH

Registration District No. 19

County of Minidoka — Primary Registration District No. 2015

City of Rupert (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Andrew Hawk

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Male	White	Married

6. DATE OF BIRTH: Sept (Month) 9 (Day) 1842 (Year)

7. AGE: 79 Yrs. 2 Mos. 24 ds. — IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: David Hawk

11. BIRTHPLACE OF FATHER (State or Country): ?

12. MAIDEN NAME OF MOTHER: Elizabeth Doven

13. BIRTHPLACE OF MOTHER (State or Country): ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Olive R Hawk
(Address) Rupert Idaho

15. Filed Nov. 10 1921 — E. E. Elmore, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 3 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 1st 1921, to Nov 3d 1921, that I last saw ~~him~~ alive on Nov 1 1921, and that death occurred on the date stated above, at 7:30 M.

The CAUSE OF DEATH* was as follows:

Bronchitis Acute

(Duration) ..... Yrs. about 10 mos. ds.

Contributory (Secondary) Mitral Regurgitation + Cerebral Sclerosis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Leland Fawgin M. D.

11th 1921 (Address) Rupert, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
K. P. Cemetery Rupert	Nov 6 1921

20. UNDERTAKER	ADDRESS
W. A. Goodman	Rupert

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
NOV 10 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 19
District No. 2015
File No. 36133
Registered No. 39

1. PLACE OF DEATH

County of Bannock
City of Pocatello (or Village of ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ella L. Hall

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widow

6. DATE OF BIRTH: Dec (Month) 15 (Day) 1846 (Year)

7. AGE: 25 Yrs. 8 Mos. 18 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: John Packham

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Lydia Kemp

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. A. Stevenson
(Address) Acequia

15. Filed Nov. 10 1921 A. H. Elmore
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) [redacted] (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1st 1921, to Sept 3 1921, that I last saw her alive on Sept 1 1921, and that death occurred on the date stated above, at 1:15 P.M.

The CAUSE OF DEATH* was as follows:
Acute Brights disease
(Duration) about Yrs. 2 mos. ds.
Contributory (Secondary) Valvular Heart Disease
(Duration) about yrs. 1 mos. ds.

(Signed) Leland Francis M. D.
19 (Address) Rupert, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Ogden Utah
DATE OF BURIAL: Sept 6 1921

20. UNDERTAKER
ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51068

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

Frozen

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36134

Registered No. 40

RECEIVED NOV 30 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 19

County of Minidoka — Primary Registration District No. 2015

City of Rupert (If outside city limits, give township) Van B. U.S. Military St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Virgil Mayes

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Widd

6. DATE OF BIRTH: Jan (Month) 16 (Day) 1921 (Year)

7. AGE: 0 Yrs. 0 Mos. 0 ds.

IF LESS than 1 day how many ..... hrs. or 30 min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business or establishment in which employed (or employer) —

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Virgil Mayes

11. BIRTHPLACE OF FATHER (State or Country) Missouri

12. MAIDEN NAME OF MOTHER Nellie Bailey

13. BIRTHPLACE OF MOTHER (State or Country) Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Virgil Mayes

(Address) Rupert Idaho

15. Filed Nov. 18 1921 E. R. Elmore, Local Registrar

MEDICAL CERTIFICATE OF DEATH

Stillborn

16. DATE OF DEATH: Jan (Month) 16 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 16 1921, to Jan 16 1921 that I last saw him alive on Jan 16 1921 and that death occurred on the date stated above, at 1:45 A. M.

The CAUSE OF DEATH* was as follows:

Failure to establish respiration

38 min (Duration) — Yrs. — mos. — ds.

Contributory (Secondary) —

(Duration) — yrs. — mos. — ds.

(Signed) Leland Frazier M. D.

19 (Address) Rupert, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rupert Cemetery — DATE OF BURIAL: Jan 16 1921

20. UNDERTAKER: W. A. Goodman — ADDRESS: Rupert Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED
DEC 15 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 19
Primary Registration District No. 2015
File No. 36135
Registered No. 47

1. PLACE OF DEATH
County of Minidoka
City of Rupert (St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Cora Howell
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Widowed

6. DATE OF BIRTH: March 17 (Month) 17 (Day) 1847 (Year)

7. AGE: 74 Yrs. 6 Mos. 2 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Lake Point Utah.

10. NAME OF FATHER: Chas. Albertson.

11. BIRTHPLACE OF FATHER (State or Country): Longworthy Iowa.

12. MAIDEN NAME OF MOTHER: Mary Ann Hepworth.

13. BIRTHPLACE OF MOTHER (State or Country): Liverpool England.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Price.
(Address) Albion Ida.

15. Filed 12-9 1921 E. B. Elmore, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. (Month) 19 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at 4 P. M.
The CAUSE OF DEATH* was as follows:
Sudden Death.
Probable, Heart Failure.
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) C. A. Evans M. D.
10-12 1921 (Address) C. A. Evans.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Albion Idaho. DATE OF BURIAL: Sept. 21 1921

20. UNDERTAKER: L. D. Talbot. ADDRESS: Burley Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 19
Primary Registration District No. 2015
File No. 36136
Registered No. 42

1. **PLACE OF DEATH**

County of Minidoka
City of Heyburn (No. 270 N. Heyburn Ida. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sarrah M. Lee

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Widowed

6. DATE OF BIRTH: Jan (Month) 22 (Day) 1842 (Year)

7. AGE: 79 Yrs. 8 Mos. 16 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Virginia Ohio

10. NAME OF FATHER: Christian S. Moffitt

11. BIRTHPLACE OF FATHER (State or Country): ~~Ind~~ Penn.

12. MAIDEN NAME OF MOTHER: Sarrah Coldren

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Johnnie Lee
(Address) Burley Idaho

15. Filed 12-9 1921 E. E. Ehmore, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. (Month) 8 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 8 — 1921, to Oct. 8 — 1921, that I last saw h. alive on Oct. 8 1921, and that death occurred on the date stated above, at 6:30 A.M.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

— (Duration) — Yrs. — mos. — ds.

Contributory (Secondary) —

— (Duration) — yrs. — mos. — ds.

(Signed) [illegible] M. D.

19..... (Address) Burley Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Heyburn Ida.	Oct. 9—1921
20. UNDERTAKER	**ADDRESS**
L. B. Talley	Burley Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-12 M. 6-15-17.

Post.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36137
Registered No. 43
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

RECEIVED DEC 1 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Canyon Minidoka Registration District No. 19
City of Burley Heyburn Primary Registration District No. 2015
If death occurs away from usual residence, give facts called for under special information. (No. ..... St.)

2. FULL NAME Sarah Elizabeth Miller.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: April (Month) 18 (Day) 1865 (Year)

7. AGE: 56 Yrs. 6 Mos. 21 ds. IF LESS than 1 day how many .... hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife.
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Upton Indiana

10. NAME OF FATHER: Charles Davis.

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Jennie Mott.

13. BIRTHPLACE OF MOTHER (State or Country): Ohio.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chas. A. Miller.
(Address) Heyburn Ida.

15. Dec. 9 Filed Nov. 1921. E. A. Elmore Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 8 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 15 1921 to Nov. 8 1921 that I last saw her alive on Nov. 8 1921 and that death occurred on the date stated above, at 12:30 P. M.

The CAUSE OF DEATH* was as follows:
Pleuro Colitis
(Duration) ..... Yrs. ..... mos. 24 ds.
Contributory (Secondary)
(Duration) ..... Yrs. ..... mos. ..... ds.
(Signed) J. C. Patterson M. D.
Nov. 9. 1921. (Address) Burley Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Burley Ida. DATE OF BURIAL: 11/10/ 1921

20. UNDERTAKER: L. B. Jaccoxy ADDRESS: Burley Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36138
Registered No.

RECEIVED NOV 30 1921 BUREAU OF VITAL STATISTICS STATE OF IDAHO

1. PLACE OF DEATH

Registration District No. 128
Primary Registration District No. Culdesac
County of Nez Perce
near City of Nekoosa (Ward No. Precinct St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Genevieve Dufour

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Single

6. DATE OF BIRTH: Oct (Month) 4 (Day) 1914 (Year)

7. AGE: 7 Yrs. Mos. 7 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Theodore Dufour

11. BIRTHPLACE OF FATHER (State or Country): Maine

12. MAIDEN NAME OF MOTHER: Maud Wood

13. BIRTHPLACE OF MOTHER (State or Country): Montana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Theodore Dufour
(Address) Silverton

15. Filed Oct 1921 George Gaymard Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 11 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 6 — 1921, to Oct 11 — 1921, that I last saw her alive on Oct 10 1921, and that death occurred on the date stated above, at 8:50 P.M.

The CAUSE OF DEATH* was as follows:
Anterior Poliomyelitis

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) George Gaymard M. D.
Oct 1921 (Address) Culdesac Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Nekoosa Idaho — DATE OF BURIAL: Oct 1921

20. UNDERTAKER: Wm Moody — ADDRESS: Culdesac Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36139
Registered No.

1. PLACE OF DEATH

Registration District No. 128

County of Key Perce

City of near Culdesac (If not in city give township)

Primary Registration District No. Culdesac & Vicinity

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mattie C. Shaw

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

RECEIVED
NOV 30 1921
BUREAU OF VITAL STATISTICS

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Sept (Month) 10 (Day) 1869 (Year)

7. AGE: 52 Yrs. 15 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: C. C. Glenn

11. BIRTHPLACE OF FATHER (State or Country): Don't Know

12. MAIDEN NAME OF MOTHER: Sarah C White

13. BIRTHPLACE OF MOTHER (State or Country): Don't Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Walter Shaw
(Address) Shaudeins Idaho

15. Filed Sept 19 21 George Gaynor (?) Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept 24th 19 21
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That [redacted] deceased from 19..., to 19..., that I last saw her alive on Sept 24" 1921, and that death occurred on the date stated above, at 10 PM.

The CAUSE OF DEATH* was as follows:
Abdominal Tumor

(Duration) One Yrs. and more mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) A. A. Hansen [redacted]

Sept 19 21. (Address) Culdesac, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: near Culdesac Idaho — DATE OF BURIAL: Sept 27 19 21

20. UNDERTAKER: W. E. Stoddard — ADDRESS: Grand Ford Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
NOV 30 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 128
Primary Registration District No. Culdesac
File No. 36140
Registered No.

1. PLACE OF DEATH
County of Nez Perce
City of near Culdesac (No. ..... St.) or vicinity

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Homer B. Leach

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Child (Write the word.)

6. DATE OF BIRTH: Dec 2 1910 (Month) (Day) (Year)

7. AGE: 10 Yrs. 9 Mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: School Child
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: William B. Leach

11. BIRTHPLACE OF FATHER (State or Country): Kentucky

12. MAIDEN NAME OF MOTHER: Sarah A Rupe

13. BIRTHPLACE OF MOTHER (State or Country): Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Sarah B. Leach
(Address): Culdesac Ida.

15. Filed Sept 19 21 George Gaisford M.D. Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. (Month) 7 (Day) 19 21 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 3 — 19 21, to Sept 7 — 19 21
that I last saw h.. alive on Sept 7 — 19 21
and that death occurred on the date stated above, at 12:30 P.M.
The CAUSE OF DEATH* was as follows:
Acute Catarrhal Laryngitis

(Duration) ..... Yrs. ..... mos. 10 ds.
Contributory (Secondary) Oedema of the Larynx (Duration) ..... yrs. ..... mos. 4 ds.

(Signed) George Gaisford M. D.
Sept 19 21 (Address) Culdesac Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Reubens Idaho — DATE OF BURIAL: Sept 8 19 21

20. UNDERTAKER: W. E. Stoddard — ADDRESS: Gifford Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
NOV 30 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

36141

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 92
Primary Registration District No. 2170
File No. 5
Registered No. 33

1. PLACE OF DEATH

County of Nez Perce Co.
City of Cameron (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Eva Meilke

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widowed

6. DATE OF BIRTH: March (Month) 3 (Day) 1829 (Year)

7. AGE: 94 Yrs. 8 Mos. 12 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER .....

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Eva Radtke

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wm E. Stoddard
(Address) Gifford

15. Filed 11-16 1921
E. Eva Watts
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 15 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 9 1921 to Oct 15 1921
that I last saw her alive on Oct 13 1921
and that death occurred on the date stated above, at 7 P.M.
The CAUSE OF DEATH* was as follows:
Gastritis
.....
.....
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) J. W. Stoudburner M. D.
1921 (Address) Lolo Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Cameron — DATE OF BURIAL: Nov 17 1921

20. UNDERTAKER — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

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FORM V. S. No. 5-25 M. 1-19.

RECEIVED
NOV 30 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 92 — 36142
Registration District No. 2170
File No. 61
Registered No. 34

1. PLACE OF DEATH
County of Nez Perce
City of Lekand (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Joseph W Stoneburner

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Feb (Month) 11 (Day) 1860 (Year)

7. AGE: 61 Yrs. 9 Mos. 7 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Doctor
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Indiana

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W E Goddard
(Address) Gifford

15. Filed 11-18 1921
E. E. Watts
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 17 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 16 1921, to Nov 17 1921, that I last saw h.im alive on Nov 17 1921, and that death occurred on the date stated above, at 3:00 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar
Suicidal
(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Daily M. D.
11/18 1921 (Address) Orofino, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Cameron — DATE OF BURIAL: Nov 22 1921

20. UNDERTAKER: W E Goddard — ADDRESS: Gifford

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 92 — 36143
Primary Registration District No. 2170
File No. 51
Registered No. 32

RECEIVED
NOV 30 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH.
County of Jefferson
City of Gifford (If not in city give township) St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Benjiman Franklin Chaney
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Oct (Month) 8 (Day) 1844 (Year)

7. AGE: 77 Yrs. — Mos. 17 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Farmer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Indiana

10. NAME OF FATHER Louis Chaney

11. BIRTHPLACE OF FATHER (State or Country) Maryland

12. MAIDEN NAME OF MOTHER Rachel Shepard

13. BIRTHPLACE OF MOTHER (State or Country) Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Belle Chaney
(Address) Gifford Idaho

15.
Filed 10-21 1921
E E Watts
Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Oct (Month) 20 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 10-12 1921, to 10-20 1921, that I last saw him alive on 10-19 1921, and that death occured on the date stated above, at 10 a M.

The CAUSE OF DEATH* was as follows:
Acute Gastritis

(Duration) — Yrs. — mos. 10 ds.
Contributory (Secondary) Senile Decay
(Duration 3 yrs. — mos. — ds.

(Signed) E. E. Watts M. D.
10-20 1921 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Gifford — DATE OF BURIAL: Oct 24 1921

20. UNDERTAKER: W E Stoddard — ADDRESS: Gifford

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

36144

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED NOV 30 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH.

County of Nez Perce — Registration District No. 92

City of Gifford — Primary Registration District No. 2170

(If not in city or town give township) ..... (St.)

File No. 5

Registered No. 31

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Washington R McCall

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH. February 2 1848
(Month) (Day) (Year)

7. AGE: 73 Yrs. 8 Mos. 6 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Tennessee

10. NAME OF FATHER: James McCall

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: Bob Brown

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. W. L. McNeil
(Address) Halsey Ore

15.
Filed 10-10 1921
E. E. Watts
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: October 8th 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from — 191—, to — 191—, that I last saw him alive on — 191—, and that death occured on the date stated above, at 5 P M.

The CAUSE OF DEATH* was as follows:
Endocarditis

(Duration) Yrs. 1 mos. — ds.

Contributory (Secondary) —
(Duration — yrs. — mos. — ds.

(Signed) E. E. Watts M. D.
19— (Address) Gifford

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Gifford — DATE OF BURIAL: 10-11 1921

20. UNDERTAKER: W. E. Goddard — ADDRESS: Gifford

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96 3614
Primary Registration District No. 1009
File No.
Registered No. 723

RECEIVED
DEC 10 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Nez Perce
City of Lewiston (No. St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Earl Raymond Wallace.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Mar (Month) 4 (Day) 1898 (Year)

7. AGE: 23 Yrs. 8 Mos. 29 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Orchard Labor
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): S. Dak.

10. NAME OF FATHER: Thornton Wallace

11. BIRTHPLACE OF FATHER (State or Country): Ontario Canada

12. MAIDEN NAME OF MOTHER: Anna Smith

13. BIRTHPLACE OF MOTHER (State or Country): Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Earl Brown
(Address) Lewiston Ida.

15. Filed Dec 12 1921 Orsam E. Bruce Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 3 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....
and that death occurred on the date stated above, at 1:30 P.M.
The CAUSE OF DEATH* was as follows:
[redacted] Acute Nephritis.
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) P. T. Hanna, M. D.
11/4/21 (Address) Lewiston Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston Ida — DATE OF BURIAL ..... 19.....

20. UNDERTAKER: Bassar Mtd. Co. — ADDRESS: Lewiston Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
DEC 10 1921
BUREAU OF VITAL STATISTICS

Registration District No. 96
Primary Registration District No. 1009

File No. 36146
Registered No. 724

1. PLACE OF DEATH

County of Nez Perce
City of Lewiston (No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jas P. Walker

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Widower

6. DATE OF BIRTH: Apr (Month) 6 (Day) 1868 (Year)

7. AGE: 53 Yrs. Mos. ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Mining
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Colo.

10. NAME OF FATHER: Carson A. Walker

11. BIRTHPLACE OF FATHER (State or Country): U.S.

12. MAIDEN NAME OF MOTHER: Martz

13. BIRTHPLACE OF MOTHER (State or Country): U.S.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) L. M. Walker
(Address) Bellingham Wn

15. Filed Dec 12 1921 Susan E. Bruce Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: November (Month) 3 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....
and that death occurred on the date stated above, at 9.30 P.M.

The CAUSE OF DEATH* was as follows:
Probably Pulmonary Embolism - Sudden death Caused before 2 annual
(Duration) Yrs. mos. ds.
Contributory (Secondary) arteriosclerosis, 4 years
(Duration) yrs. mos. ds.
(Signed) W. O. Clark M. D.
Nov 8 1921 (Address) Lewiston Idaho

*State the *Disease Causing Death*; or in deaths from **Violent Causes**, state (1) Means of Injury; and (2) whether **Accidental, Suicidal or Homicidal.**

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Lewiston Idaho	11/8 1921
20. UNDERTAKER: Vassar Mort Co	ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

Bradstock 1

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36147
Registered No. 725

1. PLACE OF DEATH

RECEIVED
DEC 10 1921
BUREAU OF VITAL STATISTICS

Registration District No. 96
Primary Registration District No. 1009
County of Nez Perce
City of Lewiston, (or Village of ....., St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Glenn P. Snyder

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6. DATE OF BIRTH: June (Month) 3 (Day) 1892 (Year)

7. AGE: 29 Yrs. 5 Mos. 1 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): W. Va.

10. NAME OF FATHER: P. A. Snyder

11. BIRTHPLACE OF FATHER (State or Country): W. Va.

12. MAIDEN NAME OF MOTHER: Clara V. Bodkins

13. BIRTHPLACE OF MOTHER (State or Country): W. Va.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) P A Snyder
(Address) Green Ida

15. Filed Dec 12 1921 Brian E. Bruce Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 4 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 4 1921, to Nov 4 1921, that I last saw h... alive on Nov 4 1921, and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Fracture of Base of Skull

(Duration) ..... Yrs. ..... mos. 2 ds.
Contributory (Secondary) Acid Horse fell
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E G Bradstock M. D.
Nov 5 1921 (Address) Lewiston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Green Idaho — DATE OF BURIAL ..... 19.....

20. UNDERTAKER: Fraser Und. Co. — ADDRESS Lewiston Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED DEC 15 1921 BUREAU OF VITAL STATISTICS STATE OF IDAHO

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 36118
Registered No. 726

1. PLACE OF DEATH

County of Nez Perce
City of Lewiston (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Frances E Brown

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Oct (Month) 5 (Day) 1883 (Year)

7. AGE: 38 Yrs. 1 Mos. 1 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): California

10. NAME OF FATHER: Cyrus C. Hobson

11. BIRTHPLACE OF FATHER (State or Country): Calif.

12. MAIDEN NAME OF MOTHER: Elizabeth McCutchen

13. BIRTHPLACE OF MOTHER (State or Country): Calif

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ernest Brown
(Address) Lewiston Idaho

15. Filed Dec 12 1921 Swan E Bruce Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 6 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 15 1921, to Nov 6 1921, that I last saw h[illegible] alive on Nov 5 1921, and that death occurred on the date stated above, at 8 P. M.
The CAUSE OF DEATH* was as follows:

Cancer of Abdomen

(Duration) 2 Yrs 2 mos. 7 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) L. G. Watkins M. D.
11/7 1921 (Address) Lewiston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston Idaho — DATE OF BURIAL: 11/8 1921

20. UNDERTAKER: Lussard Und. Co. — ADDRESS: Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED DEC 10 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 96

Primary Registration District No. 1009

File No. 36140

Registered No. 727

County of Nez Perce

City of Lewiston (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elizabeth Robbins

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): married

6. DATE OF BIRTH: June (Month) 10 (Day) 1849 (Year)

7. AGE: 72 Yrs. 4 Mos. 29 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: At home

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): North Carolina

10. NAME OF FATHER: James Hinton

11. BIRTHPLACE OF FATHER (State or Country): North Carolina

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): North Carolina

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs P.A. Briggs

(Address) Spokane Wash

15. Filed Dec 12 1921 Byron E Bruce Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: November (Month) 8 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 5 1916, to Nov 8 1921, that I last saw her alive on Nov 7 1921 and that death occurred on the date stated above, at 9 a M.

The CAUSE OF DEATH* was as follows:

Paralysis.

(Duration) 5 Yrs. ..... mos. 3 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) L F Inman M. D.

19..... (Address) Lewiston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston Ida — DATE OF BURIAL: 12/9 1921

20. UNDERTAKER: Vassar Mortuary Co — ADDRESS: Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
DEC 10 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 96

County of Nez Perce

Registration District No. 1009

City of Lewiston (No. ..... St.)

File No. 36150

Registered No. 728

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Edna Elaine Stelz

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Febr. 6 1915 (Month) (Day) (Year)

7. AGE: 6 Yrs. 9 Mos. 4 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: School Girl
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: W. E. Stelz

11. BIRTHPLACE OF FATHER (State or Country): S. Dak.

12. MAIDEN NAME OF MOTHER: Hattie M. Porter

13. BIRTHPLACE OF MOTHER (State or Country): Lewiston Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Ernest Brown
(Address): Lewiston Ida

15. Filed Dec 12 1921 Wm. E. Bruce Local Registrar

MEDICAL CERTIFICATE OF DEATH alley

16. DATE OF DEATH: Nov 10 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 3 1921, to Nov 11 1921, that I last saw h[illegible] alive on Nov 11 1931, and that death occurred on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:

Double Pneumonia

(Duration) ..... Yrs. ..... mos. 9 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. Lee M. Miller M. D.

11/13 1921 (Address) Lewiston Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Lewiston Ida — DATE OF BURIAL: 11/14 1921

20. UNDERTAKER: Vassar Bud Co. — ADDRESS: Lewiston Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51068

FORM V. S. No. 5-25 M. 1-19.

White

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36151

Registered No. 729

RECEIVED
DEC 14 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 96

Primary Registration District No. 1009

County of Nez Perce

City of Lewiston (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ned Bird

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH

(Month) (Day) (Year)

7. AGE: 60 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Salem Oregon

10. NAME OF FATHER [illegible]

11. BIRTHPLACE OF FATHER (State or Country) [illegible]

12. MAIDEN NAME OF MOTHER [illegible]

13. BIRTHPLACE OF MOTHER (State or Country) Do.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) F. F. Young

(Address)

15. Filed Dec 12 1921

Susan E. Bruce
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov 10th 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 5 1921 to Nov 10th 1921 that I last saw him alive on Nov 10 1921 and that death occurred on the date stated above, at 9 P.M.

The CAUSE OF DEATH* was as follows:

Uraemia following cystitis
Nephritis

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) W. J. Clark M. D.

Nov 12 1921 (Address) Juliaetta Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston Idaho

DATE OF BURIAL: 11/13 1921

20. UNDERTAKER

ADDRESS Lewiston Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED DEC 10 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36152

Registered No. 780

1. PLACE OF DEATH

Registration District No. 96

Primary Registration District No. 1009

County of Nez Perce

City of Lewiston (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James Pitt

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.) Single

6. DATE OF BIRTH July (Month) 7 (Day) 1837 (Year)

7. AGE 84 Yrs. 4 Mos. 6 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business or establishment in which employed (or employer): ——

9. BIRTHPLACE (State or Country) Tenn.

10. NAME OF FATHER Kaleb

11. BIRTHPLACE OF FATHER (State or Country) Tenn

12. MAIDEN NAME OF MOTHER Margaret Demarcus

13. BIRTHPLACE OF MOTHER (State or Country) Tenn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jas. Sloane

(Address) City.

15. Filed Dec 12 1921 Rosa E. Bird Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. (Month) 13 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 15 1921, to Nov 17 1921, that I last saw him alive on Nov 13 1921, and that death occurred on the date stated above, at 11.30 a. M.

The CAUSE OF DEATH* was as follows: Complication incident to old age

Duration ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Hardening of arteries

Duration 5 yrs. ..... mos. ..... ds.

(Signed) J. B. Morris M. D.

11/15 1921 (Address) Lewiston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Lewiston Idaho

DATE OF BURIAL 11/15 1921

20. UNDERTAKER

ADDRESS Lewiston Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36153

Registered No. 737

RECEIVED
DEC 10 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 96

County of Nezperce

Primary Registration District No. 1009

City of Lewiston (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Estella J. Murry

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widowed

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1 (Year)

7. AGE: 40 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Mo

10. NAME OF FATHER: Frank Corum

11. BIRTHPLACE OF FATHER (State or Country): Tenn

12. MAIDEN NAME OF MOTHER: Carolina Elmore

13. BIRTHPLACE OF MOTHER (State or Country): Tenn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E. M. Brown

(Address) Lewiston Ida

15. Filed Dec 12 1921 Susan E Bruce Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 17th. (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 8th. 1921, to Nov. 17th. 1921, that I last saw her alive on Nov. 16th. 1921, and that death occurred on the date stated above, at 12:15 A. M.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Stomach.

(Duration) One Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. F. McMahan M. D.

11-17 1921 (Address) Lewiston, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Kamiah Ida

DATE OF BURIAL ..... 19.....

20. UNDERTAKER .....

ADDRESS Lewiston Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

~~TRANSPORTATION OF CORPSE~~

36154

(Always write with black ink)

RECEIVED DEC 10 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Nez Perce

City of Lewiston

If death occurs away from usual residence, give facts called for under special information.

CERTIFICATE OF DEATH

Registration District No. 96

Primary Registration District No. 1009

(No. ..... St.)

2. FULL NAME Bud Crook

State of Idaho
DEPT. OF PUBLIC WELFARE
Bureau of Vital Statistics

File No. .....

Registered No. 732

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX.	4. COLOR OR RACE.	5. Single, married, Widowed or Divorced. (Write the word.)
Male	white	Single

6. DATE OF BIRTH. March (Month) 8 (Day) 08 (Year)

7. AGE. 13 Yrs. 8 Mos. 10 ds.

IF LESS than 1 day, how many.....hrs. or .....min.?

8. OCCUPATION.
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE. (State or Country.) .....

10. NAME OF FATHER. Albert Crook

11. BIRTHPLACE OF FATHER. (State or Country.) Neb

12. MAIDEN NAME OF MOTHER. Kate Haberle

13. BIRTHPLACE OF MOTHER. (State or County.) Ind.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Emma Brown
(Address) Lewiston Ida

15. Filed Dec 12, 1921 Susan E Brown
Local Registrar.

Place Where Remains are to be Sent	Date of Shipment
Kooskia Idaho	12/19, 1921

SHIPPING UNDERTAKER
ADDRESS Lewiston Firm Name Vassar Und. Co.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH. Nov (Month) 18th (Day), 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 18th, 1921, to Nov 18th, 1921; that I last saw h.m alive on Nov 18th, 1921, and that death occurred on the date stated above, at 4 M.
The CAUSE OF DEATH was as follows:

Internal injuries from + Pulmonary Edema
(Duration) ..... Years ..... mos. ..... ds.
Contributory (Secondary.) Fall from traveling horse causing injury to lung
(Duration) ..... Years ..... mos. 5 ds.
Signed O C Isaacson, M. D.
....., 19..... (Address) .....

* State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (for Hospitals, Institutions, Transient or Recent Residents.)
At place ..... in the .....
of death.....yrs.....mos.....days State.....yrs.....mos.....ds
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL.	Date of Burial
Kooskia Idaho	....., 19.....

20. UNDERTAKER. Address Lewiston Idaho

The information on this certificate is an exact COPY of the official certificate at place of death.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED DEC 10 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 96

Primary Registration District No. 1009

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36155

Registered No. 733

1. PLACE OF DEATH

County of Nez Perce

City of Lewiston (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Margaret D Swanson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Married

6. DATE OF BIRTH: Jan (Month) 15 (Day) 1895 (Year)

7. AGE: 26 Yrs. 10 Mos. 5 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: C.C Van Arsdol

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Della Vira

13. BIRTHPLACE OF MOTHER (State or Country): Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ernest Swanson
(Address) Lewiston Ida

15. Filed Dec 12 1921 Susan E. Bruce, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 20 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 30 1921, to Nov 20 1921 that I last saw her alive on Nov 20 1921 and that death occurred on the date stated above, at 10 A M.

The CAUSE OF DEATH* was as follows:

Uraemic Poisoning

(Duration) 2 Yrs. mos. 2 ds.

Contributory (Secondary) Chronic Nephritis

(Duration) 2 yrs. mos. ds.

(Signed) Edgar L White, M. D.

Nov 23 1921 (Address) Lewiston Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston Ida — DATE OF BURIAL: 12 1921

20. UNDERTAKER: Vassar's Co — ADDRESS: Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
DEC 10 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Nez Perce — Registration District No. 96

City of Lewiston — Primary Registration District No. 1009

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

File No. 36156

Registered No. 734

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Gust Kiberg (Wiberg)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH ..... 1..... (Month) (Day) (Year)

7. AGE: 45 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Probably Sweden

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ewe Bruce

(Address) Lewiston Ida

15. Filed Dec 12 1921 — Susan E. Bruce, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov - 22 - 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....

that I last saw h..... alive on ..... 19.....

and that death occurred on the date stated above, at 2 M.

The CAUSE OF DEATH* was as follows:

Hemorrhage
Self Inflicted Inc

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F. T. Stamp, M. D.

11/23 1921 (Address) Lewiston, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston Ida — DATE OF BURIAL: 11/26 1921

20. UNDERTAKER: Bassar Und Co. — ADDRESS: Lewiston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
36-56

1 PLACE OF DEATH
County Nez Perce State IDAHO Registered No. 134
Township ---- or Village ---- or
City Lewiston No. ---- St. ---- Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Gust Wiberg

(a) Residence. No. ---- St. ---- Ward. ----
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred ---- yrs. ---- mos. ---- ds. How long in U. S., if of foreign birth? ---- yrs. ---- mos. ---- ds.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

8—209 d
V. S. No. 98

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word):

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ---- hrs. or ---- min.
about	46			

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Labor
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Sweden

PARENTS
10 NAME OF FATHER
11 BIRTHPLACE OF FATHER (city or town)
(State or country)
12 MAIDEN NAME OF MOTHER
13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant E M Brown
(Address) Lewiston

15 Filed Dec 12, 1921 Imanuel Bruce
REGISTRAR

11—3184 GOVERNMENT PRINTING OFFICE

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 7 1921

17 I HEREBY CERTIFY, That I attended deceased from
----, 19---, to ----, 19---,
that I last saw h--- alive on ----, 19---,
and that death occurred, on the date stated above, at ----m.
The CAUSE OF DEATH* was as follows:

Paralysis
Self reported
(duration) ---- yrs. ---- mos. ---- ds.

CONTRIBUTORY
(SECONDARY)
(duration) ---- yrs. ---- mos. ---- ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) O T Harris, M. D.
, 19 (Address) Lewiston Idaho

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Lewiston Idaho	11/7/6 1921
20 UNDERTAKER	ADDRESS
Vassar Mud Co	Lewiston

FORM V. S. No. 6-25 M. 1-19.

RECEIVED DEC 1 0 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 36157
Registered No. 735

1. PLACE OF DEATH
County of Nez Perce
City of Lewiston (If outside limits, give township) St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Harold Fredrick Mansfield

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: ..... 1 (Month) (Day) (Year)

7. AGE: Yrs. 4 Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country)

10. NAME OF FATHER: Fredrick L. Mansfield

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Dr Dolph

13. BIRTHPLACE OF MOTHER (State or Country): Minn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Emil Brauer
(Address) Lewiston Ida

15. Filed Dec 12 1921 Susan E Brauer
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov 25 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 23 1921 to Nov 25 1921 that I last saw him alive on Nov 24 1921 and that death occurred on the date stated above, at 7 A. M.

The CAUSE OF DEATH* was as follows:

Bowel obstruction caused by meckel's Diverticulum

(Duration) Yrs. mos. 2 ds.

Contributory (Secondary) Meckel's Diverticulum ~~from~~ Congenital

(Duration) yrs. mos. ds.

(Signed) Paul W Johnson M. D.

11/25 1921 (Address) Lewiston Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston Ida — DATE OF BURIAL: Dec 16 1921

20. UNDERTAKER: Passar Und Co. — ADDRESS: Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

64

White
Clark

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36158

Registered No. 136

1. PLACE OF DEATH

County of Nez Perce

City of Lewiston (St.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED DEC 10 1921 BUREAU OF VITAL STATISTICS

Registration District No. 96

Primary Registration District No. 1009

2. FULL NAME S. Frances Parlett

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Feb (Month) 22 (Day) 1857 (Year)

7. AGE: 64 Yrs. 9 Mos. 5 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Andrew Connell

11. BIRTHPLACE OF FATHER (State or Country): ———

12. MAIDEN NAME OF MOTHER: Doty

13. BIRTHPLACE OF MOTHER (State or Country): ———

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15. Filed Dec 12 1921 Susan E. Bruce Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: November (Month) 27 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 27 1921, to Nov 27 1921 that I last saw he alive on Nov 27 1921, and that death occurred on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows: Coronary Thrombosis

(Duration) 1 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) V O Clark M. D.

Nov 27 1921 (Address) Lewiston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston, Idaho. DATE OF BURIAL: 11/29/1921

20. UNDERTAKER: Jaussaud Mortuary Co. ADDRESS: Lewis.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 36159
Registered No. 737

1. PLACE OF DEATH
County of Nez Perce
City of Lewiston (St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME J. F. Rogers

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: July — (Month) (Day) 1862 (Year)

7. AGE: 59 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Watchman
(b) General nature of industry, business or establishment in which employed (or employer): Packing House

9. BIRTHPLACE (State or Country): Ky.

10. NAME OF FATHER: James Rogan

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Bridget Duffy

13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. B. Rogan
(Address) Pocatello Ida.

15. Filed Dec 12 1921 Susan E. Bruce Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov 27 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 1921, to Nov. 27 1921, that I last saw h— alive on Nov. 26 1921, and that death occurred on the date stated above, at 2 A. M.
The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) many Yrs. mos. ds.
Contributory (Secondary)
(Duration) Yrs. mos. ds.

(Signed) L. J. Perkins M. D.
11/28 1921 (Address) L. J. Perkins

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston Ida — DATE OF BURIAL: 11/30 1921

20. UNDERTAKER: Rogers Undt Co — ADDRESS: Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED DEC 1 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 36160
Registered No. 738

1. PLACE OF DEATH
County of Nez Perce
City of Lewiston (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Celia Martinsons

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widow

6. DATE OF BIRTH: Oct 3 1836 (Month) (Day) (Year)

7. AGE: 85 Yrs. 1 Mos. 25 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER: Monson

11. BIRTHPLACE OF FATHER (State or Country): France

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Emil Brown
(Address) Lewiston Ida

15. Filed Dec 12 1921 Susan E. Bruce Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov 28 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Did not attend her 19 to 19
that I last saw h..... alive on ..... 19 .....,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Old age
Was all alone when death came

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Malnourish
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. H. Lovell M. D.
19 ..... (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston Ida
DATE OF BURIAL: 11/30 1921

20. UNDERTAKER: Bassar Mtd Co.
ADDRESS: Lewiston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED DEC 14 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Harris

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36161

Registered No. 739

1. PLACE OF DEATH

County of Nez Perce — Registration District No. 96

City of Lewiston — Primary Registration District No. 1009

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Josie Etterskamp

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Female	White	Widow

6. DATE OF BIRTH ..... 1 .....
(Month) (Day) (Year)

7. AGE 65 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work At Home
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Ohio

10. NAME OF FATHER Charles Etterskamp

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER Johanna Phillips

13. BIRTHPLACE OF MOTHER (State or Country) Pa.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Emma Brown
(Address) Lewiston Idaho

15.
Filed Dec 12 1921 Susan E. Bruce
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov 28 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 22 1921, to Nov. 27 1921, that I last saw h.. alive on Nov. 29 1921, and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Septic infection

(Duration) ..... Yrs. 6 mos. ..... ds.

Contributory (Secondary) Colon Cystitis.

(Duration) ..... yrs. 6 mos. ..... ds.

(Signed) F. T. Harris, M. D.

11/27/1921 (Address) Lewiston, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Lewiston Idaho — DATE OF BURIAL Nov 30 1921

20. UNDERTAKER Lissan Und. Co. — ADDRESS Lewiston, Idaho

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36162

Registered No. 713

Registration District No. 96

Primary Registration District No. 1009

RECEIVED NOV 30 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Nez Perce

City of Lewiston (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Carrie F. MacDonald

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widow

6. DATE OF BIRTH: Sept (Month) 22 (Day) 1859 (Year)

7. AGE: 62 Yrs. 0 Mos. 8 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Betty D. Jones

11. BIRTHPLACE OF FATHER (State or Country): South

12. MAIDEN NAME OF MOTHER: Ellen Drummond

13. BIRTHPLACE OF MOTHER (State or Country): Md

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. F. MacDonald

(Address) Lewiston Ida

15. Filed Nov 9 1921 Susan E. Bruce Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 30 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....

that I last saw h[illegible] alive on Sept 80 1921

and that death occurred on the date stated above, at 9 P M.

The CAUSE OF DEATH* was as follows:

Bulbar Paralysis

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) L. J. Perkins M. D.

10/5/1921 (Address) L. J. Perkins

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston Ida — DATE OF BURIAL: 10/5 1921

20. UNDERTAKER: Lucas Undertaking Co. — ADDRESS: Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 36163
Registered No. 714

1. PLACE OF DEATH
County of Nez Perce
City of Lewiston (No. ... St.)
If death occurs away from usual residence, give facts called for under special information.

RECEIVED NOV 30 1921 BUREAU OF VITAL STATISTICS

2. FULL NAME Jessie Webb Decker

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widow (Write the word.)

6. DATE OF BIRTH: Jan 1 (Month) (Day) 1848 (Year)

7. AGE: 73 Yrs. 9 Mos. 1 ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: at Home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): N. Y

10. NAME OF FATHER: Eusebius Austin Webb

11. BIRTHPLACE OF FATHER (State or Country): N. Y

12. MAIDEN NAME OF MOTHER: Sarah Carpenter

13. BIRTHPLACE OF MOTHER (State or Country): N. Y.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R L Brown
(Address) Lewiston Ida

15. Filed Nov 9 1921 Susan E Bruce Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: October (Month) 4 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 27 1921, to October 4 1921, that I last saw h.. alive on October 4 1921, and that death occurred on the date stated above, at 11:58 a M.

The CAUSE OF DEATH* was as follows:
Hemorrage of the Bowells.

(Duration) Yrs. 1 mos. 10 ds.
Contributory (Secondary): Old age Subject to Hemorrage
(Duration) yrs. mos. ds.

(Signed) L. T. Swanson M. D.
19 (Address) Lewiston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston Ida — DATE OF BURIAL: 10/5 1921

20. UNDERTAKER: Vassar Undertaking Co — ADDRESS: Lewiston Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED NOV 30 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36164

Registered No. 715

1. PLACE OF DEATH

Registration District No. 96

County of Nez Perce

Primary Registration District No. 1109

City of Lewiston (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charley Ling

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Yellow Chinese

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH ..... 1 ..... (Month) (Day) (Year)

7. AGE: 68 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Porter
(b) General nature of industry, business or establishment in which employed (or employer): Hotel

9. BIRTHPLACE (State or Country): China

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): China

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): China

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) George Wax
(Address) Lewiston Ida

15. Filed Nov 9 1921 Susan E Bruce Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct 10 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 9 1921, to Oct 10 1921, that I last saw him alive on Oct 10 1921, and that death occurred on the date stated above, at 3 P M.

The CAUSE OF DEATH* was as follows:
Pneumonia Lobar
..... (Duration) ..... Yrs. ..... mos. 3 ds.
Contributory (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E L Whitehill M. D.
Oct 11 1921 (Address) Lewiston Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Lewiston Ida — DATE OF BURIAL: 11 1921

20. UNDERTAKER: Vassar Und. Co. — ADDRESS: Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

GYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36165

Registered No. 716

1. PLACE OF DEATH

County of Nez Perce

City of Lewiston (If outside limits, give township) St.)

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 96

Primary Registration District No. 1009

RECEIVED NOV 30 1921 BUREAU OF VITAL STATISTICS

2. FULL NAME John Beasley

If death occurred in a hospital, institution or camp, give its NAME instead of street and number. alley

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Widower

6. DATE OF BIRTH: June (Month) 17 (Day) 1843 (Year)

7. AGE: 78 Yrs. 3 Mos. 23 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business or establishment in which employed (or employer): Common

9. BIRTHPLACE (State or Country): Mo.

10. NAME OF FATHER: William Beasley

11. BIRTHPLACE OF FATHER (State or Country): Tenn.

12. MAIDEN NAME OF MOTHER: Dulcina Westrope

13. BIRTHPLACE OF MOTHER (State or Country): Tenn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Zoe Beasley

(Address) 507-15th St. Lewiston Ida.

15. Filed Nov 9 1921 Susan E Bruce Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 10 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1 1921, to Oct 10 1921, that I last saw h.im alive on Oct 10 1921 and that death occurred on the date stated above, at 1/0 M.

The CAUSE OF DEATH* was as follows: Carcinoma of Stomach

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Ulcer of Stomach

(Duration) 3 yrs. ..... mos. ..... ds.

(Signed) John F Alley M. D.

19 ..... (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Lewiston Ida — DATE OF BURIAL: 10/12 1921

20. UNDERTAKER: Vassar Undertaking Co. — ADDRESS: Lewiston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 36166
Registered No. 717

RECEIVED
NOV 30 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Nez Perce
City of Lewiston (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs Ellen Barnett.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Widow

6. DATE OF BIRTH March 17 1838
(Month) (Day) (Year)

7. AGE 83 Yrs. 6 Mos. 23 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Md.

10. NAME OF FATHER Wm. Drummond

11. BIRTHPLACE OF FATHER (State or Country) Scotland

12. MAIDEN NAME OF MOTHER [redacted] Not Known

13. BIRTHPLACE OF MOTHER (State or Country) Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) .....
(Address) .....

15. Filed Nov 9 1921 Susan E. Bruce
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 10 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 4 1921, to Oct 8 1921, that I last saw h.er alive on Oct 8 1921, and that death occurred on the date stated above, at 8 A.M. The CAUSE OF DEATH* was as follows:

acute bronchitis

(Duration) 1 Yrs. X mos. 4 ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) L. G. Perkins M. D.
10/11/1921 (Address) Lewiston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Lewiston Idaho | **DATE OF BURIAL** ..... 19.....

20. UNDERTAKER | **ADDRESS** Lewiston Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-35 M. 1-19.

RECEIVED NOV 30 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36167

Registered No. 918

1. PLACE OF DEATH

County of Nez Perce

City of Lewiston

Primary Registration District No. 96

Primary Registration District No. 1009

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Isaac P. Ragan

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	White	Married

6. DATE OF BIRTH: Dec. (Month) 13 (Day) 1867 (Year)

7. AGE: 53 Yrs. 10 Mos. 2 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: Nathan Ragan

11. BIRTHPLACE OF FATHER (State or Country): Kentucky

12. MAIDEN NAME OF MOTHER: Margaret Smith

13. BIRTHPLACE OF MOTHER (State or Country): Kentuckey

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Minnie Ragan.

(Address) 1617 9th Ave. Lewiston, Idaho.

15. Filed Nov 9 1921 Susan E Bruce Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 17th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 19 17 to Oct 18 1921 that I last saw h-- alive on Oct 17 1921 and that death occurred on the date stated above, at 10-24 P.M.

The CAUSE OF DEATH* was as follows:

Arotic Regurgitation

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John H Alley M. D.

19.... (Address) Lewiston, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Lewiston, Idaho	19

20. UNDERTAKER: VASSAR UNDERTAKING CO. ADDRESS Lewiston, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
NOV 20 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36168
Registered No. 719

1. PLACE OF DEATH
County of Nez Perce
City of Lewiston
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 96
Primary Registration District No. 1009
(Ward, Village or Township) (St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Thos. J Beall

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH: Dec (Month) 28 (Day) 1832 (Year)

7. AGE: 88 Yrs. 9 Mos. 22 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): D. C.

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): "

12. MAIDEN NAME OF MOTHER: "

13. BIRTHPLACE OF MOTHER (State or Country): "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Susan E Bruce
(Address) Lewiston Ida

15. Filed Nov 9 1921 Susan E Bruce
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 21 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1920, to Oct 21 1921, that I last saw h... alive on Oct 20 1921, and that death occurred on the date stated above, at 1 A.M.

The CAUSE OF DEATH* was as follows:

Asthma

(Duration) 20 Yrs. ..... mos. ..... ds.

Contributory (Secondary) Colitis

(Duration) ..... yrs. ..... mos. 5 ds.

(Signed) J. Alan McAlley M. D.

Oct 21 1921 (Address) Lewiston Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Lewiston Idaho	19

20. UNDERTAKER: VASSAR UNDERTAKING CO. ADDRESS Lewiston Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED NOV 30 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36170

Registered No. 721

1. PLACE OF DEATH

County of Nez Perce — Registration District No. 96

City of Lewiston — Primary Registration District No. 1009

(No. ..... , ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give NAME instead of street and number.

2. FULL NAME James Early Parker

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Nov. (Month) 19th (Day) 1882 (Year)

7. AGE: 38 Yrs. 11 Mos. 4 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Auto Mechanic

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ky.

10. NAME OF FATHER: John T. Parker

11. BIRTHPLACE OF FATHER (State or Country): Ky.

12. MAIDEN NAME OF MOTHER: Sarah Boyd

13. BIRTHPLACE OF MOTHER (State or Country): Ky.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Alberta Parker

(Address) 2213 8th Ave Lewiston

15. Filed Nov 9 1921 — Susan E Bruce, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. [redacted] (Month) 23 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 15th 1921, to Oct. 21, 1921, that I last saw him alive on Oct. 22, 1921, and that death occurred on the date stated above, at 9:30 P.M.

The CAUSE OF DEATH* was as follows:

~~Pneumonia Influenza~~

Cardiac Dilatation

(Duration) 2 5 Yrs. ..... mos. ..... ds.

Contributory (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Dr. Frank C. Lint M.D.

10/24 1921. (Address) Clarkston Wash

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston Ida — DATE OF BURIAL: 10/25 1921

20. UNDERTAKER — ADDRESS: Lewiston Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED NOV 30 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36171

Registered No. 722

1. PLACE OF DEATH

County of Nezperce Registration District No. 96

City of Lenhat (or Village or Township) Primary Registration District No. 1009

(St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sylvia Teats

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Jan (Month) 20 (Day) 1908 (Year)

7. AGE: 13 Yrs. 9 Mos. 6 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: At school

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Reubens Idaho

10. NAME OF FATHER: Geo H Teats

11. BIRTHPLACE OF FATHER (State or Country): Colfax Wash.

12. MAIDEN NAME OF MOTHER: Anna Kole

13. BIRTHPLACE OF MOTHER (State or Country): Helen Mich

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Geo H Teats.

(Address) Kamiah Ida.

15. Filed Nov 9 1921 Susan E Bruce Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 10 (Month) 26 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 16 1921, to Oct 26 1921, that I last saw h.. alive on Oct 26 1921, and that death occurred on the date stated above, at 10 M.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia

(Duration) Yrs. mos. 1 ds.

Contributory (Secondary) Peritonitis following by ruptured appendix

(Duration) yrs. mos. 6 ds.

(Signed) John B Alley M. D.

Oct 27 1921 (Address) Lewiston Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. 10 days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? Kamiah Ida.

Former or usual residence Kamiah, Ida.

19. PLACE OF BURIAL OR REMOVAL: Kamiah Ida

DATE OF BURIAL: 10/28 1921

20. UNDERTAKER: A C Merchant

ADDRESS: Clarkston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED
NOV 30 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 26
Primary Registration District No. 2069
File No. 36173
Registered No. 33

1. PLACE OF DEATH
County of Oneida
City of Malad (St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Hubert M Jones

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6. DATE OF BIRTH: March (Month) 22 (Day) 1862 (Year)

7. AGE: 59 Yrs. 6 Mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): North Ogden Ut.

10. NAME OF FATHER: David R Jones

11. BIRTHPLACE OF FATHER (State or Country): Wales

12. MAIDEN NAME OF MOTHER: Ada Morgan

13. BIRTHPLACE OF MOTHER (State or Country): South Wales

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Frank Jones
(Address) Malad Ida

15.
Filed NOV 16 1921
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 3 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 23 1921, to Oct 3 1921, that I last saw h~~im~~ alive on Oct 3 1921 and that death occurred on the date stated above, at 10:30 A.M.
The CAUSE OF DEATH was as follows: Aortic Stenosis

(Duration) 1 Yrs. — mos. — ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Kerns M. D.
10/3/1921 (Address) Malad Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Malad Ida — DATE OF BURIAL: 10-5 1921
20. UNDERTAKER: D. E. Johnson — ADDRESS: Malad Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

RECEIVED
NOV 30 1921
BUREAU OF VITAL STATISTICS

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 24
County of Oneida Primary Registration District No. 2069
City of Malad, (No.) St.
File No. 36174
Registered No. 24
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Hyrum Boyd Reynolds

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Child

6. DATE OF BIRTH: Aug (Month) 27 (Day) 1921 (Year)

7. AGE: ..... yrs. 1 mos. 6 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) Child

9. BIRTHPLACE (State or Country) Malad

10. NAME OF FATHER Hyrum E Reynolds

11. BIRTHPLACE OF FATHER (State or Country) North Ogden

12. MAIDEN NAME OF MOTHER Maggie M Evans.

13. BIRTHPLACE OF MOTHER (State or Country) Malad Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) .....
(Address) Hyrum E. Reynolds

15. Filed NOV 14 1921 R T Murray M.D. Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Oct (Month) 3 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 28 1921, to Oct 3 1921
that I last saw h[illegible] alive on Oct 2 1921,
and that death occurred on the date stated above, at 8 A.M.
The CAUSE OF DEATH* was as follows:

Abscess in throat

..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory .....
(Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) J. F. Alton M. D.
Oct 4 1921 (Address) Malad Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Malad Idaho | DATE OF BURIAL: Oct. 5 1921

20. UNDERTAKER: J. Benson | ADDRESS: Malad Ida

GYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

RECEIVED
NOV 30 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36175
Registered No. 35

1. PLACE OF DEATH. Registration District No. 26
County of Oneida Primary Registration District No. 206 of
City of Pleasantview (No. , St.)
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Albert D Jones

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): Married

6. DATE OF BIRTH: 9 (Month) 22 (Day) 1875 (Year)

7. AGE: 46 yrs. mos. 17 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) Farmer & Stockman

9. BIRTHPLACE (State or Country) Mulod

10. NAME OF FATHER Zephiniah Jones

11. BIRTHPLACE OF FATHER (State or Country) Wales

12. MAIDEN NAME OF MOTHER Phoebe Davis

13. BIRTHPLACE OF MOTHER (State or Country) Wales

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Fairlie Jones
(Address) Malad

15. Filed NOV. 16 1921 R. M. Laney M.D. Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Oct (Month) 9 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 4 1921, to Oct 9 1921, that I last saw him alive on Oct 9 1921 and that death occurred on the date stated above, at 1145 M.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. F. Alton M. D.

Oct 10 1921 (Address) Malad

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: St. John Idaho
DATE OF BURIAL: Oct 12 1921

20. UNDERTAKER: J Benson
ADDRESS: Malad Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
NOV 30 1921
BUREAU OF VITAL STATISTICS

Registration District No. 26
Primary Registration District No. 2069
File No. 36176
Registered No. 36

1. PLACE OF DEATH
County of Oneida
City of Malad (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Levi Clark Axtell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write word): Widowed

6. DATE OF BIRTH: March 8 (Month) (Day) 1849 (Year)

7. AGE: 72 Yrs. 7 Mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Carpenter
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New Jersey

10. NAME OF FATHER: Timothy Axtell

11. BIRTHPLACE OF FATHER (State or Country): New Jersey

12. MAIDEN NAME OF MOTHER: Rachel Nelson

13. BIRTHPLACE OF MOTHER (State or Country): New Jersey

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Theo. Axtell
(Address): Holbrook, Ida.

15. Filed Oct 25 1921 — P. W. Mauer M. R. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. (Month) 23 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 23 1921, to Oct 23 1921, that I last saw him alive on Oct 23 1921 and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Chronic Myocarditis

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) J. F. Alston M. D.
Oct 25 1921 (Address) Malad

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Salt Lake City Ut. | DATE OF BURIAL: 10-26 1921

20. UNDERTAKER: D. E. Johnson | ADDRESS: Malad

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

Form V. S. No. 5 20M.1-16-12

RECEIVED NOV 30 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 24

County of Oneida Co. Primary Registration District No. 2064

City of Samaria (No. ....., ... St.)

File No. 36177

Registered No. 37

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary Ann Reese

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widowed

6. DATE OF BIRTH: Sept. 12 (Month) (Day) 1857 (Year)

7. AGE: 64 yrs. 1 mos. 12 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) Home wife

9. BIRTHPLACE (State or Country) Wales

10. NAME OF FATHER Richard Morse

11. BIRTHPLACE OF FATHER (State or Country) Wales

12. MAIDEN NAME OF MOTHER Maria Jones

13. BIRTHPLACE OF MOTHER (State or Country) Wales

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R. M Reese
(Address) Malad

15. Filed NOV 16 1921 R. J. Maxwell Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Oct 24 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1 1921, to Oct 24 1921, that I last saw her alive on Oct 23 1921, and that death occurred on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. F. Allen M. D.

Oct 25 1921 (Address) Malad

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Samaria Idaho — DATE OF BURIAL: Oct. 27 1921

20. UNDERTAKER: J. G. Benson — ADDRESS: Malad

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED NOV 3 1921 BUREAU OF VITAL STATISTICS

Registration District No. 26
Primary Registration District No. 2069
File No. 36178
Registered No. 38

1. PLACE OF DEATH
County of Oneida
City of Malad (If outside limits of city or village, give township.) St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Margaret Ellen Davis
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widowed
6. DATE OF BIRTH: Dec. (Month) 10 (Day) 1854 (Year)
7. AGE: 66 Yrs. 10 Mos. 19 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife.
(b) General nature of industry, business or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Willard Ut.
10. NAME OF FATHER: Richard L. Davis
11. BIRTHPLACE OF FATHER (State or Country): Wales.
12. MAIDEN NAME OF MOTHER: Rebecca Morgan.
13. BIRTHPLACE OF MOTHER (State or Country): Wales.
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R. L. Davis
(Address) Malad, Idaho
15. Filed NOV 6 1921 R. T. Mauer M.D. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. (Month) 29 (Day) 1921 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Jan 1921, to Oct 29 1921
that I last saw h.. alive on Oct 27 1921.
and that death occurred on the date stated above, at 10 P. M.
The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(Duration) 5 Yrs. ..... mos. ..... ds.
Contributory (Secondary) unknown
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) R. T. Mauer M. D.
Nov 1921 (Address) R. T. Mauer Malad Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Malad Ida	11-2 1921
20. UNDERTAKER W. C. Johnson	ADDRESS Malad

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-25 M. 1-19.

RECEIVED DEC 8 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 26
Primary Registration District No. 2064
File No. 36179
Registered No. 40

1. PLACE OF DEATH
County of Oneida
City of Samaria (St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary A. Jotter

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widowed

6. DATE OF BIRTH: Apr. (Month) 10 (Day) 1845 (Year)

7. AGE: 76 Yrs. 8 Mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) Home wife

9. BIRTHPLACE (State or Country) So. Wales.

10. NAME OF FATHER David Edwards

11. BIRTHPLACE OF FATHER (State or Country) So. Wales

12. MAIDEN NAME OF MOTHER Esther Price

13. BIRTHPLACE OF MOTHER (State or Country) So. Wales.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Lucy E Jotter
(Address) .....

15. Filed Dec 8 1921 R O Mauer M.D. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 25 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 15 1921, to Nov 25 1921, that I last saw h[illegible] alive on Nov 24 1921, and that death occurred on the date stated above, at 2 P.M.
The CAUSE OF DEATH* was as follows:

Congestive Heart Disease

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. V. Jotter M. D.
Nov 27 1921 (Address) Malad

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Samaria Idaho — DATE OF BURIAL: Nov 28 1921

20. UNDERTAKER: J. Guy Benson — ADDRESS: Malad Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36180
Registered No. 41

RECEIVED
DEC 8 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH.
Registration District No. 26
Primary Registration District No. 2064
County of Oneida
City of Malad (No. St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elizabeth C Ward

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (or Widowed)

6. DATE OF BIRTH. Jan (Month) 7 (Day) 1877 (Year)

7. AGE 44 Yrs. 10 Mos. 21 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) Housewife

9. BIRTHPLACE (State or Country) Portage

10. NAME OF FATHER Joseph Edley

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER Mary J. Jones

13. BIRTHPLACE OF MOTHER (State or Country) Malad Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. W. Ward
(Address) Malad, Idaho

15. Filed Dec 8 1921 B. M. Mauer M.D. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 28 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 24 1921, to Nov 26 1921, that I last saw h[illegible] alive on Nov 26 1921, and that death occured on the date stated above, at 12:30 P.M.

The CAUSE OF DEATH* was as follows:

1. Apoplexy
2.
3.
4.

(Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary) Unknown

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Turner M. D.
19 ..... (Address) Malad Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Malad Idaho — DATE OF BURIAL: Nov 28 1921

20. UNDERTAKER: J. Guy Benson — ADDRESS: Malad Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36181

Registered No. 3

RECEIVED
NOV 30 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 74

Primary Registration District No. 2151

County of Owyhee

City of Grand View (Ward, ..., St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Bertha Seely

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Oct (Month) 30 (Day) 1921 (Year)

7. AGE: ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or 45 min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: ✓

(b) General nature of industry, business or establishment in which employed (or employer): ✓

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: John C. Seely

11. BIRTHPLACE OF FATHER (State or Country): Nebraska

12. MAIDEN NAME OF MOTHER: Ada I. Matthews

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John C. Seely

(Address) Grand View

15. Filed Nov. 10 1921 W J Ekenbeck Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 30 (Day) 19.21 (Year)

17. I HEREBY CERTIFY, That I attended deceased ~~from~~ Oct 30 19.21, ~~to~~ ..... 19.....

that I last saw her alive on Oct 30 19.21

and that death occurred on the date stated above, at 8:30 A.M.

The CAUSE OF DEATH* was as follows:

Congenital malformation of heart

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W J Ekenbeck M. D.

Nov. 10 19.21 (Address) Grand View

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Grand View — DATE OF BURIAL: Oct. 30 19.21

20. UNDERTAKER: ✓ — ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

36182

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. /

Registered No. 4

RECEIVED
DEC 10 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 74

Primary Registration District No. 215-1

County of Owhyee

City of Grandview (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Milton E Kelly

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	White	Married

6. DATE OF BIRTH: Feb (Month) 27 (Day) 1870 (Year)

7. AGE: 51 Yrs. 8 Mos. 29 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Confectioner

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Nicholas Kelley

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Clive S Kelley

(Address) Nampa Idaho.

15. Filed Dec 10 1921 W J Eckenbeck Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 26 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 25th 1921, to Nov 26th 1921, that I last saw him alive on Nov 25th 1921, and that death occurred on the date stated above, at 3 A. M.

The CAUSE OF DEATH* was as follows:

Acute Alcoholism

autopsy held reserve report of State Chemist (Acute alcoholism)

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) William J. Eckenbeck M. D.

Nov 26 1921 (Address) Grand View Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Boise Idaho. DATE OF BURIAL: Nov 29 1921

20. UNDERTAKER: Summers & Trebs ADDRESS: Boise Idy

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36183
Registered No. 39

RECEIVED
NOV 30 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 4

County of Bayette

Primary Registration District No. 1008

City of Payette (Ward) St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Ann Swartz

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: July (Month) 6 (Day) 1844 (Year)

7. AGE: 77 Yrs. 8 Mos. 16 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ill.

10. NAME OF FATHER: Mosfoot

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Not Known

13. BIRTHPLACE OF MOTHER (State or Country): Not Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. F. Swartz
(Address) Payette Ida

15. Filed Oct 24 1921 J. C. Woodward Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: October (Month) 22 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 28 1921 to Oct 22 1921 that I last saw h[illegible] alive on Oct 22 1921 and that death occurred on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows: Senile Gangrene, Left Foot

(Duration) ..... Yrs. ..... mos. 30 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. C. Woodward M. D.

10/24/1921 (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Payette Ida — DATE OF BURIAL: 10-25 1921

20. UNDERTAKER: [illegible] — ADDRESS: Payette Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

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FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 4

Primary Registration District No. 1008

File No. 36184

County of Payette

City of Payette (St.)

Registered No. 38

If death occurs away from usual residence, give facts called for under special information.

RECEIVED NOV 30 1921 BUREAU OF VITAL STATISTICS

2. FULL NAME Infant Cockerum

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female/Male	White	Single

6. DATE OF BIRTH: Oct (Month) 12 (Day) 1921 (Year)

7. AGE: — Yrs. — Mos. 6 ds. IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: G. L. Cockerum

11. BIRTHPLACE OF FATHER (State or Country): North Carolina

12. MAIDEN NAME OF MOTHER: Cora Carico

13. BIRTHPLACE OF MOTHER (State or Country): Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) G. L. Cockerum
(Address)

15. Filed Oct 20 1921 J. C. Woodward Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 18 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 12 1921, to Oct 18 1921, that I last saw h— alive on Oct 18 1921 and that death occurred on the date stated above, at 8 P.M.

The CAUSE OF DEATH* was as follows: Intussusception

(Duration) ... Yrs. ... mos. 6 ds.

Contributory (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) G. R. Woodward M. D.

14/21 1921 (Address) Payette, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Payette Ida	Oct 18 1921

20. UNDERTAKER	ADDRESS
D. N. Adair	Payette Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

RECEIVED DEC 13 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36186

Registered No.

1. PLACE OF DEATH.

County of Shoshone

City of Not Mullan

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 70

Primary Registration District No. 1011

(No. Abrams Gulch St.)

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Mackie

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH

..... (Month) ..... (Day) 1 (Year)

7. AGE: about 38 yrs. — mos. — ds.

IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION

(a) Trade, profession or particular kind of work: Miner

(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Finland

10. NAME OF FATHER: not known

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E. E. Ward

(Address) Wallace Ida

15. Filed 11/6 1921 H. R. Mowry Deputy Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: about Oct 17 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ——— 191.., to ..... 191.., that I last saw h.. alive on Oct 16 1921 and that death occurred on the date stated above, at — M.

The CAUSE OF DEATH* was as follows: Gunshot wound of chest from person unknown

(Duration) yrs. Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) C. F. Mowry M. D.

11/7 1921 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence Mullan Ida

19. PLACE OF BURIAL OR REMOVAL: Wallace Ida — DATE OF BURIAL: Nov 7 1921

20. UNDERTAKER: Ward Undertaking Co — ADDRESS: Wallace Ida

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36187
Registered No.

RECEIVED
DEC 3 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 78
Primary Registration District No. 1011

County of Shoshone
City of Wallace (If outside limits of city or village, give township) St. 21 Penn St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lillian Waldrup

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F	White	married

6. DATE OF BIRTH ..... 1 ..... (Month) (Day) (Year)

7. AGE 36 Yrs. — Mos. — ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work housewife
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Michigan

10. NAME OF FATHER John Stephen

11. BIRTHPLACE OF FATHER (State or Country) Wales

12. MAIDEN NAME OF MOTHER Ellen Jones

13. BIRTHPLACE OF MOTHER (State or Country) Wales

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John P. Waldrup
(Address) Wallace Idaho

15. Filed Nov 14 1921 T. O'Mowery Deputy Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov 12 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1921, to Nov 12 1921, that I last saw her alive on Nov 11 1921, and that death occurred on the date stated above, at 3:40 P.M.

The CAUSE OF DEATH* was as follows: Carcinoma of Liver

(Duration) Yrs. 6 mos. ds.

Contributory (Secondary) None

(Duration) yrs. mos. ds.

(Signed) Dr. T. Mowery M. D.

11/13/1921 (Address) Wallace Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence Wallace Idaho

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Spokane Wash	Nov 13 1921

20. UNDERTAKER	ADDRESS
Ward Und Co	Wallace Idg

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

RECEIVED DEC 13 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 70

Primary Registration District No. 1011

File No. 36188

Registered No.

1. PLACE OF DEATH

County of Shoshone

City of Wallace (No. Wallace Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Alf Iverson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH: Sept (Month) 22 (Day) 1857 (Year)

7. AGE: 64 yrs. mos. ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Norway

10. NAME OF FATHER: Robin Iverson

11. BIRTHPLACE OF FATHER (State or Country): Norway

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wallace Hospital
(Address) Wallace, Idaho

15. Filed 11/5 1921 H C Mowry Deputy Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Nov (Month) 3 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 8 1921, to Nov 3 1921, that I last saw h[im] alive on Nov 3 1921 and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) Some yrs. mos. ds.

Contributory (Secondary)

(Duration) 4 yrs mos. ds.

(Signed) Edmund C. Spurr M. D.

11-4 1921 (Address) Wallace, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death?

Former or usual residence: Wallace Idaho

19. PLACE OF BURIAL OR REMOVAL: Farmington Minn — DATE OF BURIAL: Nov 5 1921

20. UNDERTAKER: Ward Undr Co — ADDRESS: Wallace Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

D C P [illegible]

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36189
Registered No. ____

1. PLACE OF DEATH. Registration District No. Medimont 70
County of Kootenai Primary Registration District No. 1011
City of Medimont (No. Providence Hospital St.)
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME H. C. Hanson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (write the word.): married wid

6. DATE OF BIRTH: Nov. (Month) 21 (Day) 1 (Year)

7. AGE: 67 yrs. 11 mos. 16 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wisconsin

10. NAME OF FATHER: Christian Hanson

11. BIRTHPLACE OF FATHER (State or Country): Norway

12. MAIDEN NAME OF MOTHER: Not known

13. BIRTHPLACE OF MOTHER (State or Country): Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ada C. Hanson
(Address) Medimont

15. Filed 11/7 1921 H. C. Mowery Deputy Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Nov (Month) 5 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 20 1921, to Nov 5 1921, that I last saw h[illegible] alive on Nov 5 1921, and that death occurred on the date stated above, at 3 P M.

The CAUSE OF DEATH* was as follows:

Cancer of Liver & Stomach

(Duration) 3 yrs. mos. ds.

Contributory (Secondary) ____ (Duration) ____ yrs. ____ mos. ____ ds.

(Signed) H. C. Mowery M.D.
11/5 1921 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the State....yrs....mos....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL ....191..

20. UNDERTAKER | ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

RECEIVED DEC 13 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36190

Registered No.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

Registration District No. 70

Primary Registration District No. 1811

County of Shoshone

City of Wallace (No. Cornelia Jr. Infirmary St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Thomas L. Fenlon

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)
M.	White	Married

6. DATE OF BIRTH

(Month) (Day) 1 (Year)

7. AGE 49 yrs. mos. ds.

IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work Traveling Salesman
(b) General nature of industry business, or dstablishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Ireland

10. NAME OF FATHER Edward Fenlon

11. BIRTHPLACE OF FATHER (State or Country) Ireland

12. ~~MAIDEN~~ NAME OF MOTHER Marie Fenlon

13. BIRTHPLACE OF MOTHER (State or Country) Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Thos. L. Fenlon
(Address) Falcon Idaho

15. Filed 11/2 1921 R. T. Mowry Deputy Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Nov (Month) 3rd (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 28 1921, to Nov 3rd 1921, that I last saw him alive on Nov 2 1921, and that death occurred on the date stated above, at 7 PM.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy 2

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) James R Bean M. D.

11/5 1921 (Address) Wallace

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death?

Former or usual residence Falcon Idaho

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Wallace Idaho	Nov. 6 1921
20. UNDERTAKER	**ADDRESS**
Woodland Co	Wallace Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
DEC 13 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 70
Primary Registration District No. 1011
File No. 36191
Registered No.

1. PLACE OF DEATH
County of
City of (No. Shoshone Co. Infirmary St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sarah Jane Deal

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: August 18 1841 (Month) (Day) (Year)

7. AGE: 80 Yrs. 1 Mos. 22 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Michigan

10. NAME OF FATHER: Benj. M. Dee

11. BIRTHPLACE OF FATHER (State or Country): Tennessee

12. MAIDEN NAME OF MOTHER: Sarah F. Biddlecom

13. BIRTHPLACE OF MOTHER (State or Country): Tennessee

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. M. Price
(Address) Kellogg, Idaho.

15. Filed 11/12 1921 F. C. Mowery Deputy Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 10 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 19..., to Nov 10 1921 that I last saw her alive on Nov 9 1921 and that death occurred on the date stated above, at 3 a.m.

The CAUSE OF DEATH* was as follows:

Senile debility

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

11/12 1921 (Signed) James R Dean M. D.
(Address) Wallace

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ...yrs...mos...days. In the State ...yrs...mos...days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Kellogg, Idaho. DATE OF BURIAL: Nov. 13 1921.

20. UNDERTAKER: M. C. Thornhill ADDRESS: Kellogg, Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

Form V. S. No. 5 20M.1-16-12 DEC 15 1921

CERTIFICATE OF DEATH

BUREAU OF VITAL STATISTICS

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36192

1. PLACE OF DEATH. Registration District No. 70
County of Shoshone Primary Registration District No. 701
City of Wallace (No. Providence Hosp. St.)
Registered No.
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Everett Mack

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	white	single

6. DATE OF BIRTH: February 19th 1896 (Month) (Day) (Year)

7. AGE: 25 yrs. 8 mos. 29 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Logger
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Great Falls Montana

10. NAME OF FATHER: Sam Mack

11. BIRTHPLACE OF FATHER (State or Country): Finland

12. MAIDEN NAME OF MOTHER: Pauline, X X

13. BIRTHPLACE OF MOTHER (State or Country): Finland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Sam Mack
(Address) Cataldo Ida

15. Filed NOV 20 1921 R. E. Mowry Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: NOV 18 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from NOV 16 1921, to NOV 18 1921, that I last saw h[illegible] alive on NOV 18 1921, and that death occurred on the date stated above, at 6:30 A.M.

The CAUSE OF DEATH* was as follows: Perforation Gastric Ulcer

(Duration) 2 hrs. mos. ds.

Contributory (Secondary) Alcoholism Acute

(Duration) yrs. mos. 1 ds.

(Signed) R. E. Mowry M. D.

11/19 1921 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Cataldo Ida — DATE OF BURIAL: Nov. 21 1921

20. UNDERTAKER: Bruce G Mostad — ADDRESS: Wallace

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SVMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36193
Registered No.

1. PLACE OF DEATH. Registration District No. 178
County of Shoshone Primary Registration District No. 1011
City of Wallace (No. Providence Hospital)
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME George Andreeh

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1 (Year)

7. AGE: 40 yrs. — mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: miner
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Austria

10. NAME OF FATHER: Valentine Andreeh

11. BIRTHPLACE OF FATHER (State or Country): Austria

12. MAIDEN NAME OF MOTHER: Katie Rako.

13. BIRTHPLACE OF MOTHER (State or Country): Austria

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Val. Habin
(Address): Mullan Idaho

15. Filed Nov 24 1921 R C Mowry Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Nov (Month) 19 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from January 1920, to Nov 19 1921, that I last saw him alive on Nov 18 1921 and that death occurred on the date stated above, at 1:30 A.M.

The CAUSE OF DEATH* was as follows:

Carcinoma Stomach

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) James R Bean M. D.
11/21/1921 (Address) Wallace

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death?

Former or usual residence: Mullan Idaho

19. PLACE OF BURIAL OR REMOVAL: Mullan Ida. | DATE OF BURIAL: Nov 21st 1921

20. UNDERTAKER: Ward Und Co | ADDRESS: Wallace Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

RECEIVED DEC 13 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 70
Primary Registration District No. 10/1
File No. 36194
Registered No.

1. PLACE OF DEATH. County of Shoshone City of Wallace (No. Wallace Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Erick Lindman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH: January (Month) 17 (Day) 1884 (Year)

7. AGE: 37 yrs. 10 mos. 7 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: miner
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER: Anders Lindman

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Maria

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Carl Lindman
(Address) Mc Cord Wis

15. Filed Nov 26 1921 H. C. Mowry Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: November (Month) 24 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 24 1921, to Nov 24 1921 that I last saw h living alive on Nov 24 1921 and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis

(Duration) yrs. 6 mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.
11/27 19 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs....mos....days. In the State....yrs....mos....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Tomahawk Wis | DATE OF BURIAL: Dec 1921

20. UNDERTAKER: Bruce G. Worstell | ADDRESS: Wallace

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SVMS - YORK CO., PTRS. & BDRS. 19760

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DEC 13 1921
BUREAU OF VITAL STATISTICS

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 170
County of Shoshone Primary Registration District No. 1011 File No. 36195
City of Wallace (No. Providence Hospital) Registered No.
If death occurs away from usual residence, give facts called for under special information.
2. FULL NAME Ruby Vivian LeFever
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH: ..... (Month) 1 (Day) ..... (Year)

7. AGE: 23 yrs. 2 mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: Alexander Jackman

11. BIRTHPLACE OF FATHER (State or Country): not given

12. MAIDEN NAME OF MOTHER: Sally Bredlove

13. BIRTHPLACE OF MOTHER (State or Country): not given

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Norman B LeFever
(Address) Mullan Ida

15. Filed Dec 1 1921 W. H. Mowry Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Nov (Month) 30 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 30 1921, to Nov 30 1921, that I last saw her alive on Nov 30 1921 and that death occurred on the date stated above, at 1 P M.

The CAUSE OF DEATH* was as follows:

Puerperal Eclampsia
6 hours
(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) James R Braw M. D.
11/30 1921 (Address) Wallace Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence Mullan Idaho

19. PLACE OF BURIAL OR REMOVAL: Kalispell Mont | DATE OF BURIAL: Dec 1st 1921

20. UNDERTAKER: Ward Undertaking Co | ADDRESS: Wallace Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 76

Primary Registration District No. 1011

File No. 36196

Registered No.

County of Shoshone

City of Burke (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

RECEIVED NOV 30 1921 BUREAU OF VITAL STATISTICS

2. FULL NAME Infant Daughter of Mrs. Mae Hall

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): single

6. DATE OF BIRTH: Oct (Month) 16 (Day) 1921 (Year)

7. AGE: ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many 3 hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Burke Idaho

10. NAME OF FATHER: Harvey Cole

11. BIRTHPLACE OF FATHER (State or Country): Washington

12. MAIDEN NAME OF MOTHER: Mary Rhoate

13. BIRTHPLACE OF MOTHER (State or Country): Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs S H English

(Address) Burke Idaho

15. Filed 12/8 1921

Local Registrar

SYMS-YORK CO. PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 16 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 16 1921, to Oct 16 1921, that I last saw her alive on Oct 16 1921, and that death occurred on the date stated above, at 6a M.

The CAUSE OF DEATH* was as follows: Exhaustion from delivery Obstruction Intestines

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas. A. Hellman M. D.

Oct 17 1921 (Address) Burke Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence none

19. PLACE OF BURIAL OR REMOVAL: [redacted] Ida — DATE OF BURIAL: Oct 17 1921

20. UNDERTAKER: Ward Undertaking Co — ADDRESS: Wallace Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

RECEIVED NOV 30 1921 BUREAU OF VITAL STATISTICS

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36197

Registered No.

1. PLACE OF DEATH. Registration District No. 10

County of Shoshone Prior Registration District No.

City of Wallace (If not in limits, give township.) 514 High Street

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Emma L. Hughes

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH: Nov 9 1854 (Month) (Day) (Year)

7. AGE: 66 yrs. 11 mos. 19 ds.

IF LESS than 1 day how many .....hrs. or .....mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: housewife
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Oregon

10. NAME OF FATHER: Morton Rassell

11. BIRTHPLACE OF FATHER (State or Country): N.Y.

12. MAIDEN NAME OF MOTHER: Susanna Foswell

13. BIRTHPLACE OF MOTHER (State or Country): not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H. Glen Coulson
(Address) Wallace Ida

15. Filed 10 30 1921 [illegible] Deputy Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: October 28 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 14 1921, to Oct 28 1921, that I last saw her alive on Oct 28 1921 and that death occurred on the date stated above, at 12-15 P.M.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

(Duration) 14 yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) James R Bean M. D.

10/29 1921 (Address) Wallace Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Spokane Wash | DATE OF BURIAL: Oct 29 1921

20. UNDERTAKER: Bruce & Trusdell | ADDRESS: Wallace

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
OCT 4 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36198

Registered No.

1. PLACE OF DEATH

Registration District No.

County of Shoshone

Registration District No.

City of Katts Spur (No. St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME James Murphy

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	W	Don't Know

6. DATE OF BIRTH Don't Know (Month) (Day) 1 (Year)

7. AGE About 40 yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Worked in
(b) General nature of industry, business or establishment in which employed (or employer) lumber

9. BIRTHPLACE (State or Country) Don't Know

10. NAME OF FATHER Don't Know

11. BIRTHPLACE OF FATHER (State or Country) Don't Know

12. MAIDEN NAME OF MOTHER Don't Know

13. BIRTHPLACE OF MOTHER (State or Country) Don't Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H E Hunt
(Address) St Maries Ida

15. Filed Oct 4 1921 F. W. Almond Local ~~Local~~ State Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 18 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....
and that death occurred on the date stated above, at 8.30 A.M.

The CAUSE OF DEATH* was as follows:
Died very suddenly on Public Road one mile West Katts Spur Shoshone Co Ida
(Duration) ... Yrs. ... mos. ... ds.
Contributory (Secondary) Supposed heart disease
(Duration) ... yrs. ... mos. ... ds.

(Signed) Chas. R. Mowery M. D.
19..... (Address) Wallace Coroner

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Woodlawn Cem.	5/20 1921
20. UNDERTAKER H E Hunt	ADDRESS St Maries

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of

City of Victor — BUREAU OF VITAL STATISTICS — St.) Registered No. 1

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Emily Ann Tonks.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): married

6. DATE OF BIRTH: May 10 (Month) (Day) 1857 (Year)

7. AGE: 64 Yrs. 5 Mos. 13 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer): Housework

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: William Littlefield

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Ann Toomer

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Geo M. Tonks

(Address) Victor Idaho.

15. Filed Nov 15 1921 — Martha Marker, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: October 23 1921 (Month) (Day) (Year)

~~Oct 8~~ 1921

17. I HEREBY CERTIFY, That I attended deceased from Oct 8 1921, to Oct 23 1921 that I last saw her alive on Oct 21 1921, and that death occurred on the date stated above, at 6:20 P.M.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

Chronic endocarditis

(Duration) 10 Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) F. A. Culbertson M. D.

10/24/1921 (Address) Driggs Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Victor Cemetery — DATE OF BURIAL: Oct 27 1921

20. UNDERTAKER: W J Kinney — ADDRESS: Driggs

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36200

Registered No. 20

RECEIVED
NOV 30 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 77

Primary Registration District No. 2176

County of Fetor

City of Felt (or Twp.) St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Wiccam Moss Jr.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	white	Single

6. DATE OF BIRTH October 28 1920
(Month) (Day) (Year)

7. AGE 1 Yrs. 1 Mos. 1 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Infant.
(b) General nature of industry, business or establishment in which employed (or employer) Infant.

9. BIRTHPLACE (State or Country) Felt; Idaho.

10. NAME OF FATHER Wm a Moss.

11. BIRTHPLACE OF FATHER (State or Country) Kansas.

12. MAIDEN NAME OF MOTHER Delvie Miner.

13. BIRTHPLACE OF MOTHER (State or Country) Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Benj. H Myers
(Address) Felt, Idaho

15. Filed Dec 2nd 1921 Martha A Marker Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH November 23 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 14 1921 to Nov 23 1921 that I last saw h.im alive on Nov 23 1921, and that death occurred on the date stated above, at 12 A.M.

The CAUSE OF DEATH was as follows:

Bronchial Pneumonia

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas H Martin M. D.

Nov 23 1921 (Address) Dietz, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Felt Cemetery	11-26 1921
20. UNDERTAKER	ADDRESS
Hoskins	Dietz

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-29.

[redacted] CERTIFICATE OF DI[redacted]

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36201

Registered No. 27

1. PLACE OF DEATH

County of Jefferson — [redacted] tion District No. 77

City of Jefferson — [redacted] Registration District No. 21 [redacted] St.)

If death occurs away from usual residence, give facts called for under special information.

REC[redacted] NOV 3[redacted] BUREAU OF VI[redacted] STATISTIC[redacted]

2. FULL NAME Jerry E. Laughlin

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH: April (Month) 23 (Day) 1843 (Year)

7. AGE: 78 Yrs. 7 Mos. 3 ds. — IF LESS than 1 day, how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer): Farming

9. BIRTHPLACE (State or Country): Missouri,

10. NAME OF FATHER: J. Laughlin

11. BIRTHPLACE OF FATHER (State or Country): Penn,

12. MAIDEN NAME OF MOTHER: E. Hoeingshead

13. BIRTHPLACE OF MOTHER (State or Country): Penn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. J. E. Laughlin
(Address) Jefferson, Idaho

15. Filed Dec 2 1931 — Martha Marker, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: November (Month) 26 (Day) 1931 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... about 19.....
and that death occurred on the date stated above, at 2 A.M.
The CAUSE OF DEATH* was as follows:
Suicide by shooting.
Himself with a 22 W.C.F. through
Left temple, Ranging, penetrating said
Duration: ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. B. Farnsworth M.D.
Nov 26 1931 (Address) Dreyer, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Jefferson Cemetery — DATE OF BURIAL: Nov 27 1931

20. UNDERTAKER: C. O. Finney — ADDRESS: Dreyer

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED NOV 30 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36202

Registered No. 33

1. PLACE OF DEATH

County of Teton — Registration District No. 74

City of Driggs (No. ..... St.) — Primary Registration District No. 2174

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lars Peter Larsen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: May 27 (Month) 1 (Day) [illegible] (Year)

7. AGE: 5[illegible] Yrs. 7 Mos. 7 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer): Farming

9. BIRTHPLACE (State or Country): Denmark

10. NAME OF FATHER: Jens Larsen

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: Dorthy Hansen

13. BIRTHPLACE OF MOTHER (State or Country): Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Charles C. Larsen
(Address) Driggs, Idaho

15. Filed Dec 2nd 1921 Martha Marker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: November 29 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 29 1921, to Nov 29 1921, that I last saw h[illegible] alive on Nov 29 1921, and that death occurred on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:
Lobar Pneumonia
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.
Dec 2 1921 (Address) Driggs Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Darby Cemetery — DATE OF BURIAL: Dec 4 1921

20. UNDERTAKER: [illegible] — ADDRESS: Driggs

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 77
Primary Registration District No. 2176
File No. 36203
Registered No. 23

RECEIVED
NOV 30 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Teton
City of Tetonia (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Maughan

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH January (Month) 10 (Day) 1859 (Year)

7. AGE 62 Yrs. 9 Mos. 12 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry, business or establishment in which employed (or employer) Farming

9. BIRTHPLACE (State or Country) Utah

10. NAME OF FATHER John Maughan Sr.

11. BIRTHPLACE OF FATHER (State or Country) England.

12. MAIDEN NAME OF MOTHER Maria Davenport.

13. BIRTHPLACE OF MOTHER (State or Country) Vermont.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Maughan
(Address) Tetonia, Idaho

15.
Filed Nov 15 1921 Martha Marker
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH October (Month) 22 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 21 1921, to Oct 21 1921, that I last saw him alive on Oct 21 1921, and that death occurred on the date stated above, at 8 A.M.

The CAUSE OF DEATH* was as follows:
Carcenoma of Pratate
Chronic Intestinal Nephritis
(Duration) 2 Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. D. Culbertson M. D.
11/22 1921 (Address) Driggs Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Weston Idaho — DATE OF BURIAL Oct 28 1921

20. UNDERTAKER W. J. King — ADDRESS Driggs

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED
NOV 30 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 77

Primary Registration District No. 2176

File No. 36204

County of Teton

City of Tetonia (No. ....., ... St.)

Registered No. 94

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Infant

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	white	Single

6. DATE OF BIRTH: Oct (Month) 18 (Day) 1921 (Year)

7. AGE: ____ Yrs. ____ Mos. ____ ds. IF LESS than 1 day how many 3 hrs. or ____ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business or establishment in which employed (or employer): Infant

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: W. W. Thompson

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Bessie Higgins

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Bessie Thompson
(Address) Tetonia Idaho

15. Filed Dec 2 nd 1921 Martha Marker Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 18 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 18 1921, to Oct 18 1921 that I last saw her alive on " " 1921, and that death occurred on the date stated above, at 9:30 P.M.

The CAUSE OF DEATH* was as follows:

Premature foetus 6 mo.

.....(Duration) .....Yrs. .....mos. .....ds.

Contributory (Secondary) .....

.....(Duration) .....yrs. .....mos. .....ds.

(Signed) Caroline Rammell Midwife M. D.

11/20/1921 (Address) Tetonia Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs. ....mos. ....days. In the State ....yrs. ....mos. ....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Tetonia Cemetery	12/19/1921

20. UNDERTAKER	ADDRESS
W. J. King.	Driggs, Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Twin Falls — Registration District No. 36

City of Murtaugh — Primary Registration District No. ____ (No. ____, ____ St.)

File No. 36205

Registered No. 12

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs P J Baker

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Female	White	Widowed

6. DATE OF BIRTH: May (Month) 28 (Day) 1827 (Year)

7. AGE: 94 Yrs. ____ Mos. 5 ds. 11 — IF LESS than 1 day how many ____ hrs. or ____ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Penn

10. NAME OF FATHER: — Smart

11. BIRTHPLACE OF FATHER (State or Country): Don't Know

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. J. Price
(Address) Murtaugh

15. Filed Nov 10 1921 — J. M. Davis, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 9 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 3rd 1921, to Nov 9 1921, that I last saw h.. alive on Nov 1 1921, and that death occurred on the date stated above, at 12:50 A. M.

The CAUSE OF DEATH* was as follows: Dropsy due to Heart Failure

(Duration) 2 Yrs. — mos. ____ ds.

Contributory (Secondary): nan

(Duration) — yrs. — mos. ____ ds.

(Signed) H B A Price M. D.

Nov 11 1921 (Address) Murtaugh

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Twin Falls	11-12-1921

20. UNDERTAKER	ADDRESS
P J Brannan	Twin Falls

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED
NOV 30 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 36
Primary Registration District No.
File No. 36206
Registered No. 11

1. PLACE OF DEATH
County of Kootenai
City of Twin Falls (No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Walton Woodland.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1 (Year)

7. AGE: 4 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: L. Woodland.

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Lavon Walton

13. BIRTHPLACE OF MOTHER (State or Country): Mont.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) L. Woodland.
(Address) Kingston Idaho

15. Filed Oct 27 1921 J. M. Davis Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 26 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 26 1921, to Oct 26 1921, that I last saw h[illegible] alive on Oct 26 1921, and that death occurred on the date stated above, at 4 P. M.
The CAUSE OF DEATH* was as follows:

Diphtheria

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. B. Price M. D.
10/26 1921 (Address) Montpelier

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Idaho | DATE OF BURIAL: 10/27 1921

20. UNDERTAKER: P. J. Grossman | ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

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NOV 30 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 36
Primary Registration District No.
File No. 36207
Registered No. 10

1. PLACE OF DEATH
County of Twin Falls
City of Murtaugh
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Majory May Turner
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write word.)

6. DATE OF BIRTH: July 2 (Month) 2 (Day) 1921 (Year)

7. AGE: Yrs. 3 Mos. 15 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business or establishment in which employed (or employer) —

9. BIRTHPLACE (State or Country): Murtaugh, Ida

10. NAME OF FATHER: D.R. Turner

11. BIRTHPLACE OF FATHER (State or Country): Ark

12. MAIDEN NAME OF MOTHER: Mary Lillian Willis

13. BIRTHPLACE OF MOTHER (State or Country): Tex

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) D.R. Turner
(Address) Murtaugh, Ida.

15. Filed Oct. 19 1921 J.J. Davis Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. (Month) 18 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 14 1921, to Oct 16 1921, that I last saw h[illegible] alive on Oct 15 1921, and that death occurred on the date stated above, at 9 A.M.
The CAUSE OF DEATH* was as follows:

Immediate Cause: Summer Complaint
(Duration) Yrs. mos. 2 ds.
Contributory (Secondary): None
(Duration) yrs. mos. ds.

(Signed) B.A. Price M. D.
19 (Address) Murtaugh

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. State yrs. mos. days
Where was disease contracted if not at place of death? Yes
Former or usual residence —

19. PLACE OF BURIAL OR REMOVAL: Twin Falls. Ida
DATE OF BURIAL: Oct 19 1921

20. UNDERTAKER: P.J. Grossman
ADDRESS: Twin Falls Ida

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED
NOV 30 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 36
Primary Registration District No.
File No. 36208
Registered No. 9

1. PLACE OF DEATH

County of Twin Falls
City of Murtaugh (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Wilford L. Moyes

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) Single

6. DATE OF BIRTH Oct. (Month) 29 (Day) 1916 (Year)

7. AGE 4 Yrs. 11 Mos. 7 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Ray V. Moyes

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Metty C. Walton

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. L. Moyes

(Address) Murtaugh Ida

15. Filed Oct. 7 1921 J. M. Davis Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. (Month) 6 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1 1921, to Oct 6 1921 that I last saw him alive on Oct 6 1921 and that death occurred on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

Diphtheria

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) B A Prum M. D.

Oct 6 1921 (Address) Murtaugh

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Twin Falls — **DATE OF BURIAL** Oct 8 1921

20. UNDERTAKER J. P. Donovan — **ADDRESS** Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

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FORM V. S. No. 5-25 M. 1-19.

RECEIVED
NOV 30 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Twin Falls Registration District No. 39

City of Burley Primary Registration District No. 2087

(If not in incorporated city or village give township) St.)

File No. 36209

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Eliza W. Peck

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M.	White	Widowed

6. DATE OF BIRTH: May (Month) 19 (Day) 1841 (Year)

7. AGE: 80 Yrs. 4 Mos. 13 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Merchant
(b) General nature of industry, business or establishment in which employed (or employer): Retired

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER: Seth Peck

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Dana Knapp.

13. BIRTHPLACE OF MOTHER (State or Country): Dana Knapp

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. Peck
(Address) Burley

15. Filed Oct 3 1921 J. W. Murphy Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 2 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 10-1-1921 to 10-2-1921, that I last saw h[im] alive on 10-2-1921, and that death occurred on the date stated above, at 1 P. M.

The CAUSE OF DEATH* was as follows:

Uremia

(Duration) ..... Yrs. ..... mos. 1 ds.

Contributory (Secondary) Chronic Nephritis

(Duration) 3 yrs. ..... mos. ..... ds.

(Signed) Geo. J. Fleming M. D.

10-2-1921 (Address) Burley

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Pleasant Valley | DATE OF BURIAL: Oct 4 1921

20. UNDERTAKER: Hansen B. Evans | ADDRESS: Burley Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
NOV 30 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Twin Falls — Registration District No. 39

City of Buhl — (No. ..... St.) — Registration District No. 2087

File No. 36210

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Edward Kudrna.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Use only word.): Single

6. DATE OF BIRTH: Aug. (Month) 18 (Day) 1921 (Year)

7. AGE: ~~Yrs.~~ 2 Mos. 2 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer): /

9. BIRTHPLACE (State or Country): Buhl.

10. NAME OF FATHER: John W. Kudrna.

11. BIRTHPLACE OF FATHER (State or Country): Russia.

12. MAIDEN NAME OF MOTHER: Mary Zablicka.

13. BIRTHPLACE OF MOTHER (State or Country): Russia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John W. Kudrna
(Address) .....

15. Filed 10-21 1921 — J. H. Wrigley, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 10 (Month) — 20 (Day) — 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 10-20- 1921, to 10-20- 1921, that I last saw him alive on 10-20- 1921, and that death occurred on the date stated above, at 8 A. M.
The CAUSE OF DEATH* was as follows:

Intestinal obstruction.

(Duration) ..... Yrs. ..... mos. 1 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Leo Fumiyo M. D.

10-21 1921 (Address) Buhl Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Buhl Cemetery — DATE OF BURIAL: Oct 22 21

20. UNDERTAKER: Buhl Mortuary — ADDRESS: Buhl Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
NOV 30 19
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Twin Falls
City of Burke (St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 39
Primary Registration District No. 2-087
File No. 36211
Registered No.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Chas. F. Rendla

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married
6. DATE OF BIRTH: August 21 (Month) (Day) 1876 (Year)
7. AGE: 45 Yrs. 1 Mos. — ds. IF LESS than 1 day how many..... hrs. or.....min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Bohemia
10. NAME OF FATHER: Karel Rendla.
11. BIRTHPLACE OF FATHER (State or Country): Bohemia.
12. MAIDEN NAME OF MOTHER: Mary Cipera.
13. BIRTHPLACE OF MOTHER (State or Country): Bohemia.
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ralph Rendla
(Address) Burke Idaho
15. Filed 10-22 1921 J. H. Murphy Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 10 (Month) 21 (Day) 21 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1st 1921, to 10-21- 1921, that I last saw him alive on 10-21- 1921, and that death occurred on the date stated above, at 6 a. M.
The CAUSE OF DEATH* was as follows:
Septic Thrombosis
-in Right Femoral vein.
(Duration) Yrs. mos. 21 ds.
Contributory (Secondary) Mitral Regurgitation
(Duration) 1 yrs. mos. ds.
(Signed) Geo. Fleming M. D.
10-21 1921 (Address) Burke, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Burke Cemetery — DATE OF BURIAL: Oct 23 1921
20. UNDERTAKER: Fowler & Gray — ADDRESS: Burke Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED NOV 30 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Twin Falls — Registration District No. 39

City of Burley (No. ....., ... St.) — Primary Registration District No. 2087

File No. 36212

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Wm Benjamin Franklin Orrell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: May (Month) 28th (Day) 1906 (Year)

7. AGE: 16 Yrs. 2 Mos. 26 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: School Boy
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Payette

10. NAME OF FATHER: Lafayette Orrell

11. BIRTHPLACE OF FATHER (State or Country): Texas

12. MAIDEN NAME OF MOTHER: Edna Duncan

13. BIRTHPLACE OF MOTHER (State or Country): Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Lafayette Orrell.
(Address) Burley Idaho

15. Filed 10-25 1921 — J. H. Wright — Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. (Month) 24 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at 11 P. M.
The CAUSE OF DEATH* was as follows:
Gun Shot wound
(Accidental)

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. F. Goodman Coroner
Oct 25 1921 (Address) Twin Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Payette	19.....
20. UNDERTAKER: Homer B Evans	ADDRESS: Burley Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

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FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED
NOV 30 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 35
Primary Registration District No. 2056
File No. 36213
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of Clover
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ulrieke Liermann

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widowed

6. DATE OF BIRTH: Dec (Month) 10 (Day) 1838 (Year)

7. AGE: 83 Yrs. 11 Mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: Degned

11. BIRTHPLACE OF FATHER (State or Country): Don't Know

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Carl Liermann
(Address) Clover, Ida

15. Filed Nov 8 1921
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 4 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 4— 1921, to Nov. 4— 1921 that I last saw h.w. alive on Nov. 4— 1921, and that death occurred on the date stated above, at 5 A. M.
The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
(Duration) ..... Yrs. ..... mos. 8 Hours.
Contributory (Secondary) Cardiac Paralysis
(Duration) ..... yrs. ..... mos. 1 Hour.

(Signed) H. A. Dwight M. D.
Nov 6 1921 (Address) Filer Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Clover — DATE OF BURIAL: Nov 8 1921

20. UNDERTAKER: J. J. Stevenson — ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36214
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

RECEIVED
NOV 30 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Twin Falls
City of Filer
If death occurs away from usual residence, give facts called for under special information.

Registration District No. #35
Filer (Registration District No. 2256)
St.)

2. FULL NAME Jessie M Boya

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Jan (Month) 1 (Day) 1899 (Year)

7. AGE: 22 Yrs. 8 Mos. 29 ds.
IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) Farmer

9. BIRTHPLACE (State or Country) Tenn

10. NAME OF FATHER: R D Boya

11. BIRTHPLACE OF FATHER (State or Country) Tenn

12. MAIDEN NAME OF MOTHER: Edna M Jewett

13. BIRTHPLACE OF MOTHER (State or Country) Ten

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R D Boya
(Address) Filer

15.
Filed Nov 3 1921 G.G. Neasbery, Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 29 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 23 1921 to Oct 29 1921
that I last saw him alive on Oct 29 1921.
and that death occurred on the date stated above, at 5:30 P. M.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation
(Duration) 5 Yrs. ..... mos. ..... ds.
Contributory (Secondary) Cardiac Paralysis
(Duration) ..... Yrs. 12 hours mos. ..... ds.

(Signed) H C Dwight M. D.
Oct 31 1921 (Address) Filer, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Odd Fellow Cemetery — DATE OF BURIAL: Nov. 2. 1921.

20. UNDERTAKER: H E Drake — ADDRESS: Filer

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36215
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Twin Falls
City of Filer
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 35
Primary Registration District No. 2056
(No. ..... St.)

RECEIVED
NOV 30 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME Catherine E Hawkins

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. May 24 1870 (Month) (Day) (Year)

7. AGE 51 Yrs. 4 Mos. 29 ds.
IF LESS than 1 day how many .... hrs. or .....min.?'

8. OCCUPATION
(a) Trade, profession or particular kind of work: Wife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kansas

10. NAME OF FATHER: A Greenwood

11. BIRTHPLACE OF FATHER (State or Country): Kans

12. MAIDEN NAME OF MOTHER: Catherine Kramer

13. BIRTHPLACE OF MOTHER (State or Country): Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Anna Hawkins
(Address) Filer

15. Filed Nov. 1 1921. T. A. Greenberg Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 29 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 25 1921 to Oct. 29 1921 that I last saw her alive on Oct. 29 1921 and that death occurred on the date stated above, at 9 P.M. M.

The CAUSE OF DEATH* was as follows:
Carcinoma of Uterus
Death following Hysterectomy
(Duration) 1 Yrs. — mos. — ds.

Contributory (Secondary)
(Duration) ..... Yrs. ..... mos. 5 ds.

(Signed) H Wilson M. D.
Oct 31 1921 (Address) Twin Falls, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Dodd Cemetery — DATE OF BURIAL: Nov 1 1921

20. UNDERTAKER: F E Duke — ADDRESS: Filer

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36216
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

RECEIVED
NOV 30 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Twin Falls
City of Filer
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 35
Primary Registration District No. 2056
(Ward ..... St.)

2. FULL NAME Earnest R. Schlatter

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH. May (Month) 11 (Day) 1911 (Year)
7. AGE: 9 Yrs. 6 Mos. 17 ds. IF LESS than 1 day how many .... hrs. or .....min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) None
9. BIRTHPLACE (State or Country) Nebraska
10. NAME OF FATHER D. B Schlatter
11. BIRTHPLACE OF FATHER (State or Country) Nebraska
12. MAIDEN NAME OF MOTHER Mary Kaufman
13. BIRTHPLACE OF MOTHER (State or Country) Iowa
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) D B Schlatter
(Address) Filer
15.
Filed Dec 1 1921 F. F. Chamberlain Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 9 (Day) 1921 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Sept 7 1921 to Sept 9 1921 that I last saw h.im alive on Sept 8 1921 and that death occurred on the date stated above, at 9 P. M.
The CAUSE OF DEATH* was as follows:
Diphtheria
.....(Duration) ..... Yrs. ..... mos. 7 ds.
Contributory (Secondary) Post diphtheritic Paralysis
.....(Duration) ..... Yrs. ..... mos. ..... ds.
(Signed) C. D. Weaver M. D.
Sept 9 1921 (Address) Twin Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Sego Cemetery — DATE OF BURIAL Sept 10 1921
20. UNDERTAKER F E Wade — ADDRESS Filer

...should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN'S ...DEATH in plain terms, so that it may be properly classified. Exact statement ...OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-12 M. 6-15-17.

RECEIVED NOV 30 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36217
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

Registration District No. 38
Primary Registration District No. 2086

1. PLACE OF DEATH
County of Twin Falls
City of Filer
If death occurs away from usual residence, give facts called for under special information.
(No. ..... St.)

2. FULL NAME Reuben Clark Broadshaw

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. July (Month) 24 (Day) 1883 (Year)

7. AGE: 38 Yrs. 7 Mos. 7 ds.
IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) Farmer

9. BIRTHPLACE (State or Country) Canada

10. NAME OF FATHER Geo Broadshaw

11. BIRTHPLACE OF FATHER (State or Country) Canada

12. MAIDEN NAME OF MOTHER Jula Clark

13. BIRTHPLACE OF MOTHER (State or Country) Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Filer
(Address) Filer

15. Filed 9-26-21 191.... G.A. Newberry Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 26 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1 1921 to Sept 26 1921 that I last saw h[illegible] alive on Sept 16 1921 and that death occurred on the date stated above, at 2 am M.

The CAUSE OF DEATH* was as follows:

Arteio Sclerosis

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Gangrene of right foot

(Duration) ..... Yrs. ..... mos. 30 ds.

(Signed) G. A. Newberry M. D.
Sept 26 1921 (Address) Filer Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Loft Cemetery — DATE OF BURIAL Sept 27 1921

20. UNDERTAKER J E Drake — ADDRESS Filer

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

RECEIVED NOV 30 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Twin Falls — Registration District No. 39

City of Burks (If not in incorporated place, give Township) — Primary Registration District No. 2081 — File No. 36219

(No. ..... St.) — Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Clara Gay

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Married

6. DATE OF BIRTH — July (Month) 12 (Day) 1887 (Year)

7. AGE — 35 Yrs. 3 Mos. 23 ds. — IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) Housewife

9. BIRTHPLACE (State or Country) Kansas

10. NAME OF FATHER W. S. Dewese

11. BIRTHPLACE OF FATHER (State or Country) Kentucky

12. MAIDEN NAME OF MOTHER Rebecca Fruls

13. BIRTHPLACE OF MOTHER (State or Country) Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) .....
(Address) .....

15. Filed 11-7 1921 — J. W. Murphy, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH — November 4th (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 11 1921, to Nov. 19 1921, that I last saw her alive on Oct. 30 1921, and that death occurred on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:
Chronic Endocarditis

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) James Moyer M. D.
Nov. 7 1921 (Address) Burk, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Edwardsburg Mich	11/8 1921
20. UNDERTAKER Homer B Evans	ADDRESS Burke Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
NOV 30 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 39
Primary Registration District No. 2087
File No. 36220
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of Burke, Ida. (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William Orlando Keller

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: May 9 1862 (Month) (Day) (Year)

7. AGE: 59 Yrs. 3 Mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: Henry Keller

11. BIRTHPLACE OF FATHER (State or Country): Penna.

12. MAIDEN NAME OF MOTHER: Sarah Shales

13. BIRTHPLACE OF MOTHER (State or Country): Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jennie L. Keller
(Address) Burke — Ida.

15. Filed 11-19 1921 J. H. Murphy Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: NOV. (Month) 19 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11-16- 1921 to 11-19 1921 that I last saw h[illegible] alive on 11-19- 1921, and that death occurred on the date stated above, at 4 a. M.
The CAUSE OF DEATH* was as follows:

Spasmodic Asthma

(Duration) ..... Yrs. ..... mos. 3 ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo. J. Ennings M. D.
11-19 1921 (Address) Burke, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Geneva Ida. DATE OF BURIAL ..... 19.....

20. UNDERTAKER: Homer B. Evans ADDRESS Burke

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
NOV 30 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 39
Primary Registration District No. 2087
File No. 36221
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of Buhl
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ivona Mildred Radford
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: (Write the word) Single

6. DATE OF BIRTH: Nov (Month) 1 (Day) 1919 (Year)

7. AGE: 2 Yrs. - Mos. 19 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Buhl

10. NAME OF FATHER: A. C. Radford

11. BIRTHPLACE OF FATHER (State or Country): Mo.

12. MAIDEN NAME OF MOTHER: Ila Crisp

13. BIRTHPLACE OF MOTHER (State or Country): Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A. C. Radford
(Address) Buhl Ida.

15. Filed Nov 21 1921 — J. N. Murphy, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 11 (Month) - 21 (Day) - 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11-21-1921, to 11-21-1921 that I last saw h[illegible] alive on 11-21-1921 and that death occurred on the date stated above, at 4 P. M.
The CAUSE OF DEATH* was as follows:
Congenital
Hydrocephalus.
(Duration) 2 Yrs. ..... mos. 19 ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Geo. Fleming M. D.
11-21-1921 (Address) Buhl, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Buhl Cemetery — DATE OF BURIAL: Nov 22 1921
20. UNDERTAKER: Twilley & Ruggles — ADDRESS: Buhl Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36222
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of Burke (No. BURKE St.)
If death occurs away from usual residence, give facts called for under special information.

RECEIVED NOV 30 1921

Registration District No. 39
Primary Registration District No. 2087

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Hazel Winegar

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH: Nov 27 1921 (Month) (Day) (Year)

7. AGE: ___ Yrs. 3 Mos. ___ ds.
IF LESS than 1 day how many ___ hrs. or ___ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: X
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Burke Ida.

10. NAME OF FATHER: James Winegar

11. BIRTHPLACE OF FATHER (State or Country): Iowa.

12. MAIDEN NAME OF MOTHER: Clara Meanecke

13. BIRTHPLACE OF MOTHER (State or Country): Ill

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) James Winegar
(Address) Burke

15.
Filed 11-30 1921
J. N. Murphy
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov 30 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11-29-1921 to 11-30-1921 that I last saw h[er] alive on 11-30-1921, and that death occurred on the date stated above, at ___ M.
The CAUSE OF DEATH* was as follows:

Intussusseption of bowel

(Duration) ___ Yrs. ___ mos. 2 ds.
Contributory (Secondary)
(Duration) ___ yrs. ___ mos. ___ ds.

(Signed) Geo. Jennings M. D.
12-1-1921 (Address) Burke, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ___ yrs. ___ mos. ___ days. In the State ___ yrs. ___ mos. ___ days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Burke — DATE OF BURIAL: 12-1 1921

20. UNDERTAKER: Homer B Evans — ADDRESS: Burke

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

Coroner

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36223

Registered No.

RECEIVED
NOV 30 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 37

Primary Registration District No. 10 75

County of Twin Falls

City of " " (Ward, County Hosp., St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Baby Nare

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	White	Single

6. DATE OF BIRTH: Oct (Month) 15 (Day) 1921 (Year)

7. AGE: ....Yrs. ....Mos. 1 ds. IF LESS than 1 day how many....hrs. or....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business or establishment in which employed (or employer) —

9. BIRTHPLACE (State or Country) Twin Falls, Ida

10. NAME OF FATHER R.P. Nare

11. BIRTHPLACE OF FATHER (State or Country) Dee

12. MAIDEN NAME OF MOTHER Marie Francis

13. BIRTHPLACE OF MOTHER (State or Country) Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R.P. Nare
(Address) 812 Walnut. Twin Falls

15. Filed Oct 21, 1921 J. F. Landheim Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 16 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 15 1921 to Oct 16 1921 that I last saw h— alive on Oct 16 1921 and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Premature birth

....(Duration) ....Yrs. ....mos. ....ds.

Contributory (Secondary)

....(Duration) ....yrs. ....mos. ....ds.

(Signed) H.W. Wilson M. D.

Oct 18 1921 (Address) Twin Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death....yrs....mos....days. In the State....yrs....mos....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls, Ida — DATE OF BURIAL: 10/22 1921

20. UNDERTAKER: P.F. Grossman — ADDRESS: Twin Falls Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

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FORM V.S. No. 6-A—5 M. 1921

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NOV 30 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Lincoln — Registration District No. 37
Primary Registration District No. 8.85
File No. 36254

City of ... (No. La Merced Hospital St.) Registered No. ...

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William R Day

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Male	White	Widowed (Write the word)

6. DATE OF BIRTH: March 30 1860 (Month) (Day) (Year)

7. AGE: 61 Yrs. 6 Mos. 8 ds. — IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer): ...

9. BIRTHPLACE (State or Country): Oregon

10. NAME OF FATHER: Geo. C. Day.

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Sarah J. Painter

13. BIRTHPLACE OF MOTHER (State or Country): Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. N. Day
(Address) Twin Falls

15. Filed Oct 21 1921 John H. Coughlin Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. (Month) 8 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 1921, to Oct. 1921, that I last saw h.m alive on Oct. 7, 1921, and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:
Myocardial Insufficiency
(Duration) ... Yrs. 8 mos. ... ds.
Contributory (Secondary) Chronic Valvular disease
(Duration) 40 yrs. ... mos. ... ds.

(Signed) Hal Bieler M. D.
Oct. 9 1921. (Address) Twin Falls, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Twalatin Ore.	1921
20. UNDERTAKER T. J. Donovan	ADDRESS Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36225

Registration District No. 37
Primary Registration District No. 1085

RECEIVED
NOV 3
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Twin Falls
City of ..... (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Amanda J Skinner

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: f

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widow

6. DATE OF BIRTH: Nov 23 (Month) (Day) 1857 (Year)

7. AGE: 70 Yrs. 10 Mos. 25 Ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Home maker
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Calif

10. NAME OF FATHER: Lashway Walton

11. BIRTHPLACE OF FATHER (State or Country): Mo Knauer

12. MAIDEN NAME OF MOTHER: ann Shaw

13. BIRTHPLACE OF MOTHER (State or Country): Ill

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Eugene J. Skinner
(Address) .....

15. Filed Oct. 20 1921 John T. Coughlin Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct 19 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 14th - 1921, to Oct 19th - 1921, that I last saw h[illegible] alive on Oct 19th 1921, and that death occurred on the date stated above, at 2 P.M.
The CAUSE OF DEATH* was as follows:

Apoplexy

..... (Duration) ..... Yrs. ..... mos. 3 ds.
Contributory (Secondary) Pneumonia
..... (Duration) ..... yrs. ..... mos. 6 ds.

(Signed) Duncan C Strand M. D.
Oct 20 1921 (Address) Twin Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Evergreen
DATE OF BURIAL ..... 19.....

20. UNDERTAKER: J E Woods
ADDRESS Twin Falls

FORM V. S. No. 5-A—25 M. 1-19.

Alive

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36226

RECEIVED
OCT 30 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
Registration District No. 37
County of Twin Falls
Primary Registration District No. 185
City of ... (If not in incorporated city or village give township) ... County, No. 10 ... St.)
Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs Anna Liermann

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word.): Married

6. DATE OF BIRTH: Sept 19 (Month) (Day) 1874 (Year)

7. AGE: 47 Yrs. 0 Mos. 21 ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife.
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Ind.

10. NAME OF FATHER: Crist Wiechning

11. BIRTHPLACE OF FATHER (State or Country): Germany.

12. MAIDEN NAME OF MOTHER: Caroline Raldenker

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Carl Liermann
(Address) Filer, Ida.

15. Filed Oct. 13. 1921 — John J. Naughton, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. (Month) 10 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 8th 1921, to Oct 10th 1921, that I last saw her alive on Oct 10th 1921, and that death occurred on the date stated above, at 2:30 AM.
The CAUSE OF DEATH* was as follows:

Acute Myocarditis

(Duration) ... Yrs. ... mos. 4 ds.
Contributory (Secondary) Post Operation Paresis of intestines
(Duration) ... yrs. ... mos. 4 ds.

(Signed) Duncan L. Watson M. D.
10/11 1921 (Address) Twin Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Clover Ida. — DATE OF BURIAL 19...

20. UNDERTAKER: L. F. Grossman — ADDRESS Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

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FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36227

Registered No.

1. PLACE OF DEATH

County of Twin Falls

City of : : : (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

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BUREAU OF VITAL STATISTICS

Registration District No. 37

Primary Registration District No. 1085

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Charls A Ostrander

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
male	white	varied

6. DATE OF BIRTH: Jan 29 (Month) (Day) 1841 (Year)

7. AGE: 80 Yrs. 7 Mos. 18 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: retired Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Newyork

10. NAME OF FATHER: penbiman ostrander

11. BIRTHPLACE OF FATHER (State or Country) Newyork

12. MAIDEN NAME OF MOTHER: ?anah Hibbord

13. BIRTHPLACE OF MOTHER (State or Country) Newyork

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A R Ostrander
(Address)

15. Filed Oct 21 1921 J. F. Coughlin Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: oct 18 (Month) 1921 (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from aug 28 1921, to Oct. 17 1921, that I last saw h~~im~~ alive on Oct 17 1921, and that death occurred on the date stated above, at 330 P.M.
The CAUSE OF DEATH* was as follows:
Carcinoma of stomach
8

(Duration) 1 Yrs. - mos. - ds.
Contributory (Secondary)
(Duration) - yrs. - mos. - ds.
(Signed) H W Wilson M. D.
Oct 20 1921 (Address) Twin Falls, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Twin Falls Idaho	Oct 20 1921
20. UNDERTAKER: J.F. Dewitt	ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

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FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36228

Registered No.

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BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Twin Falls Registration District No. 37

Primary Registration District No. 1185

City of [redacted] (If not in incorporated territory give township) St. Marcus Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary E Smith

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: fe male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: April 29 (Month) (Day) 1854 (Year)

7. AGE: 67 Yrs. 4 Mos. 26 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Penn

10. NAME OF FATHER: John R Grau

11. BIRTHPLACE OF FATHER (State or Country): Penn

12. MAIDEN NAME OF MOTHER: Dilca Grau

13. BIRTHPLACE OF MOTHER (State or Country): Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) S. E. Smith

(Address)

15. Filed Dec 27 1921 John R Coughlin Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: oct 25 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 1 1921, to Oct. 25 1921 that I last saw h.r alive on Oct. 25 1921, and that death occurred on the date stated above, at 7:30 P.M.

The CAUSE OF DEATH* was as follows:

~~Uremia~~ Cardiac insufficiency

(Duration) Several Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. D. Weaver M. D.

19..... (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Idaho — DATE OF BURIAL: oct 27 1921

20. UNDERTAKER: L E Todd — ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19..

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 37

County of Twin Falls

Primary Registration District No. 1085

File No. 36229

City of ..... (If outside limits, give township.) ..... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

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BUREAU OF VITAL STATISTICS

2. FULL NAME Alice King

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: July 29 (Month) (Day) 1 (Year)

7. AGE: 30 Yrs. 4 Mos. 4 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: house wife
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Willard Tompkins

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Mary a Norfleet

13. BIRTHPLACE OF MOTHER (State or Country): New Zealand

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J B King
(Address) 1140 N. W. Twin Falls Ida

15. Filed Nov-2- 1921 John F. Coughenour Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: oct 29 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 25 1921 to Oct 29 1921
that I last saw her alive on Oct. 28 1921
and that death occurred on the date stated above, at 9 P.M.

The CAUSE OF DEATH* was as follows:

Addisons Disease

.....

.....

.....(Duration) ....Yrs. 6 mos. ....ds.

Contributory (Secondary) .....

.....(Duration) ....yrs. ....mos. ....ds.

(Signed) D L Alexander M. D.

.....19..... (Address) Twin Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs. ....mos. ....days. In the State ....yrs. ....mos. ....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Ida — DATE OF BURIAL: oct 31 1921

20. UNDERTAKER: L E Wells — ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-A—25 M. 1-19.

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NOV 30 1921
BUREAU OF STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Twin Falls — Registration District No. 37

City of * * (St.) — Primary Registration District No. 1085

File No. 36230

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Benona Llenden

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
fe	white	Married

6. DATE OF BIRTH: Sep 9 (Month) (Day) 1 (Year)

7. AGE: 54 Yrs. 1 Mos. 22 ds. — IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Loren Bassett

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Emma Dunphy

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Frank Hansen
(Address)

15. Filed Nov 2 1921 — John A. Coughlin, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct 30 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 5 1921 to Oct 30 1921
that I last saw her alive on Oct 30 1921
and that death occurred on the date stated above, at 1 A.M.
The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency.
(Aortic Regurgitation)
accompanied by Oedema of Glottis
Probably (Duration) about ... Yrs. ... mos. ... ds.
Contributory (Secondary) Rheumatism
(Duration) Several yrs. ... mos. ... ds.

(Signed) O. M. Ginnis M. D.
19 ... (Address) 415 7th Ave E Twin Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Twin Falls Ida	Nov 1 1921
20. UNDERTAKER: J E Wood	ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-A—25 M. 1-19.

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NOV 30 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1085
File No. 36231
Registered No.

1. PLACE OF DEATH

County of Twin Falls
City of
(No. La Merced Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George B Endecott

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M

4. COLOR OR RACE White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.) Married

6. DATE OF BIRTH Aug 13 (Month) (Day) 1866 (Year)

7. AGE 57 Yrs. 1 Mos. 18 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Day Labor
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Ill

10. NAME OF FATHER Geo Endecott

11. BIRTHPLACE OF FATHER (State or Country) Mat Kansas

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Elwood E. Endecott
(Address) 304 Alw Leahy Blvd Twin Falls

15. Filed Nov 5 - 1921 John V. Coughlin Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov 1 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 28th - 1921, to Nov 1st - 1921, that I last saw h~~im~~ alive on Nov 1st 1921, and that death occurred on the date stated above, at 8 A.M.

The CAUSE OF DEATH* was as follows:

Infections Encephalitis

(Duration) Yrs. mos. 4 ds.

Contributory (Secondary) ✓

(Duration) yrs. mos. ds.

(Signed) D K Swander M. D.

Nov 4 1921 (Address) Twin Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Twin Falls Ida — **DATE OF BURIAL** Nov 2 1921

20. UNDERTAKER [illegible] — **ADDRESS** Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

RECEIVED
NOV 30 1921
BUREAU OF VITAL STATISTICS

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Twin Falls
Registration District No. 37
Primary Registration District No. 1085
File No. 36232
City of ... St.)
Registered No. ...
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Cinchew Hooker
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Oct 31 (Month) (Day) 1857 (Year)

7. AGE: 64 Yrs. ... Mos. ... ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Stock Man
(b) General nature of industry, business or establishment in which employed (or employer): ...

9. BIRTHPLACE (State or Country): Ill

10. NAME OF FATHER: Reuben Hooker

11. BIRTHPLACE OF FATHER (State or Country): Ill

12. MAIDEN NAME OF MOTHER: Elelane Wilson

13. BIRTHPLACE OF MOTHER (State or Country): Ind.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Dessa Hooker
(Address) ...

15. Filed Nov. 14 1921
John F. Coughlin
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov 14 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased ~~from~~ on Nov 13 1921, to ... 19..., that I last saw h~~im~~ alive on Nov 13 1921, and that death occurred on the date stated above, at 9 AM
The CAUSE OF DEATH* was as follows:
Lobar Pneumonia.
(Duration) ... Yrs. ... mos. 4 ds.
Contributory (Secondary) ...
(Duration) ... yrs. ... mos. ... ds.
(Signed) H. W. Wilson M. D.
Nov 14 1921 (Address) Twin Falls, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death? ...
Former or usual residence ...

19. PLACE OF BURIAL OR REMOVAL: Hyrum City Utah | DATE OF BURIAL ... 19...

20. UNDERTAKER: J. E. Trust | ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
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FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED
NOV 30 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Caught

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1085
File No. 36233
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of " "
(No. La Merced St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Fredrick James Wallace
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH: Mar 18 19 (Month) (Day) (Year)

7. AGE: 2 Yrs. 6 Mos. 23 ds. IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business or establishment in which employed (or employer) —

9. BIRTHPLACE (State or Country) Twin Falls. Ida

10. NAME OF FATHER Geo. O. Wallace

11. BIRTHPLACE OF FATHER (State or Country) Pa.

12. MAIDEN NAME OF MOTHER Madelyn A. Wynn.

13. BIRTHPLACE OF MOTHER (State or Country) N.D.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Geo. O Wallace
(Address) Twin Falls Ida

15. Filed Nov. 14 1921 John F. Coughlin Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov 9 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 8- 1921 to same day 1921
that I last saw him alive on Nov 8 1921
and that death occurred on the date stated above, at 4 a.m.
The CAUSE OF DEATH* was as follows: Burns of 1st & 2nd degree

(Duration) about 1 yrs. 18 hrs. mos. ds.
Contributory (Secondary) Following bathing in water
(Duration) yrs. mos. ds.

(Signed) John F Coughlin M. D.
Nov 14 1921 (Address) Twin Falls. Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls — DATE OF BURIAL: 11-11 1921

20. UNDERTAKER: P. J. Grossman — ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED
NOV 5 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Twin Falls Registration District No. 37

City of [illegible] Primary Registration District No. 1085

(St.)

File No. 36234

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charles W McCormick

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6. DATE OF BIRTH: July (Month) 27 (Day) 1862 (Year)

7. AGE: 59 Yrs. 7 Mos. 5 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mo.

10. NAME OF FATHER: George McCormick

11. BIRTHPLACE OF FATHER (State or Country): Virginia

12. MAIDEN NAME OF MOTHER: Emily Swartman

13. BIRTHPLACE OF MOTHER (State or Country): Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Chas. W. McCormick
(Address) Twin Falls

15. Filed Nov. 1st 1921 John V. Gray Jr. Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 22 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 11 21 to Oct 22 1921, that I last saw h[illegible] alive on Oct 21 1921, and that death occurred on the date stated above, at 6 a.m. The CAUSE OF DEATH* was as follows:

Streptococcus Torrillitis

(Duration) ..... Yrs. ..... mos. 11 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. W. Wilson M. D.

Oct 28 1921 (Address) Twin Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls, Ida — DATE OF BURIAL: 10-26-1921

20. UNDERTAKER: P. J. Grossman — ADDRESS: Twin Falls Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
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FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
NOV 30 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 37

Primary Registration District No. 1085

File No. 36235

County of Twin Falls

City of ..... (No. ..... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME August Gatz

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6. DATE OF BIRTH: Oct 31 (Month) (Day) 1843 (Year)

7. AGE: 88 Yrs. ..... Mos. 11 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: August Gatz

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: not known

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Celia A. Gatz

(Address) 241-4th Ave E

15. Filed Nov. 1st 1921 John F. Laughlin Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov 11 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 10th 1921, to Nov 11 1921, that I last saw him alive on Nov 11 1921, and that death occurred on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

..... (Duration) ..... Yrs. ..... mos. 10 ds.

Contributory (Secondary) Chronic Nephritis

..... (Duration) ..... yrs. 6 mos. ..... ds.

(Signed) Duncan L. Alexander M. D.

11/12 1921 (Address) Twin Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Ida — DATE OF BURIAL: Nov 13 1921

20. UNDERTAKER: L E Edwards — ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

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FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

RECEIVED NOV 30 1921 BUREAU OF VITAL STATISTICS

Registration District No. 87

Primary Registration District No. 1085

File No. 36236

County of Twin Falls

City of ..... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Eddie Reese Anderson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: ~~Single~~ Widowed

6. DATE OF BIRTH: Oct (Month) 18 (Day) 1874 (Year)

7. AGE: 47 Yrs. ..... Mos. 9 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: John Roberts

11. BIRTHPLACE OF FATHER (State or Country): Ky.

12. MAIDEN NAME OF MOTHER: Serena Dungan

13. BIRTHPLACE OF MOTHER (State or Country): Tenn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15. Filed Nov. 14 1921 John T. Coughlin Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: ~~Oct~~ Nov. (Month) 1 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I ~~attended~~ Saw deceased from Oct 30 1921, to ~ 19....., that I last saw h.r alive on Oct 30 1921, and that death occurred on the date stated above, at .....M.

The CAUSE OF DEATH* was as follows:

Found her in Uraemic Coma, ~~Eclamptic~~ - did not permit study of case or give Medical treatment

(Duration) .....Yrs. .....mos. .....ds.

Contributory (Secondary) .....

(Duration) .....yrs. .....mos. .....ds.

(Signed) Dr. J. R. Morgan M. D.

Nov. 4 1921 (Address) Twin Falls, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls — DATE OF BURIAL: 11/3 1921

20. UNDERTAKER: P. J. Grossman — ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

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SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED NOV 30 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

2

1. PLACE OF DEATH
County of Twin Falls Registration District No. 37
Primary Registration District No. 1085
File No. 36237
City of " " (No.) (St.)
Registered No.
If death occurs away from usual residence, give facts called for under special information.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Sarah Ellen Keeley

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widowed

6. DATE OF BIRTH: June 9 (Month) (Day) 1844 (Year)

7. AGE: 47 Yrs. 5 Mos. 21 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer): "

9. BIRTHPLACE (State or Country): Kansas

10. NAME OF FATHER: Norval M. Hemby

11. BIRTHPLACE OF FATHER (State or Country): Don't Know

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Gertrude Rossland
(Address): Burns Oregon

15. Filed Nov. 14 1921 John F. Coughlin Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 7 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 9 1921, to Oct 30 1921
that I last saw h.r alive on Oct 30 1921
and that death occurred on the date stated above, at 1 P.M.
The CAUSE OF DEATH* was as follows:

Illness of the Stomach

(Duration) 2 Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) H N Leete M. D.
11/4 1921 (Address) Twin Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Ida — DATE OF BURIAL: 11-5 1921

20. UNDERTAKER: P J Grossman — ADDRESS: Twin Falls Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

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FORM V. S. No. 3A—25 M. 1-19.

RECEIVED NOV 30 1921 BUREAU OF VITAL STATISTICS No. 31105

CERTIFICATE OF DEATH

Uelion

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Twin Falls Registration District No. 37
Primary Registration District No. 1885
City of ... (If not in incorporated city or village write the word "Not.") ... St.)
File No. 36238
Registered No. ...

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Estie Virginia Mahuken

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Single

6. DATE OF BIRTH: Oct (Month) 26 (Day) 1921 (Year)

7. AGE: ... Yrs. ... Mos. 2 ds. IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: J. C. Mahuken

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Agnes Johnson

13. BIRTHPLACE OF MOTHER (State or Country): ...

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. C. Mahuken
(Address) Oakley, Idaho

15. Filed Nov. 14 1921 John F. Greenhalgh Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 28 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 26 1921, to Oct 28 1921, that I last saw h-er alive on Oct 28 1921 and that death occurred on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:
Premature birth
...(Duration) ... Yrs. ... mos. ... ds.
Contributory (Secondary) ...
...(Duration) ... yrs. ... mos. ... ds.

(Signed) R. O. Wilson M. D.
Nov 7 1921 (Address) Twin Falls, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death? ...
Former or usual residence ...

19. PLACE OF BURIAL OR REMOVAL: Twin Falls — DATE OF BURIAL: Oct 30 1921

20. UNDERTAKER: L. J. Grossman. ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Twin Falls — Registration District No. 37

City of " " (No. , St.) — Primary Registration District No. 1085

File No. 36239

Registered No.

If death occurs away from usual residence, give facts called for under special information.

RECEIVED NOV 30 1921 BUREAU OF VITAL STATISTICS

2. FULL NAME Baby Moon

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Single

6. DATE OF BIRTH — Nov (Month) 4 (Day) 921 (Year)

7. AGE — Yrs. Mos. 4 ds. — IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business or establishment in which employed (or employer) —

9. BIRTHPLACE (State or Country) Twin Falls, Ida.

10. NAME OF FATHER Perry Moon

11. BIRTHPLACE OF FATHER (State or Country) Ind.

12. MAIDEN NAME OF MOTHER Mable Harmison

13. BIRTHPLACE OF MOTHER (State or Country) Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Perry Moon

(Address) Twin Falls, Ida

15. Filed Nov 11 1921 — John T. Coughlin, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH — Nov (Month) 8 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 4 1921, to Nov 8 1921, that I last saw her alive on Nov 8 1921, and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Premature birth.

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) H W Chandler M. D.

1921 (Address) Twin Falls Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL — Twin Falls Ida — DATE OF BURIAL — 11-9 1921

20. UNDERTAKER — J. J. Grossman — ADDRESS — Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED NOV 30 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Twin Falls Registration District No. 37

Primary Registration District No. 2085

File No. 36240

City of ..... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sarah Cochran

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Mar 27 (Month) (Day) 1859 (Year)

7. AGE: 72 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Canada

10. NAME OF FATHER: William Stinson

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Not known

13. BIRTHPLACE OF MOTHER (State or Country): .....

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Iva Wilson

(Address) Twin Falls Ida

15. Filed Oct 21 1921 J. P. Compkins Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 19 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 30 1921, to Oct 19 1921 that I last saw h.e.r. alive on Oct 19 1921 and that death occurred on the date stated above, at 1500 P.M.

The CAUSE OF DEATH* was as follows:

Loss of cardiac compensation
Mitral regurgitation

..... (Duration) years ..... mos. ..... ds.

Contributory (Secondary) Apoplexy

..... (Duration) ..... yrs. ..... mos. 6 ds.

(Signed) E. R. Van Court, M. D.

10-20-1921 (Address) Twin Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 15 yrs. ..... mos. ..... days. In the State 15 yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence Iowa

19. PLACE OF BURIAL OR REMOVAL: Twin Falls — DATE OF BURIAL: Oct 23 1921

20. UNDERTAKER: J. E. Verritt — ADDRESS: Twin Falls

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED NOV 30 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36241

1. PLACE OF DEATH

Registration District No. 37
Primary Registration District No. 2685

County of Twin Falls
City of .... (If outside limits of city or village, give township.) .... St.)
Registered No. ....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Henry Cope

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married
6. DATE OF BIRTH: August (Month) 23 (Day) 1849 (Year)
7. AGE: 72 Yrs. 1 Mos. 20 ds. IF LESS than 1 day how many .... hrs. or .... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer): ....
9. BIRTHPLACE (State or Country): Indiana
10. NAME OF FATHER: Henry Cope
11. BIRTHPLACE OF FATHER (State or Country): Don't know
12. MAIDEN NAME OF MOTHER: Asenah Mercer
13. BIRTHPLACE OF MOTHER (State or Country): Don't know
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Laura Cope
(Address) Twin Falls
15. Filed Oct 21 1921 J. F. Coughlin Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. (Month) 3 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ~~Sept~~ .... 19.... to .... 19....
that I last saw h.... alive on .... 19....
and that death occurred on the date stated above, at 10:30 P.M.
The CAUSE OF DEATH* was as follows:
Found death had occurred
Cause fractured neck at
atlas due to fall probably
due to Stroke of Paralysis. .... yrs. .... mos. .... ds.
Contributory (Secondary) .... (Duration) .... yrs. .... mos. .... ds.

(Signed) John R. Morgan, M. D.
Oct 3 1921 (Address) Twin Falls, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .... yrs. .... mos. .... days. In the State .... yrs. .... mos. .... days
Where was disease contracted if not at place of death? ....
Former or usual residence ....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Twin Falls	.... 19....
20. UNDERTAKER	ADDRESS
J. J. Ironman	Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED
NOV 30 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 2085
File No. 36242
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of (St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Albert Cochran
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: June 4 (Month) (Day) 1862 (Year)

7. AGE: 59 Yrs. 4 Mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ind

10. NAME OF FATHER: William Cochran

11. BIRTHPLACE OF FATHER (State or Country): Ky

12. MAIDEN NAME OF MOTHER: Sarah Hunt

13. BIRTHPLACE OF MOTHER (State or Country): Ky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John F. Cochran
(Address) Twin Falls

15. Filed Nov 1 1921 John F. Coughlin Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct 27 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3-2 1921, to 10-27 1921, that I last saw h[illegible] alive on 10-10 1921, and that death occurred on the date stated above, at 8:00 A.M.
The CAUSE OF DEATH* was as follows:
Intestinal carcinoma

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) T J Watson M. D.
10-28 1921 (Address) Twin Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls
DATE OF BURIAL ..... 19 .....

20. UNDERTAKER: J E Wurd
ADDRESS Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED DEC 12 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Washington — Registration District No. 86

City of Weiser — Primary Registration District No. 1010

(Ward) (St.)

File No. 36243

Registered No. 72

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elmer Jaffry

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH

(Month) (Day) 1 (Year)

7. AGE about 62 yrs. Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Minnesota

10. NAME OF FATHER —

11. BIRTHPLACE OF FATHER (State or Country) —

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER (State or Country) —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John R. Peery

(Address) Weiser Ida

15. Filed 10/6/21 19 W. R. Hamilton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 4 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 1921 to Sept 4 1921 that I last saw h[illegible] alive on Sept 2 1921 and that death occurred on the date stated above, at 8 P M.

The CAUSE OF DEATH* was as follows:

Cancer of Bladder

(Duration) Yrs. 6 mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) W Marshall M. D.

10-6 1921 (Address) Weiser

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Fullerist Cemetry	10-6 1921

20. UNDERTAKER	ADDRESS
Northam & McCann	Weiser Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED DEC 13 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 86
Primary Registration District No. 1010
File No. 36244
Registered No. 43

County of Washington
City of Weiser (No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James Rose

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	Wht	widowed

6. DATE OF BIRTH: July (Month) 23 (Day) 1 (Year)

7. AGE: 93 Yrs. 2 Mos. 2 ds.

IF LESS than 1 day: how many ____ hrs. or ____ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Stockman
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: ———

11. BIRTHPLACE OF FATHER (State or Country): ———

12. MAIDEN NAME OF MOTHER: ———

13. BIRTHPLACE OF MOTHER (State or Country): ———

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C Vona Cox
(Address) Weiser Idaho

15. Filed 9/26/21 19 W. R. Hamilton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 9 (Month) 25 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 10th 1921, to Sept. 25 1921, that I last saw h alive on 19, and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:
Cancer of liver

(Duration) 2 Yrs. 2 mos. 4 ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) C C Cornant M. D.
9-26 1921 (Address) Weiser Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Hillcrest Cemetery	9-26 1921
20. UNDERTAKER	ADDRESS
Northam McCann	Weiser Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
DEC 12 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 86
Primary Registration District No. 1010
File No. 36246
Registered No. 45

1. PLACE OF DEATH

County of Washington
City of Weiser (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ben Westerberg
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: - (Month) - (Day) 1870 (Year)

7. AGE: 51 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Denmark

10. NAME OF FATHER: Do not know

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: Do not know

13. BIRTHPLACE OF MOTHER (State or Country): Do not know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) James Hamm
(Address) Weiser, Idaho

15. Filed Oct-18th 1921 W. R. Hamilton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 16 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 13 1921, to Oct 16 1921, that I last saw him alive on Oct 16 1921, and that death occurred on the date stated above, at 1.00 P.M.

The CAUSE OF DEATH* was as follows:
Shock, following hemorrhage due to self inflicted laceration of throat by Razor
(Duration) ..... Yrs. ..... mos. 3 ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C C Garrard M. D.
10/16 1921 (Address) Weiser Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Weiser Cemetery | DATE OF BURIAL: 10-18 1921

20. UNDERTAKER: Northam McCann | ADDRESS: Weiser Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
DEC 12 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 86
Registration District No. 2112
File No. 36247
Registered No. 46

1. PLACE OF DEATH
County of Washington
City of Weiser (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Robert Leishman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widowed (Write the word.)

6. DATE OF BIRTH: Feb. (Month) third (Day) 1836 (Year)

7. AGE: 85 Yrs. 8 Mos. 14 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Scottland

10. NAME OF FATHER: John Leishman

11. BIRTHPLACE OF FATHER (State or Country): Scottland

12. MAIDEN NAME OF MOTHER: Jean Allen

13. BIRTHPLACE OF MOTHER (State or Country): Scottland.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Agnes Bennett
(Address) Weiser Idaho

15. Filed Dec-18th 1921
J. R. Hamilton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec- (Month) 17th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec- 1920 to Dec-17th 1921 that I last saw h..... alive on ....., 19....., and that death occurred on the date stated above, at 7a M.

The CAUSE OF DEATH* was as follows:

Cancer of rectum

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Invalid 15 yrs

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G. M. Waterhouse M. D.

Oct 18 1921 (Address) Weiser Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Wellsville Utah
DATE OF ~~BURIAL~~ Removal: 12/19 1921

20. UNDERTAKER: Thorthaus & McCann
ADDRESS: Weiser Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

RECEIVED DEC 12 1921 BUREAU OF VITAL STATISTICS

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Washington
City of Weiser (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 86
Primary Registration District No. 2112
File No. 36248
Registered No. 47
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ruth Maril Coble

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Feb (Month) 21 (Day) 1921 (Year)

7. AGE: — Yrs. 8 Mos. 6 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ida

10. NAME OF FATHER: Emery C. Coble

11. BIRTHPLACE OF FATHER (State or Country): Neb.

12. MAIDEN NAME OF MOTHER: Annie Hooper

13. BIRTHPLACE OF MOTHER (State or Country): — —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. B. Larsen
(Address) Weiser Ida

15. Filed Oct 28 1921 W. R. Hamilton Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 27 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 17 1921, to Oct 27 1921, that I last saw her alive on Oct 26 1921 and that death occurred on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:

Entero Colitis

..... (Duration) ..... Yrs. ..... mos. 10 ds.

Contributory (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G M Wilkinson M. D.

Oct 28 1921 (Address) Weiser Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Hillcrest Cemetery — DATE OF BURIAL: 10-28 1921

20. UNDERTAKER: Markham & McCann — ADDRESS: Weiser Ida

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
DEC 12 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 87

County of Washington

Primary Registration District No.

File No. 36249

City of Midvale (No. , St.)

Registered No. 479

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Wm Babbitt.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widowed

6. DATE OF BIRTH: March 10 1837 (Month) (Day) (Year)

7. AGE: 84 Yrs. 7 Mos. 22 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Pennsylvania

10. NAME OF FATHER: Milton Babbit

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J M Babbit
(Address) Weiser Ida

15. Filed 11/2/21 19 Dr R. Hamilton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: November 2 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from October 26 1921 to Nov. 2 1921 that I last saw h.~~im~~ alive on October 31 1921, and that death occurred on the date stated above, at 6 A.M.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia.

(Duration) Yrs. mos. 8 ds.

Contributory (Secondary) Senility.

(Duration) yrs. mos. ds.

(Signed) F A Smith M. D.

11-2-1921 (Address) Midvale Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mann's Creek Cemetery — DATE OF BURIAL: Nov 3 1921

20. UNDERTAKER: Northam McCann — ADDRESS: Weiser Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

S. No. 5-25 M. 1-19.

RECEIVED
DEC 12 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

PLACE OF DEATH

County of Washington — Registration District No. 86

City of Weiser — Primary Registration District No. Weiser — File No. 36250

(No. ____, ____ St.) — Registered No. 49

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Baby Waldrop

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Wht

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH: Nov (Month) 4 (Day) 1921 (Year)

7. AGE: Yrs. — Mos. — ds.

IF LESS than 1 day how many 3 hrs. or ____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Thos Waldrop

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Della L. Broogg.

13. BIRTHPLACE OF MOTHER (State or Country): Oklahoma

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Thos Waldrop

(Address) Cabin Ida

15. Filed Nov 5-th 1921 — W R Hamilton, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 11 (Month) 4 (Day) 19 21 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11 4 1921, to 11 4 1921 that I last saw him alive on 11 4 1921 and that death occurred on the date stated above, at 4.40 M.

The CAUSE OF DEATH* was as follows:

Prematurity Birth.

(Duration) ____ Yrs. ____ mos. ____ ds.

Contributory (Secondary)

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) Emmett O. Finney M. D.

11-5 1921, (Address) Weiser Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Hillcrest Cemetery — DATE OF BURIAL: 11/5 1921

20. UNDERTAKER: Northam & McCann — ADDRESS: Weiser Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAREFULLY in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED DEC 12 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Farmers

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36251

Registered No. 50

1. PLACE OF DEATH

Registration District No. 86

Primary Registration District No. 2112

County of Washington

City of Weiser (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Alexander D Morgan

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: May (Month) 14 (Day) 1844 (Year)

7. AGE: 77 Yrs. 5 Mos. 27 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: Joseph Morgan

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER: Jane Woodfin

13. BIRTHPLACE OF MOTHER (State or Country): No Carolina

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Emma Morgan

(Address) Weiser Idaho

15. Filed 11/12 1921

W R Hamilton
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 10 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9/28 1921, to Nov 10 1921, that I last saw him alive on 9/28 1921, and that death occurred on the date stated above, at 4:30 P.M.

The CAUSE OF DEATH* was as follows:

Cardio cardetes.

..... (Duration) ? Yrs. ..... mos. ..... ds.

Contributory (Secondary) Hypostatic Pneumonia

..... (Duration) ..... yrs. ..... mos. 2 ds.

(Signed) Ernest O. Tenney M. D.

11/12 1921 (Address) Weiser, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Manns Creek

DATE OF BURIAL: 11-12 1921

20. UNDERTAKER: Northam O'M & Cann

ADDRESS: Weiser Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED DEC 12 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 86

Primary Registration District No. 2112

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36252

Registered No. 37

1. PLACE OF DEATH

County of Washington

City of Weiser (If outside limits of city or village, give township.) St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary E. Poor

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: June (Month) 5 (Day) 1840 (Year)

7. AGE: 81 Yrs. 5 Mos. 5 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Teacher

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): N. Y.

10. NAME OF FATHER: Isaac Poor

11. BIRTHPLACE OF FATHER (State or Country): N.Y.

12. MAIDEN NAME OF MOTHER: Nancy Pope

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. A. V. Morgan

(Address) Weiser Idaho.

15. Filed 11/11/21 19.....

W. R. Hamilton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 10 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 20 1921, to Nov 10 1921, that I last saw h.. alive on Nov 10 1921, and that death occurred on the date stated above, at 8P M.

The CAUSE OF DEATH* was as follows:

Paralysis of bowels

(Duration) ..... Yrs. ..... mos. 20 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C C Conard M. D.

11/11 1921 (Address) Weiser Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Fullerton Cemetery — DATE OF BURIAL: Nov. 12 1921

20. UNDERTAKER: Mortson & McCann — ADDRESS: Weiser

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36253
Registered No. 57

1. PLACE OF DEATH

Registration District No. 86
Primary Registration District No. 2112
County of Washington
City of Weiser (No. ..... St.)

RECEIVED
DEC 15 1921
BUREAU OF VITAL STATISTICS

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Agnes Pehan

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Feb (Month) 13 (Day) 1855 (Year)

7. AGE: 66 Yrs. 2 Mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Minnesota

10. NAME OF FATHER: John Khul

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Katherine Mergens

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Geo. Pehan
(Address) Weiser Ida.

15. Filed 11/17/21 19.....
W. R. Hamilton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 15 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9/12 1921, to 11/15 1921, that I last saw her alive on 11/15 1921, and that death occurred on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:
Chr. Bronchitis
Myocarditis

(Duration) 10 Yrs. ..... mos. ..... ds.
Contributory (Secondary) Hemmy's Effusion
(Duration) ..... yrs. ..... mos. 10. ds.

(Signed) Ernesto. Finney. M. D.
11/17 1921 (Address) Weiser Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Hillcrest Cemetery — DATE OF BURIAL: 11-17 1921

20. UNDERTAKER: Northam McCann — ADDRESS: Weiser Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36254

Registered No. 53

1. PLACE OF DEATH

County of Washington

City of Weiser (No. ..... St.)

Registration District No. 86

Primary Registration District No. 2112

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ruth Wilma Hicks

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

RECEIVED DEC

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Oct 31 1911 (Month) (Day) (Year)

7. AGE: 10 Yrs. 1 Mos. 15 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: School Girl

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Custer. So Dak

10. NAME OF FATHER: Roy Hicks

11. BIRTHPLACE OF FATHER (State or Country): Kansas

12. MAIDEN NAME OF MOTHER: Minnie B Good

13. BIRTHPLACE OF MOTHER (State or Country): Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Roy Hicks

(Address) Weiser RR No 3

15. Filed Nov 17th 1921 W. R. Hamilton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov 16 21 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 15 1921 to Nov 16 1921 that I last saw her alive on Nov 16 1921, and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Hemmorhage of brain

Basilar Skull Fracture

(Duration) ..... Yrs. ..... mos. 3 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C C Conner M. D.

Nov 17 1921 (Address) Weiser Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Hillcrest Cemetery — DATE OF BURIAL: Nov 19 1921

20. UNDERTAKER: Moorhead McLean — ADDRESS: Weiser Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED DEC 5 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36255
Registered No. 521

1. PLACE OF DEATH
County of Washington
City of Weiser
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 86
Name of Registration District No. 1010
(No. E. Main St.)

2. FULL NAME Martin G. McEndree

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH: March (Month) 4th (Day) 1857 (Year)

7. AGE: 64 Yrs. 8 Mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Engineer
(b) General nature of industry, business or establishment in which employed (or employer): Merchant

9. BIRTHPLACE (State or Country): Skyler. Mo.

10. NAME OF FATHER: Martin McEndree

11. BIRTHPLACE OF FATHER (State or Country): Ky.

12. MAIDEN NAME OF MOTHER: Etta Goldsberry

13. BIRTHPLACE OF MOTHER (State or Country): Ky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs M. G. McEndree
(Address) Weiser Idaho

15. Filed Dec 19th 1921 — W R Hamilton, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 17 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 17 1921 to Nov 17 1921
that I last saw him alive on Nov 17 1921
and that death occurred on the date stated above, at 7.30 P.M.
The CAUSE OF DEATH* was as follows:
Dilatation of heart
1 hr (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) C C Canard M. D.
Nov 19 1921 (Address) Weiser Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Cectaco, Ore	11 19 1921

20. UNDERTAKER	ADDRESS
Northam & McCown	Weiser

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED DEC 12 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 86
Primary Registration District No. 1010.

File No. 36256
Registered No. 55

1. PLACE OF DEATH
County of Washington
City of Weiser (If outside limits of city or village, give township.) St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Egbert C. Waldo

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Jan (Month) 26 (Day) 1857 (Year)

7. AGE: 64 Yrs. 9 Mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Elijah Waldo

11. BIRTHPLACE OF FATHER (State or Country): Wis

12. MAIDEN NAME OF MOTHER: Cordelia Ellsworth

13. BIRTHPLACE OF MOTHER (State or Country): Ill

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Roy E. Waldo
(Address) Weiser Idaho

15. Filed 11/24 1921 W. R. Hamilton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 11 (Month) 22 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11/13 1921, to 11-22, 1921 that I last saw him alive on 11 22 1921 and that death occurred on the date stated above, at 6 A.M.

The CAUSE OF DEATH* was as follows:

Angina Pectoris.

(Duration) ..... Yrs. ..... mos. 9 ds.
Contributory (Secondary) Hyper. Arterial Sclerosis
(Duration) 6 yrs. ..... mos. ..... ds.

(Signed) Ernest O. Finney M. D.
11/24 1921 (Address) Weiser, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Fullerton Cemetery — DATE OF BURIAL: 11-24 1921

20. UNDERTAKER: Northam & McCann — ADDRESS: Weiser Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36257
Registered No. 36

1. PLACE OF DEATH
County of Washington
City of Weiser (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 86
Primary Registration District No. 1010.
BUREAU OF VITAL STATISTICS

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary Jane McGuffin

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widowed

6. DATE OF BIRTH: May 28 1839 (Month) (Day) (Year)

7. AGE: 82 Yrs. 5 Mos. 25 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: ——
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ill.

10. NAME OF FATHER: David R Harris

11. BIRTHPLACE OF FATHER (State or Country): Ky

12. MAIDEN NAME OF MOTHER: Mary Ann Murrell

13. BIRTHPLACE OF MOTHER (State or Country): Ky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Sadie D. Forsyth
(Address) Weiser Ida.

15. Filed 11/24 1921 W R Hamilton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 11 (Month) 23 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw her alive on Sept 19 1921,
and that death occurred on the date stated above, at 4 P.M.
The CAUSE OF DEATH* was as follows:
Senility
.....(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
.....(Duration) ..... Yrs. ..... mos. ..... ds.
(Signed) C. A. Shuler M. D.
11/24 1921 (Address) Weiser Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Boise Idaho — DATE OF BURIAL: 11/24 1921

20. UNDERTAKER: Northam & Toney — ADDRESS: Weiser

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED DEC 12 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 56

Primary Registration District No. 1010.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36258

Registered No. 37

1. PLACE OF DEATH

County of Washington

City of Weiser (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Minnie Shirk

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	white	

6. DATE OF BIRTH: Nov. (Month) 22 (Day) 1871 (Year)

7. AGE: — Yrs. — Mos. 1 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER W. F. Shirk

11. BIRTHPLACE OF FATHER (State or Country) Canada

12. MAIDEN NAME OF MOTHER Florence Hyde

13. BIRTHPLACE OF MOTHER (State or Country) Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. F. Shirk
(Address) Weiser Idaho

15. Filed 11/24/21 19..... W. R. Hamilton Local Registrar

SUNS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 23 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 22 1921, to Nov 23 1921 that I last saw h.er alive on Nov. 22. 1921, and that death occurred on the date stated above, at 2 a M.

The CAUSE OF DEATH* was as follows:
Premature birth account
Diabetis of Mother.

(Duration) ..... Yrs. ..... mos. 1 ds.
Contributory (Secondary) Convulsions & Acidosis.
(Duration) ..... yrs. ..... mos. 1 ds.

(Signed) Ernest D. Turner M. D.
11/24 1921 (Address) Weiser Ida Ho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Hillcrest Cemetery — DATE OF BURIAL: 11 24 1921

20. UNDERTAKER: Mc Cann & Mc Cann — ADDRESS: Weiser Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
DEC 15 1931
BUREAU OF VITAL STATISTICS

Registration District No. 53
Primary Registration District No. 2160
File No. 36259
Registered No.

1. PLACE OF DEATH

County of Bannock
City of Pleasanty (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Russell John Mack

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Boy
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Apr. (Month) 16, (Day) 1923 (Year)

7. AGE: Yrs. 6 Mos. 19 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Pleasanty, Idaho.

10. NAME OF FATHER Chas. A. Mack

11. BIRTHPLACE OF FATHER Utah (State or Country)

12. MAIDEN NAME OF MOTHER Gertrude Scheibla

13. BIRTHPLACE OF MOTHER Utah (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. A. Mack
(Address) Pleasanty Idaho

15. Filed Dec. 5, 1931
H. H. Bonbrigen
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 4, (Day) 1931 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 23, 1931, to Nov. 4, 1931, that I last saw him alive on Nov. 4, 1931, and that death occurred on the date stated above, at 5:30 P.M.

The CAUSE OF DEATH* was as follows:

Intestinal Intoxication

(Duration) ..... Yrs. ..... mos. 10 ds.

Contributory (Secondary) Malnutrition

(Duration) ..... yrs. 6 mos. 19 ds.

(Signed) H. H. Bonbrigen M. D.

11-5-1931 (Address) Pleasanty, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Pleasanty, Ida. DATE OF BURIAL: 11-6-1931

20. UNDERTAKER: C. L. Saylor ADDRESS: Pleasanty

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36260
Registered No.

1. PLACE OF DEATH
County of Bannock
City of Swan Lake (St.)
Registration District No. 83
Primary Registration District No. 2160

RECEIVED DEC 15 1921 BUREAU OF STATISTICS

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Ann Fawcett

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F	W	Widow

6. DATE OF BIRTH: July (Month) 10 (Day) 1858 (Year)

7. AGE: 63 Yrs. 4 Mos. 27 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: Leonard Kitchen

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Susan Jones

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Fawcett
(Address) Swan Lake Utah

15. Filed Dec. 9 1921
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. (Month) 7 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 19 1921, to Dec. 7 1921, that I last saw her alive on Dec 3 1921 and that death occurred on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis

(Duration) 3 Yrs. mos. ds.
Contributory (Secondary) Mitral disease Heart
(Duration) 3 yrs. mos. ds.

(Signed) G W States M. D.
Dec 8 1921 (Address) Preston Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Preston Idaho	Dec 10 1921
20. UNDERTAKER	ADDRESS
W. C. Hendricks	Preston Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36262

Registered No.

1. PLACE OF DEATH

County of Bannock

City of Virginia (St.)

Registration District No. 83

Primary Registration District No. 2160

RECEIVED DEC 1 1921 BUREAU OF VITAL STATISTICS

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single.

6. DATE OF BIRTH: Oct 16 (Month) (Day) 1921 (Year)

7. AGE: ....Yrs....Mos. 7 ds. IF LESS than 1 day how many....hrs. or....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Virginia, Ida.

10. NAME OF FATHER: P. A. Marshall,

11. BIRTHPLACE OF FATHER (State or Country): Saline Co, Mo.

12. MAIDEN NAME OF MOTHER: Sara Parks

13. BIRTHPLACE OF MOTHER (State or Country): Saline Co Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Porter L. Marshall,
(Address) Virginia, Idaho.

15. Filed Oct, 23, 1921 — Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. (Month) 23 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 16, 1921, to Oct. 23, 1921. that I last saw her alive on Oct. 23, 1921. and that death occurred on the date stated above, at 2:15 P.M.

The CAUSE OF DEATH* was as follows: Insanitation.

(Duration) ....Yrs....mos. 7 ds.
Contributory (Secondary): Broncho Pneumonia Influenza

(Duration) —yrs. —mos. —ds.

(Signed) H. H. Hodgkinson M. D.
10-23 1921 (Address) Blackfoot, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death....yrs....mos....days. In the State....yrs....mos....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Downey, Idaho, — DATE OF BURIAL: 10-24-1921

20. UNDERTAKER: Moore — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-12 M. 6-15-17.

RECEIVED DEC 18 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36263
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

Registration District No. 52
Primary Registration District No. 2136
(No. ....., ... St.)

1. PLACE OF DEATH
County of Bear Lake
City of Mount Pelen
If death occurs away from usual residence, give facts called for under special nformation.

2. FULL NAME Mary A. Meyers

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female

4. COLOR OR RACE White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.) Married

6. DATE OF BIRTH. Sept (Month) 14 (Day) 1876 (Year)

7. AGE 44 Yrs. 11 Mos. 6 ds. IF LESS than 1 day how many .... hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho.

10. NAME OF FATHER Carl S. Olsen.

11. BIRTHPLACE OF FATHER (State or Country) Norway

12. MAIDEN NAME OF MOTHER Not known.

13. BIRTHPLACE OF MOTHER (State or Country) Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. Meyers
(Address) Bear Lake Idaho

15. Filed 12-18- 1921 N. M. Stevens Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 20 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 10 1921 to Aug 20 1921 that I last saw her alive on Aug 20 1921 and that death occurred on the date stated above at .....M.

The CAUSE OF DEATH* was as follows:
Cirhosis Hemmorhage
.....
.....
.....(Duration) ..... Yrs. — mos. ..... ds.
Contributory (Secondary) Pneumonia Incident
.....(Duration) ..... Yrs. ..... mos. ..... ds.
(Signed) Geo. E. Cuthbert M. D.
Aug 20 1921 (Address) Montpelier

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the ,State....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Ovid Idaho. **DATE OF BURIAL** Aug 24 1921

20. UNDERTAKER J. M. Williams **ADDRESS** Montpelier Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-12 M. 6-15-17.

RECEIVED DEC 19 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36264
Registered No. .....

1. PLACE OF DEATH
County of Bear Lake
City of Montpelier,
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 52
Primary Registration District No. 2136
(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Howard M. Wilson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married
6. DATE OF BIRTH. Feb. (Month) 16 (Day) 1888 (Year)
7. AGE: 33 Yrs. 7 Mos. 25 ds. IF LESS than 1 day how many .... hrs. or .....min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: R.R. Conductor
(b) General nature of industry, business, or establishment in which employed (or employer): O.S.L. Ry R.
9. BIRTHPLACE (State or Country): West Virginia
10. NAME OF FATHER: Don't know
11. BIRTHPLACE OF FATHER (State or Country): West Virginia
12. MAIDEN NAME OF MOTHER: Sarah E Comeley
13. BIRTHPLACE OF MOTHER (State or Country): West Virginia
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Howard Wilson
(Address) Montpelier Idaho
15. Filed Oct 15 1921 — N. Helms, Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 11th (Day) 1921 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Oct 4 1921 to Oct 11 1921
that I last saw h... alive on Oct 11 1921
and that death occurred on the date stated above, at 4 P. M.
The CAUSE OF DEATH* was as follows:
Influenza - Pneumonia
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... Yrs. ..... mos. ..... ds.
(Signed) ..... M. D.
Oct 17 1921. (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Montpelier, Idaho — DATE OF BURIAL: Oct. 14 1921
20. UNDERTAKER: F. M. Williams — ADDRESS: Montpelier Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-12 M. 6-15-17.

36265

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 39205
Registered No. .....

RECEIVED DEC 16 BUREAU OF STATISTICS

1. PLACE OF DEATH
County of Bear Lake Registration District No. 52
City of Georgetown Primary Registration District No. 2136
If death occurs away from usual residence, give facts called for under special information. .....St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Alice Kelsey Vale

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Feb (Month) 15 (Day) 1861 (Year)

7. AGE 60 Yrs. 8 Mos. 2 ds. IF LESS than 1 day how many .... hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Nurse
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Brigham City Utah

10. NAME OF FATHER Herbert Kelsey

11. BIRTHPLACE OF FATHER (State or Country) Ohio

12. MAIDEN NAME OF MOTHER Swindle

13. BIRTHPLACE OF MOTHER (State or Country) Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Alice Vale
(Address) Georgetown

15. Filed 12-15- 1917 W. N. Kemp Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 15 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1 1921 to Oct 1 1921
that I last saw h[illegible] alive on Oct 1 1921
and that death occurred on the date stated above, at 9 P. M.
The CAUSE OF DEATH* was as follows:
Interstitial Nephritis
.....
.....
.....(Duration) .....Yrs. ..... mos. ..... ds.
Contributory (Secondary) Heart Trouble
.....(Duration) .....Yrs. ..... mos. ..... ds.
(Signed) Mrs. Alice Vale M. D.
Oct 18 1921 (Address) Georgetown

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs. ....mos. ....days. In the State ....yrs. ....mos. ....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Dingle Idaho. DATE OF BURIAL Oct 19, 1921

20. UNDERTAKER F. M. Williams ADDRESS Montpelier, Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED DEC 18 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36266

1. PLACE OF DEATH

County of Bear Lake — Registration District No. 52

City of Montpelier — Primary Registration District No. 2136

(No. ..... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Hean R Burgoyne

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Infant

6. DATE OF BIRTH: April (Month) 2nd (Day) 1921 (Year)

7. AGE: ..... Yrs. 7 Mos. 0 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Elmer S Burgoyne

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Irene Pearce

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Elmer Burgoyne
(Address) Montpelier Ida

15. Filed 12-15-1921 — A N Tuttle, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 2 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 2 1921, to Nov 2 1921, that I last saw h.... alive on Oct 10 1921 and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:
Encephalomalacea

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo E Cudley M. D.

11-2 1921 (Address) Montpelier

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Montpelier Ida — DATE OF BURIAL: Nov 3 1921

20. UNDERTAKER: J McWilliams — ADDRESS: Montpelier

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-25 M. 1-19.

RECEIVED DEC 18 19- BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 52

Registration District No. 2136

File No. 36267

County of Bear Lake

City of Montpelier (No. ..... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Putnam Sullivan

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widower (Write the word.)

6. DATE OF BIRTH: March 4 (Month) (Day) 1920 (Year)

7. AGE: 1 Yrs. 8 Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Montpelier Idaho

10. NAME OF FATHER: P. J. Sullivan

11. BIRTHPLACE OF FATHER (State or Country): St. Louis, Ill.

12. MAIDEN NAME OF MOTHER: Bertha Beckwith

13. BIRTHPLACE OF MOTHER (State or Country): Wyoming

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) P. J. Sullivan

(Address) Montpelier Ida

15. Filed 12-15- 1921 N. H. Young Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. 4th (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 4 1921, to Nov 4 1921, that I last saw him alive on Nov 4 1921, and that death occurred on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Burned by fire.

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) N. H. Young M. D.

11-5- 1921 (Address) Montpelier

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Montpelier Ida — DATE OF BURIAL: 11-8- 1921

20. UNDERTAKER: H. McWilliams — ADDRESS: Montpelier

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36268
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

RECEIVED DEC 18 1917 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Bear Lake Registration District No. 52
City of Montpelier Primary Registration District No. 2136
If death occurs away from usual residence, give facts called for under special information. (....., ... St.)

2. FULL NAME Alfred W Smith

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married
6. DATE OF BIRTH. Nov. (Month) 9 (Day) 1850 (Year)
7. AGE: 71 Yrs. — Mos. 2 ds. IF LESS than 1 day how many .... hrs. or .....min.?'
8. OCCUPATION
(a) Trade, profession or particular kind of work: Shool Janitor
(b) General nature of industry, business, or establishment in which employed (or employer) .....
9. BIRTHPLACE (State or Country): Ireland.
10. NAME OF FATHER: Robert Smith
11. BIRTHPLACE OF FATHER (State or Country): England
12. MAIDEN NAME OF MOTHER: Dont Know?
13. BIRTHPLACE OF MOTHER (State or Country): England.
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Geo. A. Smith
(Address) Montpelier Idaho
15. Filed 12-15-17 N. W. Kenny Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 11 (Day) 1917 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Sept 11 1917 to Nov 11 1917 that I last saw h. liv. alive on Nov. 3rd 1917 and that death occurred on the date stated above, at 4 a M.
The CAUSE OF DEATH* was as follows: Myocardial Insufficiency
..... (Duration) 2 Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... Yrs. ..... mos. ..... ds.
(Signed) N. W. Kenny M. D.
Nov 12 1917 (Address) Montpelier

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Montpelier Idaho — DATE OF BURIAL: Nov 13 1917
20. UNDERTAKER: F. M. Williams — ADDRESS: Montpelier Idaho

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36269
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

RECEIVED DEC 18 1921 BUREAU OF STATS

1. PLACE OF DEATH
County of Bear Lake Registration District No. 52
Primary Registration District No. 2136
City of Montpelier (If outside limits of city or village, give township.) No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME ... Charlotte Mabel Krogue.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Baby

6. DATE OF BIRTH. March (Month) 3. (Day) 1917 (Year)

7. AGE: 4 Yrs. 8 Mos. 17 ds.
IF LESS than 1 day how many .... hrs. or .....min.?'

8. OCCUPATION
(a) Trade, profession or particular kind of work ... At Home
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho.

10. NAME OF FATHER Angus Krogue

11. BIRTHPLACE OF FATHER (State or Country) Idaho.

12. MAIDEN NAME OF MOTHER Bertha Andreason

13. BIRTHPLACE OF MOTHER (State or Country) Denmark.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) ... Angus Krogue
(Address) ... Montpelier, Idaho.

15. Filed 12-13- 1921 ... A. V. King ... Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH ... Nov. (Month) 20 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 1. 1921 to Nov. 19. 1921 that I last saw her alive on Nov. 19. 1921; and that death occurred on the date stated above, at .....M.

The CAUSE OF DEATH* was as follows:
Aortic Regurgitation
Heart
.....(Duration) ..... Yrs. ..... mos. 12 ds.
Contributory (Secondary) Dyspepsia
.....(Duration) ..... Yrs. ..... mos. 14 ds.
(Signed) ... A. V. King ... M. D.
Nov 21. 1921. (Address) ... Montpelier Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the State....yrs.....mos....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Montpelier, Idaho. DATE OF BURIAL: Nov. 23. 1921

20. UNDERTAKER: F. M. Williams ADDRESS: Montpelier Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
DEC 18 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Lemhi — Registration District No. 41

City of Gilmore Ida. (No. ..... St.) — Primary Registration District No. 2116

File No. 36270

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Joseph H Andrew

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widowed (Write the word.)

6. DATE OF BIRTH: Not known (Month) (Day) 1 (Year)

7. AGE: 58 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Quartz Miner

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: Not known

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Anna Handcock

13. BIRTHPLACE OF MOTHER (State or Country): England.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Joseph Andrew

(Address) Gilmore, Idaho.

15. Filed Dec 10, 1921 — Chas Bellamy, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: December 6" 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 13 1921, to Dec 6th 1921, that I last saw h.... alive on Dec 6 1921, and that death occurred on the date stated above, at 10:45 A.M.

The CAUSE OF DEATH* was as follows:

Mitral regurgitation

..... (Duration) One Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F B Wright M. D.

12/9 1921 (Address) Salmon

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Gilmore Cemetery — DATE OF BURIAL: 12-8" 1921

20. UNDERTAKER: H. C. Dowlen — ADDRESS: Salmon

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
DEC 18 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 4
Primary Registration District No. 2116
File No. 36271
Registered No.

1. PLACE OF DEATH

County of Lemhi
City of Salmon (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Eric Maurice Searose

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Mal	White	Single

6. DATE OF BIRTH June 26" 1858
(Month) (Day) (Year)

7. AGE 63 Yrs. 5 Mos. 16 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Stockholm Sweden

10. NAME OF FATHER L. Eric Searose

11. BIRTHPLACE OF FATHER (State or Country) Skölleröta

12. MAIDEN NAME OF MOTHER Christina Hoglun

13. BIRTHPLACE OF MOTHER (State or Country) Skölleröta Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Linnard Searose
(Address) Salmon Idaho

15. Dec. 12 1921
Filed 19
Alfo Bellows
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov 12" 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from some time in 1918, to 1919 19.....
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at 12:30 P.M.
The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs

(Duration) Yrs. 3 mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D S Wright M. D.
12/1 1921 (Address) Salmon

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Wm C Taebler	11-14" 1921

20. UNDERTAKER	ADDRESS
W C Taebler	Salmon Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED DEC 19 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH.

Registration District No. 41

Primary Registration District No. 2116

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36272

Registered No. .....

1. PLACE OF DEATH.

County of Lemhi

City of Salmon (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William A. Rose

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. 7-26 (Month) 8 (Day) 1853 (Year)

7. AGE: 68 Yrs. 9 Mos. 16 ds.

IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer.

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: Henry Rose.

11. BIRTHPLACE OF FATHER (State or Country): Illinois

12. MAIDEN NAME OF MOTHER: Elibeth White Rose

13. BIRTHPLACE OF MOTHER (State or Country): Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Will H Rose

(Address) Spokane Wash

15.

Filed Dec 19 1921 Chas Billamy Local Registrar

Deputy

SYMS - YORK CO., PTRS. & BDRS. 24853

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: November 16th (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 16th 1921, to Nov 16th 1921, that I last saw h[illegible] alive on Nov 16 1921, and that death occured on the date stated above, at 10 E M.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(Duration) One Yrs. mos. ds.

Contributory (Secondary) Acute Indigestion

(Duration) Days Yrs. [illegible] mos. ds.

(Signed) F B Wright M. D.

12/9 1921. (Address) Salmon

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Salmon Cemetery

DATE OF BURIAL: 11-20 1921

20. UNDERTAKER: W C Doebler

ADDRESS: Salmon Ida

FORM V. S. No. 5-25 M. 1-19.

RECEIVED DEC 13 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 41

Primary Registration District No. 2116

File No. 36273

Registered No.

County of Lemhi

City of Salmon (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Charlotte Gertrude Harris

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): married

6. DATE OF BIRTH: May (Month) 18th (Day) 1879 (Year)

7. AGE: 42 Yrs. 6 Mos. 17 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kansas

10. NAME OF FATHER: Christopher Ostrander

11. BIRTHPLACE OF FATHER (State or Country): Wisconsin

12. MAIDEN NAME OF MOTHER: Henrietta Baldwin

13. BIRTHPLACE OF MOTHER (State or Country): Wisconsin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) H. E. Ostrander

(Address) Salmon Idaho

15. Filed Dec. 10 1921 Chas. Bellamy Local Registrar

Deputy

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: December 4th (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 13th 1921, to Dec 4th 1921, that I last saw her alive on Dec 4th 1921, and that death occurred on the date stated above, at 7.30 P.M.

The CAUSE OF DEATH* was as follows:

Autointoxication Uraemia

(Duration) Yrs. 6 mos. ds.

Contributory (Secondary): Syphilis

(Duration) Yrs. 2 mos. ds.

(Signed) F. B. Wright M. D.

12/9 1921 (Address) Salmon

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Salmon Cemetery — DATE OF BURIAL: 12-6 1921

20. UNDERTAKER: Wm C Doolen — ADDRESS: Salmon Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

NOTE.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

READING INK—THIS IS A PERMANENT RECORD
be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS
th terms, so that it may be properly classified. Exact statement of OCCUPA-
tion on back of certificate.

REGISTERED DEC 10 1921 Copy

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 36273

PLACE OF DEATH
County of Lemhi
City of Salmon

Registration District No. 41
Primary Registration District No. 216
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. .....

2. FULL NAME Charlotte Gertrude Hanne

(a) Residence. No. ..... St. .....
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): married

3a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) May 18th 1879

7. AGE: Years 42 | Months 6 | Days 17 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Kansas

10. NAME OF FATHER Christopher Ostrander

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Wisconsin

12. MAIDEN NAME OF MOTHER Henrietta Baldwin

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Wisconsin

Informant H. C. Ostrander
(Address) Salmon Idaho

Filed Dec 10 – 1921 Chas C. Bellamy Registrar
dlp

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 4th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 13, 1921, to Dec 4, 1921
that I last saw her alive on Dec 4, 1921
and that death occurred, on the date stated above, at 7.30 m.
The CAUSE OF DEATH* was as follows:

Pneumonia Atypical

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Hypostatic

(duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....

(Signed) G. L. Wright, M. D.
Dec 9 –, 1921 (Address) Salmon Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Salmon Cemetery	12-1 1921

20. Undertaker W. W. C. Dobler Address Salmon Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36274

Registered No.

RECEIVED DEC 3 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Twin Falls Registration District No. 37

City of Twin Falls Primary Registration District No. 2085

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Lewis

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Married

6. DATE OF BIRTH: July 4 (Month) (Day) 1 (Year)

7. AGE: 38 Yrs. 4 Mos. 1 ds. IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Neb

10. NAME OF FATHER: Eli Boone

11. BIRTHPLACE OF FATHER (State or Country): Mat Known

12. MAIDEN NAME OF MOTHER: Emmaline Repon

13. BIRTHPLACE OF MOTHER (State or Country): Mat Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. L. Lewis
(Address) Twin Falls

15. Filed Nov. 28 1921 John F. Coughlin Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov 28 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 28 1921 to Nov 28 1921, that I last saw h-r alive on Nov 28, 1921, and that death occurred on the date stated above, at 7:15 A.M.

The CAUSE OF DEATH* was as follows:

Strychnine, poisoning (suicidal)

4 Hours

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary) Manic depressive insanity

(Duration) ... yrs. ... mos. 10 ds.

(Signed) W. G. Fitz M. D.

11/28/1921 (Address) Twin Falls Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Twin Falls	Nov 29 1921
20. UNDERTAKER	ADDRESS
J. E. Kent	Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-A—25 M. 1-19.

DEC 18 1921

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Twin Falls — Registration District No. 37

City of " " — Primary Registration District No. 1085

(No. ..... St.)

File No. 36276

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William Cowling

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	white	widowed

6. DATE OF BIRTH: Nov (Month) 20 (Day) 1848 (Year)

7. AGE: 73 Yrs. 0 Mos. 6 ds. — IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) Retired

9. BIRTHPLACE (State or Country) England

10. NAME OF FATHER Thos Chas Cowling

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER Elezebeth Trebbevey

13. BIRTHPLACE OF MOTHER (State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mary S Cowling
(Address) Twin Falls Ida.

15. Filed Nov 28 1921 — John T. Coughlin, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 26 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 17th 1921, to Nov 26th 1921
that I last saw him alive on Nov 26 1921
and that death occurred on the date stated above, at 4.40 P.M.
The CAUSE OF DEATH* was as follows:

Acute Dilitation Heart

..... (Duration) ..... Yrs. ..... mos. 2 ds.
Contributory (Secondary) Recurrent infection Gall Bladder
..... (Duration) 14 yrs. ..... mos. ..... ds.

(Signed) Duncan L Graham M. D.
Nov 27 1921 (Address) Twin Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Piper City Ill. — DATE OF BURIAL ..... 19.....

20. UNDERTAKER: L J Grossman — ADDRESS Twin Falls Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED
DEC 18 1921
BUREAU OF VITAL STATISTICS
RECEIVED

CERTIFICATE OF DEATH

Alexander.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36277

Registered No.

1. PLACE OF DEATH

County of Twin Falls Registration District No. 37

City of " " Registration District No. 1085

(If not in incorporated city or village give township.) (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Chas. J Jameson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Widowed

6. DATE OF BIRTH Dec (Month) 11 (Day) 1853 (Year)

7. AGE 68 Yrs. 11 Mos. 9 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry, business or establishment in which employed (or employer) Retired -

9. BIRTHPLACE (State or Country) Quincey, Ill.

10. NAME OF FATHER Leonard A Jameson

11. BIRTHPLACE OF FATHER (State or Country) Ohio

12. MAIDEN NAME OF MOTHER Sullivan

13. BIRTHPLACE OF MOTHER (State or Country) Don't Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R. D. Harvey
(Address) Kimberly, Idaho

15. Filed Nov. 28 1921 John F Coughlin Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 20 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 16th 1921, to Nov 20 1921 that I last saw h.. alive on Nov 18 1921 and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Acute Uremia

(Duration) Yrs. mos. 10 ds.

Contributory (Secondary) Chronic Interstitial Nephritis.

(Duration) ? yrs. mos. ds.

(Signed) Duncan L Y Brand M. D.

Nov 21 1921 (Address) Twin Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Twin Falls Ida | DATE OF BURIAL 11/22 1921

20. UNDERTAKER P. J. Grossman | ADDRESS Twin Falls Ida

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

...ON RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED DEC 18 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Wilson

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37

Primary Registration District No. 1085

File No. 36278

Registered No.

1. PLACE OF DEATH

County of Twin Falls

City of " " (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Herman Wolf.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	White	Single

6. DATE OF BIRTH

~~Aug.~~ July 29 (Month) (Day) 1894 (Year)

7. AGE

27 Yrs. 3 Mos. 2 ~~Ds.~~

IF LESS than 1 day how many hrs, or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Farmer.

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE Norfolk Mebr (State or Country)

10. NAME OF FATHER Frank Wolf.

11. BIRTHPLACE OF FATHER Germany (State or Country)

12. MAIDEN NAME OF MOTHER Rosina Leuthold

13. BIRTHPLACE OF MOTHER Switzerland (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Miss Tracy Wolf.

(Address)

15. Filed Dec. 5 1921 John T. Coughlin Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 25 (Day) 1921. (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 13 1921, to Nov 25 1921, that I last saw h— alive on Nov 18 1921, and that death occurred on the date stated above, at —M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 2 Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) H. W. Wilson M. D.

Nov. 26 1921 (Address) Twin Falls Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Twin Falls | DATE OF BURIAL Nov 27 1921

20. UNDERTAKER P. J. Grossman | ADDRESS Twin Falls Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SPACE RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED DEC 18 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Mc Ginnis.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36279

Registered No.

1. PLACE OF DEATH

County of Twin Falls Registration District No. 37

Primary Registration District No. 1285

City of — (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lana Rovena Jones

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: March 7 1919 (Month) (Day) (Year)

7. AGE: 2 Yrs. 8 Mos. 4 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: Wm Roy Jones

11. BIRTHPLACE OF FATHER (State or Country): Kas.

12. MAIDEN NAME OF MOTHER: Kermit Lana Hunt

13. BIRTHPLACE OF MOTHER (State or Country): Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm R. Jones.

(Address) Kimberly, Ida

15. Filed Dec 5. 1921 John W. Coughlin Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 11 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 27 1921 to Nov 11 1921 that I last saw h[illegible] alive on Nov 11 1921 and that death occurred on the date stated above, at 6 P M. The CAUSE OF DEATH* was as follows:

Broncho Pneumonia.

(Duration) ..... Yrs. ..... mos. 13 ds.

Contributory (Secondary) Endocarditis

(Duration) ..... yrs. ..... mos. 3 ds.

(Signed) D H McGinnis M. D.

1921 (Address) 415 W. Main Twin Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls. DATE OF BURIAL: Nov 15 1921

20. UNDERTAKER: B. F. Grossman ADDRESS: Twin Falls Ida.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Twin Falls Registration District No. 37

City of ..... (If outside limits of city or village, give township.) Primary Registration District No. 1085 St.)

File No. 36280

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

RECEIVED DEC 18 1921 BUREAU OF VITAL STATISTICS

2. FULL NAME William David Stoddard

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Aug (Month) 11 (Day) 1911 (Year)

7. AGE: 10 Yrs. 3 Mos. ..... ds. 7

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: School Boy

(b) General nature of industry, business or establishment in which employed (or employer): "

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Wm Henry Stoddard

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Catherine Coffin

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Catherine Stoddard

(Address) Box 1124 Twin Falls Ida

15. Filed Dec. 5 1921 John T. Coughlin Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 11 (Month) 17 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11-11 1921, to 11-17-1921 that I last saw him alive on 11-17 1921 and that death occurred on the date stated above, at 1 P M.

The CAUSE OF DEATH* was as follows:

Bronchs Pneumonia

..... (Duration) ..... Yrs. ..... mos. 6 ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Dr. J R Morgan M. D.

11-18 1921 (Address) Twin Falls, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Ida

DATE OF BURIAL: 11-20 1921

20. UNDERTAKER: P J Grossman

ADDRESS: Twin Falls Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED DEC 18 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Twin Falls Registration District No. 37

City of ( ) (No. , St.) Registration District No. 1085

File No. 36281

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ray Carson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	white	Single

6. DATE OF BIRTH: June 8 1921 (Month) (Day) (Year)

7. AGE: X Yrs. 5 Mos. 8 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: E S Carson

11. BIRTHPLACE OF FATHER (State or Country): Kansas

12. MAIDEN NAME OF MOTHER: Esher Johnson

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): E S Carson
(Address): 243 Ramage St.

15. Filed Nov. 17 1921 John T. Coughlin Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov 16 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11/14/1921, to 11/16/1921 that I last saw him alive on 11/16/1921 and that death occurred on the date stated above, at 6:45 P.M.

The CAUSE OF DEATH* was as follows:

Acute Toxic Colitis

(Duration) Yrs. mos. 3 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) W. H. Tate M. D.

11/16/1921 (Address) Twin Falls, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Boise Idaho — DATE OF BURIAL 19

20. UNDERTAKER: J E Wood — ADDRESS Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
DEC 18 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 87

Primary Registration District No. 1085

File No. 36282

County of Twin Falls

City of ( ) St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lloyd Lavern Casler

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1 (Year)

7. AGE: 2 Yrs. 6 Mos. 3 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Seth A Casler

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Laura. Dean

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) S A Casler

(Address) Twin Falls

15. Filed Nov. 28- 1921 John T. Coughlin Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov 26 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 25 1921, to Nov 26 1921 that I last saw him alive on Nov 26 1921 and that death occurred on the date stated above, at 5- PM.

The CAUSE OF DEATH* was as follows:

Diphtheria

..... (Duration) ..... Yrs. ..... mos. 6 ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H H Leete M. D.

11/27 1921 (Address) Twin Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Ida — DATE OF BURIAL: Nov 29 [illegible]

20. UNDERTAKER: [illegible] — ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SPACE RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED DEC 18 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Twin Falls Registration District No. 37

City of ( ) (No. , St.) Primary Registration District No. 1085

File No. 36284

Registered No.

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lena Musick

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Sept 12 1 (Month) (Day) (Year)

7. AGE: 57 Yrs. Mos. ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ill

10. NAME OF FATHER: William Bagle

11. BIRTHPLACE OF FATHER (State or Country): Canada

12. MAIDEN NAME OF MOTHER: Emeline Logan

13. BIRTHPLACE OF MOTHER (State or Country): Ill

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Alice Musick Staats
(Address):

15. Filed Nov 23 1921 John T. Lewis Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov 23 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 26 1921, to Nov 18 1921, that I last saw her alive on Oct 18 1921, and that death occurred on the date stated above, at 3:10 P.M.

The CAUSE OF DEATH* was as follows:
Chronic Valvular Heart Disease

(Duration) 2 Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) H. W. Wilson M. D.

Nov. 23 1921 (Address) Twin Falls Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Seneca Ill DATE OF BURIAL 19

20. UNDERTAKER: L. E. Evett ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED
DEC 18 19
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Twin Falls — Registration District No. 37
City of ( ) — Primary Registration District No. 1085
(No. ..... St.)
File No. 36285
Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Daniel B Adams

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Nov 13 (Month) (Day) 1854 (Year)

7. AGE: 67 Yrs. 1 Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Realty man
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ind

10. NAME OF FATHER: Aron E Adams

11. BIRTHPLACE OF FATHER (State or Country): Ind

12. MAIDEN NAME OF MOTHER: Katherin May

13. BIRTHPLACE OF MOTHER (State or Country): Ind

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C E Adams
(Address) Twin Falls Idaho

15. Filed Dec 15 1921 — Joshua F. Coughlin, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec 13 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 5 1921, to Oct 8, 1921
that I last saw him alive on Dec 12, 1921.
and that death occurred on the date stated above, at 5:15 P.M.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary): Arteriosclerosis
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Haf Bieler M. D.
Dec 15 1921 (Address) Twin Falls, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Ida — DATE OF BURIAL: Dec 15 1921

20. UNDERTAKER: L O Veeder — ADDRESS: Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36286

Registered No. .....

1. PLACE OF DEATH.

Registration District No. 83

Primary Registration District No. 2160

County of Bannock

City of Blackfoot St.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
DEC 18 1921
BUREAU OF VITAL STATISTICS

2. FULL NAME Sarah Emma Gene Bunnup

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Oct (Month) 3 (Day) 1920 (Year)

7. AGE ..... Yrs. 11 Mos. 10 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Bannock Co Idaho

10. NAME OF FATHER John L Bunnup

11. BIRTHPLACE OF FATHER (State or Country) Bannock Co Idaho

12. MAIDEN NAME OF MOTHER Elva Julia Heat

13. BIRTHPLACE OF MOTHER (State or Country) California

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John L. Bunnup

(Address) Blackfoot Idaho

15. Filed Sept. 13 — 1921

G J Hackingson
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. (Month) 13, (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 11, 1921, to Sept. 13, 1921, that I last saw h[illegible] alive on Sept. 13, 1921, and that death occured on the date stated above, at 1:40 P.M.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia

(Duration) ..... Yrs. ..... mos. 7 ds.

Contributory (Secondary) none

(Duration) — yrs. — mos. — ds.

(Signed) G. J. Hackingson M. D.

10/3-1921 (Address) Blackfoot, Ida.

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Blackfoot Ida R.F.D. | DATE OF BURIAL: Sept. 15, 1921

20. UNDERTAKER: E. E. Boyton | ADDRESS: Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

Taylor.

CERTIFICATE OF DEATH

36287

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 36287
Registered No. 369

1. PLACE OF DEATH

County of Ada
City of Boise
(No. 710 E. Fannock St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Harry E. Rasmussen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	White	Married

6. DATE OF BIRTH: June 10 (Month) 1884 (Day) (Year)

7. AGE: 37 Yrs. 6 Mos. 12 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Carpenter
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kansas

10. NAME OF FATHER: Claus Rasmussen

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: Emma Wright

13. BIRTHPLACE OF MOTHER (State or Country): New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) M. H. Rasmussen
(Address) 202 Idora Ave

15. Filed 12-23 1921 — R. L. Pratt, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: December 22nd 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 22nd 1921, to Dec 22nd 1921, that I last saw him alive on Dec 22nd 1921, and that death occurred on the date stated above, at 3:30 PM

The CAUSE OF DEATH* was as follows:

death followed anesthesia for appendix operation
No definite cause found

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) L. M. Taylor M. D.

12/23 1921 (Address) Boise, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Morris Hill Cemetery	Dec 26 1921
20. UNDERTAKER	ADDRESS
Summers & Teeds	Boise Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 24 3628

Primary Registration District No. 2020 File No. 3628

County of Elmore

City of Mtn. Home (No. ....., ... St.) Registered No. 19

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ella Esther Lahtinen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Single

6. DATE OF BIRTH: June, 7", 1891 (Month) (Day) (Year)

7. AGE: 30 Yrs. 4 Mos. 8 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Nurse
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Finland

10. NAME OF FATHER: Adolph Lahtinen

11. BIRTHPLACE OF FATHER (State or Country): Finland

12. MAIDEN NAME OF MOTHER: Anna Nybantas

13. BIRTHPLACE OF MOTHER (State or Country): Finland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Adolph Lahtinen
(Address) Mtn. Home, Idaho.

15. Filed 12/1/1921. 19 ..... J. E. Evans. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. 24. 1921. 19..... (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 10/20/21 19..... to 10/22/21 19....., that I last saw her alive on 10/22/21 19....., and that death occurred on the date stated above, at about 5 A.M.

The CAUSE OF DEATH* was as follows:

Abscess Mastoid Cells, left side
Same broke into left Lateral Sinus

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Otitis Media

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) O. P. Hamilton M. D.

10/25 1921. (Address) Mtn. HOME, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Mtn Home Ida	10-25-1921
20. UNDERTAKER	**ADDRESS**
W. M. Conover	Mtn Home Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 98
Primary Registration District No. 2176
File No. 3629
Registered No. 2

RECEIVED
JAN 10 1922
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Jefferson
City of Roberts (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Godfrey Galia
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): married

6. DATE OF BIRTH: 8 (Month) - 26 (Day) 1881 (Year)

7. AGE: 32 Yrs. 9 Mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer on
(b) General nature of industry, business or establishment in which employed (or employer): O.S.L. Section

9. BIRTHPLACE (State or Country): Austria

10. NAME OF FATHER: Antone Galia

11. BIRTHPLACE OF FATHER (State or Country): Austria

12. MAIDEN NAME OF MOTHER: Mary Chimelare

13. BIRTHPLACE OF MOTHER (State or Country): Austria

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Lou Ledwina
(Address) Roberts Ida

15. Filed 1-10 1922 Ray H. Fisher
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 6 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 24 1921 to June 5 1921 that I last saw h... alive on June 5 1921 and that death occurred on the date stated above, at 1A M.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous nephritis

(Duration) 10 yrs. 1 mos. ... ds.

Contributory (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) Earl D. Jones M. D.
6-7 1921 (Address) Roberts Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Roberts
DATE OF BURIAL: 6-7 1921

20. UNDERTAKER: Cliff C. Hayes
ADDRESS: Ida Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12 RECEIVED CERTIFICATE OF DEATH 36292

DEC 15 1921

BUREAU OF VITAL STATISTICS

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 98

County of Jefferson Primary Registration District No. 2176 File No. 36292

City of Roberts (No. ....., ... St.) Registered No. 9

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Godfrey Galia

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Oct. (Month) 26 (Day) 1888 (Year)

7. AGE: 32 yrs. 9 mos. 10 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer on
(b) General nature of industry business, or dstablishment in which employed (or employer): O. S. L. Section

9. BIRTHPLACE (State or Country): Austria

10. NAME OF FATHER: Anton Galia

11. BIRTHPLACE OF FATHER (State or Country): Austria

12. MAIDEN NAME OF MOTHER: Mary Schmelare

13. BIRTHPLACE OF MOTHER (State or Country): Austria

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) L. J. Ledonia

(Address) Roberts Ida

15. Filed Jan 10 1922 Ray S. Fisher, Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June (Month) 6 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 7 1921, to 6/6 1921, that I last saw h[illegible] alive on June 5 1921 and that death occurred on the date stated above, at 1 A. M.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) Earl D. Jones

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Earl D. Jones M. D.

6/6 1921 (Address) Roberts Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Roberts Ida. DATE OF BURIAL ..... 191...

20. UNDERTAKER: C. C. Hayes, Idaho Falls, Idaho ADDRESS

SYMS - YORK CO., PTRS. & BDRS. 19760

JAN 10 1922

Form V. S. No. 5 20M.1-16-12 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

36293

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 9-18

County of Ada

City of Star Idaho (No. ..... St.)

Primary Registration District No. —

File No. 1

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Jerry Young

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: April (Month) 1 (Day) 1855 (Year)

7. AGE: 66 yrs. 8 mos. 19 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Northwest Missouri

10. NAME OF FATHER: Hyrum Young

11. BIRTHPLACE OF FATHER (State or Country): Indiana

12. MAIDEN NAME OF MOTHER: Sarah Hillhouse

13. BIRTHPLACE OF MOTHER (State or Country): Tennessee

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Ed. Young
(Address): Star Idaho

15.
Filed Dec 21 191 21 Orville Jackson Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec 20 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 21, 1921, to Dec 20 1921, that I last saw h[e] alive on Dec 19 1921, and that death occurred on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Starvation. from exposure
Pneumonia — Closure of Bowel

(Duration) ..... yrs. 6 mos. ..... ds.

Contributory (Secondary) Endangered Potash Poisoning

(Duration) 4 yrs. ..... mos. ..... ds.

(Signed) C. C. Lee M. D.

12/22/1921 (Address) Star Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Star Cemetery — DATE OF BURIAL: Dec 21 191 21

20. UNDERTAKER: W. H. McFarlane — ADDRESS: Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-19.

JAN 10 1922
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No.....

Primary Registration District No.....

File No. 36294

County of Ada

City of Nine Mile West Meridian (No. 1 Mile West of Meridian)

Registered No. 23

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Rebecca A. McMillen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F	White	Widow

6. DATE OF BIRTH: Oct 22 1828 (Month) (Day) (Year)

7. AGE: 93 Yrs. 1 Mos. 24 ds. IF LESS than 1 day how many.....hrs. or.....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Tenn.

10. NAME OF FATHER: Rinehart

11. BIRTHPLACE OF FATHER (State or Country): Louisiana

12. MAIDEN NAME OF MOTHER: Mary Shaw

13. BIRTHPLACE OF MOTHER (State or Country): Tenn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Joseph M. McMillen
(Address) Meridian Idaho

15. Filed 12-17 1921 H. F. Neal Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. (Month) 16 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 9 1921, to Dec. 16 1921, that I last saw h.. alive on Dec. 16 1921, and that death occurred on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:
Bronchial Pneumonia &
abscess Kidney

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. F. Neal M. D.

12/16 1921 (Address) Meridian

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Boise Idaho	Dec. 19 1921
20. UNDERTAKER	ADDRESS
Summers & Krebs	Boise Id

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36295
Registered No. 24

RECEIVED
JAN 10 1922
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Ada
City of Meridian (If not in incorporated limits, give township) St.)
Registration District No.
Primary Registration District No. 11
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sarah L. Chamberlin-Smith
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: Caucasian
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Jan (Month) 14 (Day) 1847 (Year)

7. AGE: 74 Yrs. 11 Mos. 3 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Lowaley Iowa x

10. NAME OF FATHER: John D Endlow *

11. BIRTHPLACE OF FATHER (State or Country): Pennsylvania x

12. MAIDEN NAME OF MOTHER: Dont Know

13. BIRTHPLACE OF MOTHER (State or Country): Ohio or Illinois x

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Homer H Chamberlin (Son)
(Address) 1354 Elm St Baker Oregon

15. Filed 12/17 1921
H F Kinsel
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 17 (Day) 21 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12-8-1921 to 12-17 1921
that I last saw h[illegible] alive on 12-15 1921
and that death occurred on the date stated above, at 9 — M.
The CAUSE OF DEATH* was as follows:
Hemorrhage Brain
(Duration) Yrs. mos. 9 ds.
Contributory (Secondary) High Blood Pressure
(Duration) yrs. mos. ds.
(Signed) H F Kinsel M. D.
12.17.1921 (Address) Meridian

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Meridian Cemetery
DATE OF BURIAL: Dec 18 1921

20. UNDERTAKER: W B Waters
ADDRESS: Meridian Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36297

Registered No. 371

1. PLACE OF DEATH

Registration District No. 2

Primary Registration District No. 1004

County of Ada

City of Boise (If outside limits, give township) State (St.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
JAN 10 1922
BUREAU OF VITAL STATISTICS

2. FULL NAME Grace Elizabeth Gooding

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: May (Month) 2 (Day) 1902 (Year)

7. AGE: 19 Yrs. 7 Mos. 22 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Schoolteacher
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Gooding Idaho.

10. NAME OF FATHER: Walter James Gooding

11. BIRTHPLACE OF FATHER (State or Country): England.

12. MAIDEN NAME OF MOTHER: Alice Goddard

13. BIRTHPLACE OF MOTHER (State or Country): Michigan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address) W. J. Gooding Jr. Boise Idaho

15. Filed 12-26 1921 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 24 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 11 1921 to Dec 24 1921, that I last saw h.r alive on Dec 24 1921, and that death occurred on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:

Septicaemia !

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Infected Toe

6 weeks (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J S Sprague M. D.

12/25 1921 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence Gooding Idaho

19. PLACE OF BURIAL OR REMOVAL: Gooding Idaho — DATE OF BURIAL: 12/28 1921

20. UNDERTAKER: Schreiber & Heidenfelder — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

Dr. Sprague

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36298

Registered No. 372

1. PLACE OF DEATH

County of Ada

City of Boise (No. 410 State St.)

Registration District No. 2

Primary Registration District No. 104

If death occurs away from usual residence, give facts called for under special information.

JAN 14 1922
BUREAU OF VITAL STATISTICS

2. FULL NAME Erick C. Berg

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Jan (Month) 26 (Day) 1866 (Year)

7. AGE: 55 Yrs. 11 Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Builder & Contractor
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Norway

10. NAME OF FATHER: Christopher Berg

11. BIRTHPLACE OF FATHER (State or Country): Norway

12. MAIDEN NAME OF MOTHER: ?

13. BIRTHPLACE OF MOTHER (State or Country): Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Marie L Berg
(Address) Mountain Home

15. Filed 12-26-1921 R. Z. Pratt
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. (Month) 25 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 11 1921, to Dec 25 1921, that I last saw h-m alive on Dec 23 1921, and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:
Abscess of Kidney

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Dr Callvert M. D.

19 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence Mountain Home Ida

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery | DATE OF BURIAL: 12/26/1921

20. UNDERTAKER: Schreiber & Siebenfaden | ADDRESS: Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

NOTE.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36299
Registered No. 373

1. PLACE OF DEATH

County of Ada
City of Boise (No. 711 Washington St.)
Registration District No. 7
Primary Registration District No. 1404

If death occurs away from usual residence, give facts called for under special information.

RECEIVED JAN 10 1922 BUREAU OF VITAL STATISTICS

2. USUAL RESIDENCE Same

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Oct. (Month) 1 (Day) 1821 (Year)

7. AGE: 100 Yrs. 3 Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Coal Miner
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): U. States

10. NAME OF FATHER: Not obtainable

11. BIRTHPLACE OF FATHER (State or Country): Not obtainable

12. MAIDEN NAME OF MOTHER: Not obtainable

13. BIRTHPLACE OF MOTHER (State or Country): Not obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Sister M. Fintan
(Address) St. Alphonsus Hospital

15. Filed 12-27 1921 L. F. Craft Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. (Month) 27 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 15 1921 to Dec 27 1921 that I last saw h- alive on Dec 1st 1921 and that death occurred on the date stated above, at 8 A. M.

The CAUSE OF DEATH* was as follows:

Pneumonia.

(Duration) Yrs. mos. 10 ds.

Contributory (Secondary) Carcinoma of upper lip

(Duration) 2 yrs. 0 mos. 0 ds.

(Signed) Isaac B. Ward M. D.

12-27 1921 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ...yrs...mos...days. In the State ...yrs...mos...days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: St. Johns Cemetery — DATE OF BURIAL: 12/28 1921

20. UNDERTAKER: Schreiber & Heidenfelder — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36300
Registered No. 357

1. PLACE OF DEATH

Registration District No. 2
Primary Registration District No. 1004
County of Ada
City of Boise (If not in incorporated limits, give township.) St.)

RECEIVED JAN 10 1922 BUREAU OF VITAL STATISTICS

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Alice Irwin

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Female	White	Married (Write the word.)

6. DATE OF BIRTH: Nov. (Month) 15 (Day) 1861 (Year)

7. AGE: 60 Yrs. — Mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housekeeper
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Mr. Sweeney

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Clara Stapleton

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) .....
(Address) Charles W. Irwin Boise Ida

15. Filed Dec 9 1921 — R. H. Pratt, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 6th (Day) 19.... (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 1921, to Dec 6th 1921, that I last saw h.. alive on Dec 6th 1921, and that death occurred on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:

Cancer of Uterus

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. B. Freeman M. D.

12/7, 1921. (Address) Boise, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Morris Hill Cemetery	12/9 1921

20. UNDERTAKER	ADDRESS
Schrecher & Sidenfaden	Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. [illegible]—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 3630

Registered No. 358

1. PLACE OF DEATH

County of Ada.

City of Boise (No. 923 N. 22nd St.)

Registration District No. 2

Primary Registration District No. 10-4

RECEIVED JAN 10 1924 BUREAU OF VITAL STATISTICS

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Thomas Gambling

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married.

6. DATE OF BIRTH: May 17 1841
(Month) (Day) (Year)

7. AGE: 80 Yrs. 6 Mos. 27 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: Don't Know

11. BIRTHPLACE OF FATHER (State or Country): England.

12. MAIDEN NAME OF MOTHER: Don't Know

13. BIRTHPLACE OF MOTHER (State or Country): England.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. McBratney
(Address) Boise Idaho.

15. Filed Dec. 10 - 1921 P. H. Pratt Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. 9 - 1921.
(Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 18 1921 to Dec 9 1921 that I last saw him alive on Nov 15 1921 and that death occurred on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) ..... Yrs. ..... mos. 15 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. W. Anderson M. D.

12/9/21 19 (Address) Boise, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Liberty Idaho — DATE OF BURIAL 19

20. UNDERTAKER: W. McBratney — ADDRESS: Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36302
Registered No. 3-57

RECEIVED JAN 10 1922 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Ada Registration District No. 2
City of Boise (If not in incorporated limits, give township) Precinct No. 1004 (St.) State St. 410

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jerome Peterlin

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Sept. (Month) (Day) 1866 (Year)

7. AGE: 55 Yrs. Mos. 3 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer & Miner
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Italy

10. NAME OF FATHER: Anton Peterlin

11. BIRTHPLACE OF FATHER (State or Country): Italy

12. MAIDEN NAME OF MOTHER: Mary Salla

13. BIRTHPLACE OF MOTHER (State or Country): Italy

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Charles Peterlin
(Address) Bellevue Ida

15.
Filed Dec 12 1921 R. H. Pruett
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 10 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 9 1921, to Dec 10 1921, that I last saw h[illegible] alive on Dec 10 1921, and that death occurred on the date stated above, at 11:30 M.
The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) Yrs. mos. 6 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Jno. R. Numan M. D.
12/14/19 (Address) Boise Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence Bellevue Idaho

19. PLACE OF BURIAL OR REMOVAL: Bellevue Ida
DATE OF BURIAL: 12/12/1921

20. UNDERTAKER: Schreiber & Hidenfaden
ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JAN 12 1922

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36303

Registered No. 360

1. PLACE OF DEATH

County of Ada

City of Boise. (No. 1905 E Franklin St.)

Registration District No. 2

Primary Registration District No. 1004

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Minnie M. Clark.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F.	White.	Widow

6. DATE OF BIRTH: June (Month) 5 (Day) 1864 (Year)

7. AGE: 57 Yrs. 6 Mos. 5 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Ohio.

10. NAME OF FATHER: Albert Clark.

11. BIRTHPLACE OF FATHER (State or Country): Ohio.

12. MAIDEN NAME OF MOTHER: Amanda Kerr.

13. BIRTHPLACE OF MOTHER (State or Country): Ohio.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. R. Clark
(Address) 1705 Franklin St Boise Ida

15. Filed Dec 12 1921 R. N. Pratt Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: December (Month) 10 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I ~~attended~~ deceased ~~from~~ Dec-10 1921, ~~to~~ ~~19~~ ~~that I last saw h~~ ~~alive~~ on Dec 10 1921, and that death occurred on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:
General debility
Been sick for 13 Years. General
bread (Duration) 2 yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Clyde E. Summers Coroner A. C. Ada County
12/13 1921 (Address) Boise Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Morris Hill Cem.	Dec 14 1921
20. UNDERTAKER	ADDRESS
Summers & Cole.	Boise, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36305

Registered No. 36

1. PLACE OF DEATH

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2

Primary Registration District No. (No. 4) 10. West State St.)

2. FULL NAME Charles Henry Shepherd

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	White	Single

6. DATE OF BIRTH: Oct 9 1872 (Month) (Day) (Year)

7. AGE: 49 Yrs. 2 Mos. 9 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Jeweler
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): North Carolina

10. NAME OF FATHER: Jacob Shepherd

11. BIRTHPLACE OF FATHER (State or Country): North Carolina

12. MAIDEN NAME OF MOTHER: Clarilla May

13. BIRTHPLACE OF MOTHER (State or Country): North Carolina

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) D. W. Shepherd
(Address) Telluride Colorado

15. Filed Dec 16 1921 C. W. Pratt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. (Month) 16 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 9 1921, to Dec 16 1921, that I last saw him alive on Dec 16 1921, and that death occurred on the date stated above, at 4:40 P.M.

The CAUSE OF DEATH* was as follows:
Tubercular peritonitis

(Duration) ..... Yrs. ..... mos. 7 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Dr. Ralph Frank M. D.

12/16 1921 (Address) Boise - Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Cambridge Idaho	Dec 18 1921
20. UNDERTAKER	ADDRESS
Summers & Tubbs	Boise Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36306
Registered No. 363

Registration District No.
Primary Registration District No. 1004

1. PLACE OF DEATH

County of Ada
City of Boise
(No. Soldiers Home St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Samuel Fletcher

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	White	Single

6. DATE OF BIRTH April 1 (Month) (Day) (Year)

7. AGE 82 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Veteran Civil War
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) England

10. NAME OF FATHER George Fletcher

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (State or Country) Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. B. Fletcher
(Address) San Jose, Calif

15. Filed Dec 17 1921 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec 14 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12/11/21 19.., to 12/14 19.21 that I last saw h[illegible] alive on 12/14 19.21, and that death occurred on the date stated above, at 9P M.

The CAUSE OF DEATH* was as follows:

Senility

(Duration) Yrs. mos. ds.

Contributory (Secondary) Intestinal Paralysis

(Duration) yrs. mos. ds.

(Signed) Fred A Fitzsimmons M. D.

12/19 19.21 (Address) Boise

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ...yrs...mos...days. In the State ...yrs...mos...days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Morris Hill Cemetery	Dec 19 1921
20. UNDERTAKER	**ADDRESS**
Summers & Kibbe	Boise Idg

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36307
Registered No. 364

1. PLACE OF DEATH

County of Ada

City of Boise (No. St. Lukes Hospital St.)

Registration District No. 2

Primary Registration District No. 1504

If death occurs away from usual residence, give facts called for under special information.

RECEIVED JAN 10 1922 BUREAU OF VITAL STATISTICS

2. FULL NAME James Robert Paxton

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Dec 18 – 1921
(Month) (Day) (Year)

7. AGE: — Yrs. — Mos. ds.

IF LESS than 1 day how many 12 hrs. or — min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Boise Idaho.

10. NAME OF FATHER: J. L. Paxton

11. BIRTHPLACE OF FATHER (State or Country): Neb

12. MAIDEN NAME OF MOTHER: Ellen Hannah Yount

13. BIRTHPLACE OF MOTHER (State or Country): Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. McBratney
(Address) Boise Idaho

15. Filed Dec. 20 1921 P. H. Smith Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec 19 – 1921
(Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 18 1921, to Dec 19 19 21, that I last saw h. alive on Dec 19 19 21, and that death occurred on the date stated above, at 7 A M.

The CAUSE OF DEATH* was as follows: Pneumonia bilat

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) John Bonk M. D.

12/19 19 21 (Address) Boise. Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 12/22/21

20. UNDERTAKER: W. McBratney — ADDRESS: Boise Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36308

Registered No. 365

1. PLACE OF DEATH

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2

Primary Registration District No. 8 1004

(No. 1601 N. 8, St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Alice Taylor

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F	White.	married

6. DATE OF BIRTH: Dec 20, 1863 (Month) (Day) (Year)

7. AGE: 58 Yrs. 0 Mos. 1 ds. IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Minnesota

10. NAME OF FATHER: Anson Hanf

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H L Straight
(Address) 1601 N. 8th St.

15. Filed Dec 21 1921 R. H. Trail Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec 21 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 20 1921, to Dec 21 1921, that I last saw her alive on Dec 1921, and that death occurred on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ... Yrs. ... mos. 1 ds.

Contributory (Secondary): Nephritis

(Duration) ... yrs. ... mos. ... ds.

(Signed) O H Parker M. D.

12/21 1921 (Address) 303 Idaho Bldg

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Dec 22 1921

20. UNDERTAKER: Summers & Kirk — ADDRESS: Boise Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36309

Registered No. 367

1. PLACE OF DEATH

County of Ada.

City of Boise.

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2.

Primary Registration District No. 7 or 4

(No. 315 So 2nd St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Louis S. Corbin

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
M.	White.	Widower

6. DATE OF BIRTH: Oct (Month) 15 (Day) 1836 (Year)

7. AGE: 85 Yrs. 2 Mos. 4 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kentucky

10. NAME OF FATHER: Louis S Corbin

11. BIRTHPLACE OF FATHER (State or Country): Kentucky

12. MAIDEN NAME OF MOTHER: Elizabeth Nickinson

13. BIRTHPLACE OF MOTHER (State or Country): Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Louis S. Corbin
(Address) 315 S 2nd St Boise Ida

15. Filed Dec. 21 1921 P. H Pratt Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 19 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1, 1921, to Dec 19 1921
that I last saw him alive on Dec 1 1921,
and that death occurred on the date stated above, at 3 P. M.
The CAUSE OF DEATH* was as follows:
Angina Pectoris

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) P L Payne M. D.

12/19 1921 (Address) 501 Hyrum St

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery. DATE OF BURIAL: Dec 22 1921

20. UNDERTAKER: Summers & Cobb. ADDRESS: Boise Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Ada — Registration District No. 2

City of Boise — Primary Registration District No. 1 or 4 — File No. 36511

(No. 1207 Lincoln St.) — Registered No. 350

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Louis J McFadden

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	White	married

6. DATE OF BIRTH: September 21 (Month) (Day) 1876 (Year)

7. AGE: 45 Yrs. 2 Mos. 10 ds. — IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Carpenter
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kansas

10. NAME OF FATHER: William W. McFadden

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Louisa E Bishop

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Lozo S McFadden
(Address) Boise Idaho

15. Filed Dec 3 1921 — R H Grant, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec 1 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 20 1921 to Dec 1 1921 that I last saw h..... alive on ..... 19....., and that death occurred on the date stated above, at 5 P M.

The CAUSE OF DEATH* was as follows:
Acute congestion of lungs
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary): Tuberculosis —
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John Bowers M. D.
Dec 3 1921 (Address) Boise Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Morris Hill Cemetery	Dec 3 1921
20. UNDERTAKER	ADDRESS
[redacted] Rivers & Trefs	Boise Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

Dutton

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Ada

City of Boise (If outside limits of city or village, write RURAL.)

BUREAU OF VITAL STATISTICS

Registration District No. 2

Primary Registration District No. 1004

4333 So 9th St.

File No. 36312

Registered No. 351

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John S. Johnson Rue.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
M.	White	Married (~~the wife~~)

6. DATE OF BIRTH: June 15 (Month) 1872 (Day) (Year)

7. AGE: 49 Yrs. 5 Mos. 18 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Planer
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Norway.

10. NAME OF FATHER: John Rue

11. BIRTHPLACE OF FATHER (State or Country): Norway.

12. MAIDEN NAME OF MOTHER: Unknown.

13. BIRTHPLACE OF MOTHER (State or Country): Norway.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Georgine R. Rue
(Address) 4333 S 9 st.

15. Filed Dec 5 19 21 R. H. Pratt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec 3 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12/1- 1921, to 12-3- 1921
that I last saw him alive on 12-3- 1921
and that death occurred on the date stated above, at 5:30 P.M.

The CAUSE OF DEATH* was as follows: —
Broncho Pneumonia
Asthma.
Complication of Pneumonia
(Duration) ... Yrs. ... mos. ... ds.
Contributory (Secondary) Asthma
(Duration) ... yrs. ... mos. ... ds.

(Signed) C. L. Dutton M. D.
19..... (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Morris Hill Cem.	Dec 6 1921
20. UNDERTAKER	ADDRESS
Summers & Hobb.	Boise Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED JAN 10 1920 BUREAU OF STATISTICS

CERTIFICAT[illegible]

1. PLACE OF DEATH

County of Ada, Registration District No. [illegible]

City of Boise, Primary Registration Distri[illegible]

(No. [illegible] St.) Registered No. [illegible]

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Alice M. Frazier

If death occurred in hospital, institution give its NAME street and numb[illegible]

WRITE PLAINLY, with pen and ink—DO NOT USE PENCIL. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Widow

6. DATE OF BIRTH: Jan. (Month) 9 (Day) 1837 (Year)

7. AGE: 64 Yrs. Mos. 27 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housekeeper
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kappa California

10. NAME OF FATHER: James R. Gilson

11. BIRTHPLACE OF FATHER (State or Country): Tennessee

12. MAIDEN NAME OF MOTHER: Sarah J. Jeans

13. BIRTHPLACE OF MOTHER (State or Country): Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Arthur Frazier
(Address) Boise Idaho

15. Filed Dec. 8 1924 P. H. Pratt Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. (Month) 7 (Day)

17. I HEREBY CERTIFY, That I attended deceased from June 15 1924 to Dec 7 1924 that I last saw h[illegible] alive on Dec 6 and that death occurred on the date stated above, at 7 [illegible]

The CAUSE OF DEATH* was as follows:

Chronic nephritis

(Duration) 1.5 Yrs. mos.

Contributory (Secondary) Senile debility

(Duration) yrs. mos.

(Signed) [illegible]

Dec 8 1924, (Address) Boise, Ida.

*State the Disease Causing Death; or in deaths from Violent C[illegible] (1) Means of Injury; and (2) whether Accidental, Suicidal or H[illegible]

18. LENGTH OF RESIDENCE (For Hospitals, In[illegible] Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Meridian — DATE OF [illegible]: Dec 9

20. UNDERTAKER: W. B. Maher Meridian — ADDRESS: Idaho

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36314
Registered No. 350

RECEIVED JAN 1922

1. PLACE OF DEATH

County of Ada
Registration District No. 2
Primary Registration District No. 1004
City of Boise (No. 1113 No 15 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Emma S. Franklin.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F.	White.	Married

6. DATE OF BIRTH: June (Month) 30 (Day) 1875 (Year)

7. AGE: 46 Yrs. 5 Mos. 7 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home.
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: — Stratton

11. BIRTHPLACE OF FATHER (State or Country): Unknown.

12. MAIDEN NAME OF MOTHER: Jane Shockley

13. BIRTHPLACE OF MOTHER (State or Country): Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. J. Franklin
(Address) Boise Ida

15. Filed Dec. 8. 1921 R. H. Pratt Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 7 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from [illegible] 1921, to Dec 7 1921, that I last saw h[illegible] alive on Dec 7 1921, and that death occurred on the date stated above, at 10:25 A. M.

The CAUSE OF DEATH* was as follows:

[illegible] Stomach

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.

Dec 9 1921. (Address) [illegible]

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Morris Hill Cemetery	Dec 9 1921

20. UNDERTAKER	ADDRESS
Summers & Hobbs.	Boise Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36315
Registered No. 376

1. PLACE OF DEATH

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2

Primary Registration District No. 1004

(No. 410 W State St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Sarah Amelia Moss

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: April 4 (Month) (Day) 1894 (Year)

7. AGE: 27 Yrs. 8 Mos. 23 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Penn

10. NAME OF FATHER: E W Rhoads

11. BIRTHPLACE OF FATHER (State or Country): Penn

12. MAIDEN NAME OF MOTHER: Mary Bartels

13. BIRTHPLACE OF MOTHER (State or Country): Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E W Rhoads

(Address) Boise Idaho

15. Filed Dec 28 1927 R. W. Pratt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 27 (Day) 1927 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 1st 1927, to Dec 27 1927, that I last saw h.e alive on Dec 27 1927, and that death occurred on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

Dementia Paralytica

(Duration) Yrs. 3 mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Jno. R. Nunnally M. D.

12/28/1927 (Address) Boise

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Dec 30 1927

20. UNDERTAKER: Summers & Trulo — ADDRESS: Boise Idy

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 16016
Registered No. 377

1. PLACE OF DEATH
County of Ada
City of Boise (No. 718 W. Kinsley Ave.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Judson Rose
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: September (Month) 10th (Day) 1827 (Year)

7. AGE: 94 Yrs. 3 Mos. 19 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): State of New York

10. NAME OF FATHER: Not Known

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Mabel Sailor
(Address) 718 W. Kinsley Ave. Boise Idaho

15. Filed Dec 30 - 1921
R. H. Pratt
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: December (Month) 29 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 28 1921, to Dec 29 1921 that I last saw him alive on Dec 28 1921 and that death occurred on the date stated above, at 9 A. M.
The CAUSE OF DEATH* was as follows:
Apoplexy
(Duration) ..... Yrs. ..... mos. 2 ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) ..... M. D.
12-30 1921 (Address) P.O. Frazier 407 Overland Bldg Boise

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Meridian Cemetery — DATE OF BURIAL: 1/1 1922

20. UNDERTAKER: Schreiber & Sidenfaden — ADDRESS: Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 36317
Registered No. 1

1. PLACE OF DEATH

County of Ada
City of Boise (No. 410 State St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Beatris Diaz

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: June 29 1898 (Month) (Day) (Year)

7. AGE: 23 Yrs. 6 Mos. 1 ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Spain

10. NAME OF FATHER: Juan Cruz Echeverria

11. BIRTHPLACE OF FATHER (State or Country): Spain

12. MAIDEN NAME OF MOTHER: Saludana Carpeno

13. BIRTHPLACE OF MOTHER (State or Country): Spain

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Emil Diaz
(Address) Mountain Home

15. Filed Dec 30 1921 R. V. Pratt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec 30 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 29 1921, to Dec 30 1921, that I last saw her alive on Dec 30 1921, and that death occurred on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:
Accidental Burns from Kerosene.

(Duration) ... Yrs. ... mos. 2 ds.
Contributory (Secondary) Toxemia.
(Duration) ... yrs. ... mos. 2 ds.

(Signed) Wm A Foelsch M. D.
12/31 1921 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. 2 days
Where was disease contracted if not at place of death? Mountain Home.
Former or usual residence Mountain Home Ida.

19. PLACE OF BURIAL OR REMOVAL: Mountain Home Ida | DATE OF BURIAL: 1/2 1922

20. UNDERTAKER: Schreiber & Sidenfaden | ADDRESS: Boise

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36318

Registered No. 379

1. PLACE OF DEATH

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2

Primary Registration District No. 1004

(No. 1111 Ada St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Edna Elizabeth Teater

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
F	White	Single

6. DATE OF BIRTH: May 27 1894 (Month) (Day) (Year)

7. AGE: 27 Yrs. 7 Mos. 4 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Washington

10. NAME OF FATHER: Lloyd F Teater

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Sarah Litzke

13. BIRTHPLACE OF MOTHER (State or Country): Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Fowler A. Teater
(Address) Boise Idaho

15. Filed Jan 3 1922 P. W. Pratt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec 31 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 30 1921, to Dec. 31 1921, that I last saw her alive on Dec 31 1921, and that death occurred on the date stated above, at 8:30 P.M.

The CAUSE OF DEATH* was as follows:

acute tuberculosis

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. W. Kingsbury M. D.

Jan 1922 (Address) 404 Idaho Bldg

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Jan. 3 1922

20. UNDERTAKER: Summers & Kuhn — ADDRESS: Boise Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

(3)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36319

Registered No. 78.

1. PLACE OF DEATH

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No. 2905

(No. 1/2 mile N. Cole School St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Cora. May. Poulter

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married.

6. DATE OF BIRTH: June 17 - 1874
(Month) (Day) (Year)

7. AGE: 47 Yrs. 5 Mos. 28 ds.
If LESS than 1 day how many ____ hrs. or ____ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Robert R. Moss

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Mary Herrick

13. BIRTHPLACE OF MOTHER (State or Country): Don't Know.

14. THE ABOVE IS ~~TRUE~~ TO THE BEST OF MY KNOWLEDGE
(Informant) W. McBratney
(Address) Boise Idaho.

15. Filed Dec. 17 1921 D. H. Clark
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec, 15 - 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 15 1921, to Dec 15 1921, that I last saw h~~e~~ alive on — — 1921, and that death occurred on the date stated above, at 7.30 P.M.

The CAUSE OF DEATH* was as follows:

Strangulation —
while cooking county
(Duration) ____ Yrs. ____ mos. ____ ds.

Contributory (Secondary)
(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) John Baer M. D.
12/16 1921 (Address) Boise. Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 12/18 1921

20. UNDERTAKER: W. McBratney — ADDRESS: Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Ada

Registration District No. 8

Primary Registration District No. 2 2 3

File No. 36320

City of ... (Not in) Dry Creek 10 Miles North of Boise

Registered No. 77

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James M. Hanley

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

RECEIVED JAN 10 1922 BUREAU OF STATISTICS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: July (Month) 21 (Day) 1858 (Year)

7. AGE: 63 Yrs. 4 Mos. 25 ds.

IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Rancher and

(b) General nature of industry, business or establishment in which employed (or employer): Stock Raiser

9. BIRTHPLACE (State or Country): Saline Co Missouri

10. NAME OF FATHER: Archibald H. Hanley

11. BIRTHPLACE OF FATHER (State or Country): W. Va.

12. MAIDEN NAME OF MOTHER: Phoebe Claycomb

13. BIRTHPLACE OF MOTHER (State or Country): W. Va

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) [redacted] H McGuffin

(Address) ...

15. Filed Dec 17 1921 — R. H. Pratt, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. (Month) 16 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 14 1921, to Dec 16 1921, that I last saw h... alive on ... 19..., and that death occurred on the date stated above, at 1.30 P. M.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary) ...

(Duration) ... yrs. ... mos. ... ds.

(Signed) ... M. D.

19... (Address) ...

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death? ...

Former or usual residence Dry Creek North of Boise

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 12/18 1921

20. UNDERTAKER: Schreiber & Hidenfadden — ADDRESS: Boise

FORM V. S. No. 5-25 M. 1-19.

JAN 1922
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 8
Primary Registration District No. 2 & 8
(No. 15 miles West of Boise St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36321
Registered No. 80

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Ada
City of

2. FULL NAME Linabel A. Reed

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Feb (Month) 17 (Day) 1916 (Year)

7. AGE: 5 Yrs. 10 Mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: A H. Reed

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Alice Day

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A H Reed
(Address) REDmail Boise Idg

15. Filed 12 23 1921 R. T. Reid Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: DEC. (Month) 22 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 22 1921, to Dec 22 1921 that I last saw h. alive on ..... 19....., and that death occurred on the date stated above, at 3.30 P.M.

The CAUSE OF DEATH* was as follows:
Accidentally killed by being struck by an Automobile causing fractured scull
(Duration) Yrs. ..... mos. ..... ds.
Contributory (Secondary) Instantaneous
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
12/23/1921 (Address) O P French Boise Ida

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Dec 24 1921

20. UNDERTAKER: Summers & Tibbs — ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

GYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
JAN 14 1922
BUREAU OF STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 8
Primary Registration District No. 8008
File No. 36322
Registered No. 81

1. PLACE OF DEATH

County of Ada
City of Boise
If death occurs away from usual residence, give facts called for under special information.
(No. 3 Miles S.W. of Boise St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Eugene W. Daniels

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M.	White	Single

6. DATE OF BIRTH (Month) (Day) 1872 (Year)

7. AGE 49 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Second Hand dealer
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Unknown

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (State or Country) Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Clyde E. Summers
(Address) 906 Bannock St. Boise Ida.

15. Filed Dec. 30 1921 R. M. Bradley Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Unknown 19 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I ~~attended~~ deceased from Date
Nov. 11 1921, to 19,
~~that I last saw h~~ alive on 19,
and that death ~~occurred~~ on the date stated above, at M.

The CAUSE OF DEATH* was as follows:
Unknown found remains buried in a grave. He had been missing for some time. And Cause of death was as Unknown.
(Duration) ~~Unknown~~ ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) Clyde E. Summers Coroner of Ada County
12/30 1921 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Morris Hill Cemetery — **DATE OF BURIAL** Dec. 31 19 21

20. UNDERTAKER Summers & Tuttle — **ADDRESS** Boise Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JAN 10 1922 BUREAU OF STATISTICS

CERTIFICATE OF DEATH

36323

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Ada — Registration District No. ____

City of ____ (No. Hill Road 1 Mile St.) — Primary Registration District No. ____

File No. 82

Registered No. ____

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Laura Leigh

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F.	White	Married

6. DATE OF BIRTH: Oct (Month) 26th (Day) 1856 (Year)

7. AGE: 65 Yrs. 2 Mos. 3 ds. — IF LESS than 1 day how many ____ hrs. or ____ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House Keeper
(b) General nature of industry, business or establishment in which employed (or employer): ____

9. BIRTHPLACE (State or Country): Schoolcraft Co. Penn

10. NAME OF FATHER: John R Heazler

11. BIRTHPLACE OF FATHER (State or Country): [illegible]

12. MAIDEN NAME OF MOTHER: Elizabeth Miller

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Elizabeth Leigh
(Address) Boise, Idaho

15. Filed Dec. 31 1921 — R H Pratt, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

Dr. Tallman

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 31st (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ____ 19____, to ____ 19____ that I last saw h____ alive on ____ 19____, and that death occurred on the date stated above, at 11 A.M.
The CAUSE OF DEATH* was as follows:

____ (Duration) ____ Yrs. ____ mos. ____ ds.

Contributory (Secondary) ____

____ (Duration) ____ yrs. ____ mos. ____ ds.

(Signed) ____ M. D.

____ 19____ (Address) ____

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days
Where was disease contracted if not at place of death? ____
Former or usual residence ____

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Morris Hill Cemetery	1/2 1922

20. UNDERTAKER	ADDRESS
Schreiber & Sidenfaden	(Boise)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

36325

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 28
Primary Registration District No. 21
File No. 45
Registered No. 3706

1. PLACE OF DEATH
County of Bannock
City or Pocatello
(No. 292 W. Young St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John G. Robasser
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single
6. DATE OF BIRTH: Sept 25 (Month) — 1853 (Day) (Year)
7. AGE: 67 Yrs. 10 Mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Contractor
(b) General nature of industry, business or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Pennsylvania
10. NAME OF FATHER: Conrad Robasser
11. BIRTHPLACE OF FATHER (State or Country): Switzerland
12. MAIDEN NAME OF MOTHER: Caroline Fritz
13. BIRTHPLACE OF MOTHER (State or Country): Germany
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Mary E. Bufford
(Address) 202 W Young
15. Filed 8/4 1921
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August (Month) 1 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 20 1919, to Aug 1921, that I last saw h.imself alive on Aug 1 1921, and that death occurred on the date stated above, at 12 M.
The CAUSE OF DEATH* was as follows;
Arterial sclerosis
(Duration) Few Yrs. — mos. — ds.
Contributory (Secondary) Cerebral Hemorrhage
(Duration) — yrs. — mos. 10 ds.
(Signed) W. J. Howard M. D.
8/4/1921 (Address) Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain View — DATE OF BURIAL: Aug 6 1921
20. UNDERTAKER: Johnson Bros — ADDRESS: Pocatello

FORM V. S. No. 5-25 M. 1-19.

Dr. Ray

CERTIFICATE OF DEATH

36326

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 28
Primary Registration District No. 2161A
File No. 45
Registered No. 3707

1. PLACE OF DEATH
County of Bannock
City of Pocatello
(No. Sacred Heart Hospital St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Catherine H. Bowen
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Divorced

6. DATE OF BIRTH: Oct 24 - 1865
(Month) (Day) (Year)

7. AGE: ... Yrs. ... Mos. ... ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housekeeper
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: unknown

11. BIRTHPLACE OF FATHER (State or Country): unknown

12. MAIDEN NAME OF MOTHER: unknown

13. BIRTHPLACE OF MOTHER (State or Country): unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ruth Bowen
(Address) Pocatello Idaho

15. Filed 12/5 19 21
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
12 - 3 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 29 1921, to Dec 3 1921
that I last saw h.lr alive on 12 - 3 1921
and that death occurred on the date stated above, at about noon M.
The CAUSE OF DEATH* was as follows:
Streptococcus Septicemia
(Duration) ... Yrs. ... mos. 5 ds.
Contributory (Secondary)
(Duration) ... yrs. ... mos. 5 ds.
(Signed) D C Ray M. D.
19... (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain View — DATE OF BURIAL: ... 19...

20. UNDERTAKER: Schumacher & Son — ADDRESS: City

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

36327

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 28
Primary Registration District No. 2161
(No. General Hospital St.)
File No. 45
Registered No. 3708

1. PLACE OF DEATH
County of Bannock
City of Pocatello
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mae Jensen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Child (Write the word.)

6. DATE OF BIRTH: May 28 (Month) (Day) 1913 (Year)

7. AGE: 8 Yrs. 6 Mos. 6 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At School
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Rupert Idaho.

10. NAME OF FATHER: James C Jensen

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Almira Crandall

13. BIRTHPLACE OF MOTHER (State or Country): Payson Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs J. C. Jensen
(Address) Rupert Ida.

15. Filed 12/5 1921 — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 4 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 30 1921, to Dec 4 1921, that I last saw her alive on Dec 4 1921, and that death occurred on the date stated above, at 7:30 P.M.

The CAUSE OF DEATH* was as follows:
Acute Suppurative appendicitis

(Duration) ..... Yrs. ..... mos. 5 ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J M Tay M. D.
Dec 4 1921 (Address) Pocatello, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rupert Idaho. DATE OF BURIAL: Dec 7 1921

20. UNDERTAKER: Schumacher & Stacy ADDRESS: City

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-12 M. 6-15-17.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

36328

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 45
Registered No. 3709

1. PLACE OF DEATH
County of Bannock
City or Pocatello Sda
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 28
Primary Registration District No. 2161
(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mrs Lennie Ewell Cage

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): married

6. DATE OF BIRTH. Feb (Month) 6 (Day) 1866 (Year)

7. AGE 54 Yrs. 8 Mos. 29 ds.
IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Indiana

10. NAME OF FATHER Norman Conde

11. BIRTHPLACE OF FATHER (State or Country) Ireland

12. MAIDEN NAME OF MOTHER Amanda Conde

13. BIRTHPLACE OF MOTHER (State or Country) Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. G. R. Mull
(Address) Blackfoot Ida

15. Filed 12/7 1921
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 5 (Day) 21 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 10 1921 to Dec 5 1921
that I last saw her alive on Dec 5 1921
and that death occurred on the date stated above, at 2.15 P.M.

The CAUSE OF DEATH* was as follows:
Inoperable cancer of liver
(Duration) 2 Yrs. mos. ds.
Contributory (Secondary) Emaciation
(Duration) Yrs. mos. ds.
(Signed) [signature] M. D.
Dec 19 21 (Address) Pocatello Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. 2 days. In the State 7 yrs. 4 mos. ... days

Where was disease contracted if not at place of death? Malignancy
Former or usual residence Blackfoot Ida

19. PLACE OF BURIAL OR REMOVAL: Shelley Idaho — DATE OF BURIAL: 12-7-1921

20. UNDERTAKER: E T Funk — ADDRESS: Blackfoot Ida

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

36330

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 28
Primary Registration District No. 2161
File No. 16
Registered No. 3911

1. PLACE OF DEATH
County of Bannock
City of Pocatello
(No. General Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Elma Elizabeth Prose

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Child (Write the word.)

6. DATE OF BIRTH: May (Month) 16 (Day) 1915 (Year)

7. AGE: 6 Yrs. 6 Mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At School
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Lava Hot Springs, Ida.

10. NAME OF FATHER: Joshiah Prose

11. BIRTHPLACE OF FATHER (State or Country): Samaria Idaho

12. MAIDEN NAME OF MOTHER: Ruby E Chatterton

13. BIRTHPLACE OF MOTHER (State or Country): Richmond Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Joshiah Prose
(Address): Pocatello

15. Filed 1/8 1921 — J R Ganey, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: December (Month) 6 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11/6 1921, to 12-6 1921
that I last saw h-e alive on 12-6 1921,
and that death occurred on the date stated above, at 11-9 M.
The CAUSE OF DEATH* was as follows:
Bronchopneumonia
(Duration) Yrs. 1 mos. — ds.
Contributory (Secondary) Emphysema
(Duration) yrs. — mos. 10 ds.

(Signed) J P Young M. D.
1/8 1921 (Address) Pocatello Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain View Cem — DATE OF BURIAL: Dec 8 1921

20. UNDERTAKER: Schumacher & Hall — ADDRESS: Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH 36331

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 28
Primary Registration District No. 2161
File No. 46
Registered No. 3712

1. PLACE OF DEATH
County of Bannock
City of Pocatello
(No. 445 N. Johnson St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Irene Carlson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6. DATE OF BIRTH: Dec (Month) 30 (Day) 1893 (Year)

7. AGE: 27 Yrs. 11 Mos. 23 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kansas

10. NAME OF FATHER: Kinsey

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: not Known

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Earl Carlson
(Address) 445 N. Johnson Pocatello Idaho

15. Filed Dec 8 1921 J. R. Young Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 7 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 4 1921, to Dec 7 1921 that I last saw h er alive on Dec 7 1921 and that death occurred on the date stated above, at 9:15 P. M.

The CAUSE OF DEATH* was as follows:
Small pox (Black).

(Duration) ..... Yrs. ..... mos. 7 ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Carl W Clark M. D.
Dec 8 1921 (Address) Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death — yrs. — mos. 19 days. In the State — yrs. — mos. 19 days
Where was disease contracted if not at place of death? Probably Colorado
Former or usual residence Denver Colo.

19. PLACE OF BURIAL OR REMOVAL: Mt View Cem. DATE OF BURIAL: Dec 8 1921

20. UNDERTAKER: L. L. McClain ADDRESS: Pocatello Ida

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

36332

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 28
Primary Registration District No. 2161
File No. 46
Registered No. 3713

1. PLACE OF DEATH
County of Bannock
City of Pocatello
(No. 440 S. 6th St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Irma Goodwin

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH: Dec 8th 1921
(Month) (Day) (Year)

7. AGE: Premature Birth
Yrs. Mos. ds.
IF LESS than 1 day old, how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Edwin C. Goodwin

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Eva Wright

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Edwin Goodwin
(Address) 440 S. 6th

15. Filed 12/9 1921
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec 9th 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 8 1921, to Dec 9th 1921, that I last saw h— alive on Dec 9th 1921, and that death occurred on the date stated above, at ... M.

The CAUSE OF DEATH* was as follows:
Hydrocephalus
7/12 Premature Twin
(Duration) ... Yrs. ... mos. ... ds.
Contributory (Secondary)
(Duration) ... yrs. ... mos. ... ds.

(Signed) H. S. Wacaser M. D.
12/9 1921 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain View | DATE OF BURIAL: ... 1921

20. UNDERTAKER: D. Thomason & Sons | ADDRESS: City

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 6-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36333
Registered No.

1. PLACE OF DEATH
County of Bannock
City of Pocatello
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No.
(No. 820 W Bonneville St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Harry Thompson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.):

6. DATE OF BIRTH: no history (Month) (Day) 1 (Year)

7. AGE: about 65 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business or establishment in which employed (or employer): Butcher

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: no history

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: no history

13. BIRTHPLACE OF MOTHER (State or Country): England.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. M. Davis
(Address) 936 So Main

15.
Filed 12/10 1921
J. P. Young
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 7th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 31 1921 to Dec 7th 1921 that I last saw h... alive on ... and that death occurred on the date stated above, at 7 A.M.
The CAUSE OF DEATH* was as follows:
Double Pyelitis
(Duration) 1 Yrs. mos. ds.
Contributory (Secondary) stricture of the urethra
(Duration) 20 yrs. mos. ds.
(Signed) [illegible] M. D.
Dec 8th 1921 (Address) Pocatello

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.) Gem Boarding House
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. 37 days
Where was disease contracted if not at place of death? no history
Former or usual residence Banner Co Ida.

19. PLACE OF BURIAL OR REMOVAL: Pocatello Cemetery
DATE OF BURIAL: 12/10 1921

20. UNDERTAKER: W. T. Walker
ADDRESS: Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

36334

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 28
Primary Registration District No. 2161
(No. ..... St.)

File No. 46
Registered No. 3715

1. PLACE OF DEATH

County of Bannock.
City of Pocatello
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Betsy Dawson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: widow (Write the word.)

6. DATE OF BIRTH: April (Month) 14 (Day) 1845 (Year)

7. AGE: 76 Yrs. 6 Mos. 21 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): England.

10. NAME OF FATHER: Partridge

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Not Known

13. BIRTHPLACE OF MOTHER (State or Country): ——

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mr Harry Puckett
(Address) 129 So 10 Ave.

15. Filed 12/12 1921

J. Hansen
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 10 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec several years 19..., to Dec 11 1921
that I last saw h.. alive on Dec 10 1921
and that death occurred on the date stated above, at 7 A.M.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage

..... (Duration) ..... Yrs. ..... mos. Few ds.
Contributory (Secondary) Chronic Nephritis
Cerebral Hemorrhage
..... (Duration) 11 yrs. ..... mos. ..... ds.

(Signed) J. M. Kay M. D.
12/12 1921 (Address) Pocatello, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (~~For Hospitals, Institutions, Transients or~~ Recent Residents.)
At place of death 10 yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence 129 So 10 Ave Pocatello

19. PLACE OF BURIAL OR REMOVAL: Mt View Cemetery — DATE OF BURIAL: Dec 12 1921

20. UNDERTAKER: A. L. McFarr. — ADDRESS: Pocatello Ida

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

36336

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 28
Primary Registration District No. 2161
File No. 46
Registered No. 3717

1. PLACE OF DEATH
County of Bannock
City of POCATELLO, IDAHO
(No. 248 So. 1st Ave. St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Marcus Huerta
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Male	Mexican	Single (Never married)

6. DATE OF BIRTH: October 7 (Month) (Day) 1918 (Year)

7. AGE: 1 Yrs. 2 Mos. 6 ds. IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: Gumesindo Huerta

11. BIRTHPLACE OF FATHER (State or Country): Mexico

12. MAIDEN NAME OF MOTHER: Tomasa Garcia

13. BIRTHPLACE OF MOTHER (State or Country): Mexico.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Gumesindo Huerta
(Address) POCATELLO, IDAHO

15. Filed Dec 13 1921 J. W. Young Local Registrar POCATELLO, IDAHO

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 13 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12-7 1921, to 12-13 1921
that I last saw h— alive on 12-17 1921
and that death occurred on the date stated above, at 7.A.M.
The CAUSE OF DEATH* was as follows:
Bronchial pneumonia
(Duration) ... Yrs. ... mos. 14 ds.
Contributory (Secondary)
(Duration) ... yrs. ... mos. ... ds.
(Signed) D. C. Ray M. D.
12/13 1921 (Address) POCATELLO, IDAHO

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. 11 days. In the State Life yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence Buena Vista Ida.

19. PLACE OF BURIAL OR REMOVAL: Mt View Cem. Pocatello DATE OF BURIAL: 12/14 1921

20. UNDERTAKER: H. L. McMAN ADDRESS: POCATELLO, IDAHO

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

36337

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 28
Primary Registration District No. 2161
File No. 76
Registered No. 3718

1. PLACE OF DEATH

County of Bannock

City of POCATELLO, IDAHO (No. 525 So 5th ave St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Rose Kuhn

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married

6. DATE OF BIRTH: July (Month) 3 (Day) 1861 (Year)

7. AGE: 60 Yrs. 5 Mos. 10 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: house wife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Vancouver B.C.

10. NAME OF FATHER: Moses Monick

11. BIRTHPLACE OF FATHER (State or Country): Alsac Lorraine France.

12. MAIDEN NAME OF MOTHER: Adaline Greenberg

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Daughter Mrs. A. Salmenson.
(Address) 525 So 5th ave POCATELLO, IDAHO

15. Filed Dec 13 1921

J. W. Young
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: December (Month) 13 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 7th 1921, to Dec. 13 1921 that I last saw h.. alive on Dec. 12 1921 and that death occurred on the date stated above, at 12.15 a.m. M.

The CAUSE OF DEATH* was as follows:

Diptheria

..... (Duration) ..... Yrs. ..... mos. 4 ds.

Contributory (Secondary) Shock from operation

..... (Duration) ..... yrs. ..... mos. 6 ds.

(Signed) [illegible] M. D.

12/13 1921 (Address) POCATELLO, IDAHO

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 3 yrs. ..... mos. ..... days. In the State 3 yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence Ogden. Utah.

19. PLACE OF BURIAL OR REMOVAL: Ogden Utah — DATE OF BURIAL: Dec 19 1921

20. UNDERTAKER: H. L. McHAN — ADDRESS: POCATELLO, IDAHO

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

36338

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 24
Primary Registration District No. 2141
File No. 46
Registered No. 3719

1. PLACE OF DEATH
County of Bannock
City of Pocatello
If death occurs away from usual residence, give facts called for under special information.
And St Anthony Hospital
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Carter F. Ironsen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.):

6. DATE OF BIRTH: Dec 25th 1916 (Month) (Day) (Year)

7. AGE: 4 Yrs. 11 Mos. 17 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work:
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mont

10. NAME OF FATHER: Carl F. Ironsen

11. BIRTHPLACE OF FATHER (State or Country): Minn

12. MAIDEN NAME OF MOTHER: Gertrude E. Cleveland

13. BIRTHPLACE OF MOTHER (State or Country): Wisconsin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Carl F. Ironsen
(Address) Rigby Idaho

15. Filed 12/13 1921
J. Young
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec 13 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1st 1921 to Dec 13 1921
that I last saw h.. alive on Dec 13 1921
and that death occurred on the date stated above, at 1.30 P.M.
The CAUSE OF DEATH* was as follows:

Septicaemia

..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Acute Mastoiditis
..... (Duration) ..... yrs. 1 mos. 10 ds.

(Signed) [illegible] M. D.
12/13 1921 (Address) Pocatello

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rigby Idaho
DATE OF BURIAL: Dec 15 1921
20. UNDERTAKER: [illegible]
ADDRESS: City

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36339
Registered No.

1. PLACE OF DEATH
County of Bannock
City of Pocatello
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No.
(No. Laramie Wyoming St.)

2. FULL NAME Mary Theresa Krall

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widow (Write the word)

6. DATE OF BIRTH: October 1 (Month) (Day) 1846 (Year)

7. AGE: 76 Yrs. 2 Mos. 13 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House Keeper
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: August Weidman

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Mat K Staus

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Cyril R. Krall
(Address) Idaho Falls Idaho

15. Filed December 16 1921
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: December 13 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Organic Heart disease
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) C. A. Edgerton Register M. D.
12/15 1921 (Address) Laramie Wyo.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. 2 mos. ..... days. In the State ..... yrs. 2 mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence Pocatello, Idaho

19. PLACE OF BURIAL OR REMOVAL: Mt View Cem. — DATE OF BURIAL: DEC 17 1921

20. UNDERTAKER: McHan Und. Co. — ADDRESS: Pocatello Ida.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

36340

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bannock

City of Pocatello

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 28

Primary Registration District No. 21 61

(No. General Hospital St.)

File No. 46

Registered No. 3721

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Herbert Worrell Smith

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Infant (Write the word.)

6. DATE OF BIRTH: December 11 1921 (Month) (Day) (Year)

7. AGE: — Yrs. — Mos. 4 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Pocatello Ida.

10. NAME OF FATHER: Frank N Smith

11. BIRTHPLACE OF FATHER (State or Country): Elgin Idaho

12. MAIDEN NAME OF MOTHER: Bertha Struegen

13. BIRTHPLACE OF MOTHER (State or Country): Lewiston Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Frank N Smith

(Address) 425 — 4th

15. Filed 12/15 1921

J. Mouns
Local Register

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: December 15 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 11 1921, to Dec 15 1921

that I last saw him alive on Dec 14 1921,

and that death occurred on the date stated above, at 5:30 A.M.

The CAUSE OF DEATH* was as follows:

Atelectasis Pulmonum

Blue Baby - Failure of closure of foramen ovale

(Duration) Yrs. mos. 3 ds.

Contributory (Secondary) Low weight Premature

(Duration) yrs. mos. ds.

(Signed) J. M. Kay M. D.

Dec 15 1921 (Address) Pocatello, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain View Cem — DATE OF BURIAL: Dec 15 1921

20. UNDERTAKER: Schumacher & Hall — ADDRESS: Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

36343

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bannock
City of Pocatello
(No. 1104 No Hayes St.)

Registration District No. 28
Primary Registration District No. 2161
File No. 46
Registered No. 3724

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jane B Cox

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widow (Write the word.)

6. DATE OF BIRTH: May (Month) 22 (Day) 1846 (Year)

7. AGE: 81 Yrs. 6 Mos. 27 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): England.

10. NAME OF FATHER: Edward Brattie

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Margaret Armstrong

13. BIRTHPLACE OF MOTHER (State or Country): Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) George Cox
(Address) 740 No Johnson

15. Filed 12/22 1921 — J R Young — Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: December (Month) 19 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 19 1920, to Dec 19 1921, that I last saw h.e alive on Dec 18 1921, and that death occurred on the date stated above, at 8 P M.

The CAUSE OF DEATH* was as follows:
Carcinoma of Uterus

(Duration) 1 Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) J R Young M. D.
12/22 1921 (Address) Pocatello

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain View Cem — DATE OF BURIAL: Dec 19

20. UNDERTAKER: Schumacher & Hall — ADDRESS: Pocatello

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

28 36344

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 46

Registered No. 3725

1. PLACE OF DEATH

County of Bannock

City of Pocatello

(No. 209 So 7th Ave St.)

Registration District No.

Primary Registration District No. 4161

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Evelyn M. White

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: January 13 84

(Month) (Day) (Year)

7. AGE: 78 Yrs. 11 Mos. 8 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Vermont

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Earl S White

(Address) Pocatello

15. Filed 12/22 1921

J. H. Young. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec 21 1921

(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 21 1921 to Dec 21 1921 that I last saw her alive on Dec 21 1921 and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) Yrs. mos. 6 hrs ds.

Contributory (Secondary) old age

(Duration) yrs. mos. ds.

(Signed) Carl W. Clark M. D.

Dec 21 1921 (Address) Pocatello Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Pocatello

DATE OF BURIAL: 12/24 1921

20. UNDERTAKER: W. B. Packer

ADDRESS: Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

36345

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 46

Registered No. 3726

1. PLACE OF DEATH

County of Bannock

City of Pocatello

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 28

Primary Registration District No. 21 & 1

(No. 1444 No Arthur St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mrs Mary Larsen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6. DATE OF BIRTH: Dec 25 1887 (Month) (Day) (Year)

7. AGE: 35 Yrs. 11 Mos. 28 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Marion D Patton

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: /

13. BIRTHPLACE OF MOTHER (State or Country): /

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Larsen

(Address) Blaine Ida

15. Filed 12/23 1921

J. H. Young
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec 23 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 25 1921 to Dec 23rd 1921 that I last saw her alive on Dec 23rd 1921 and that death occurred on the date stated above, at 10.30 A.M.

The CAUSE OF DEATH* was as follows:

Insanition

(Duration) Yrs. 3 mos. ..... ds.

Contributory (Secondary) none

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Arthur M. D.

Dec 23 1921 (Address) Pocatello Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mt View Cemetery

DATE OF BURIAL: 12/27 1921

20. UNDERTAKER: W. V. Wacker

ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

36347

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 28

County of Bannock

Primary Registration District No. 2162

File No. 46

City of POCATELLO, IDAHO

(No. Pocatello Gen. Hospital)

Registered No. 3728

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Walter Thomas Kane

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write word): Single

6. DATE OF BIRTH: May 26 1903
(Month) (Day) (Year)

7. AGE: 21 Yrs. 8 Mos. 26 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Student

(b) General nature of industry, business or establishment in which employed (or employer): and farm labores

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Thomas Kane.

11. BIRTHPLACE OF FATHER (State or Country): Michigan

12. MAIDEN NAME OF MOTHER: Mary Ramey.

13. BIRTHPLACE OF MOTHER (State or Country): Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Thomas Kane

(Address) Salmon City, Idaho.

15. Filed Dec 24 1921

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: December 24 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 27 1921, to Dec 24 1921, that I last saw h.. alive on Dec 23 1921, and that death occurred on the date stated above, at 7 a. M.

The CAUSE OF DEATH* was as follows:

Acut pancreatitis

(Duration) ..... Yrs. ..... mos. 27 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Thos F. Rhem M. D.

12/24 1921 (Address) POCATELLO, IDAHO

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. 1 mos. ..... days. In the State Life yrs. mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence Salmon City, Idaho

19. PLACE OF BURIAL OR REMOVAL: Salmon City, Idaho

DATE OF BURIAL: 12.26 1921

20. UNDERTAKER: H. L. McHAN

ADDRESS: POCATELLO, IDAHO

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

36348

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 28
Primary Registration District No. 2-161
File No. 46
Registered No. 3729

1. PLACE OF DEATH
County of Bannock
City of Pocatello
(No. Lynn Hospital St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Wilson
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married
6. DATE OF BIRTH: Exact Date Unknown (Month) (Day) 1876 (Year)
7. AGE: 45 Yrs. Mos. ds. — IF LESS than 1 day: ... hrs. or ... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Idaho
10. NAME OF FATHER: Oley Hansen
11. BIRTHPLACE OF FATHER (State or Country): Norway
12. MAIDEN NAME OF MOTHER: Marley
13. BIRTHPLACE OF MOTHER (State or Country): Cal—
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) James Wilson
(Address) 888 Washington ave
15. Filed 12/28 1921
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 27 (Day) 1921 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Dec 17th 1921, to Dec 27 1921
that I last saw her alive on Dec 27th 1921
and that death occurred on the date stated above, at 5:30 P.M.
The CAUSE OF DEATH* was as follows:
pus tubes removal
(Duration) ... Yrs. ... mos. ... ds.
Contributory (Secondary) post-operative pneum
(Duration) ... yrs. ... mos. ... ds.
(Signed) ... M. D.
Dec 28 1921 (Address) Pocatello

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain View — DATE OF BURIAL: Dec 29 1921
20. UNDERTAKER: Dehnunch & Hall — ADDRESS: Pocatello Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

36349

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 28 21 61 — File No. 46

Primary Registration District No. — Registered No. 3730

1. **PLACE OF DEATH**

County of Bannock

City of Pocatello (No. 1 Fr Tuchaway Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. **FULL NAME** Thomas Ryan

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. **SEX** Male

4. **COLOR OR RACE** white

5. **SINGLE, MARRIED, WIDOWED OR DIVORCED** (Write the word.) Single

6. **DATE OF BIRTH** Exact date unknown 1833
(Month) (Day) (Year)

7. **AGE** 88 Yrs. Mos. ds. — IF LESS than 1 day how many hrs. or min.

8. **OCCUPATION**
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business or establishment in which employed (or employer): Railroad Employee

9. **BIRTHPLACE** (State or Country) Ireland

10. **NAME OF FATHER** Ryan

11. **BIRTHPLACE OF FATHER** (State or Country) Ireland

12. **MAIDEN NAME OF MOTHER** Unknown

13. **BIRTHPLACE OF MOTHER** (State or Country) Unknown

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**
(Informant) P. H. Keenan
(Address) Pocatello Ida

15. Filed 12/29 19 21 — J. W. Young, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH** Dec. 29 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 1921, to dec. 29 1921, that I last saw h[im] alive on dec 28 1921, and that death occurred on the date stated above, at 10 M.

The CAUSE OF DEATH* was as follows:
Valvular disease
arteriosclerosis

(Duration) Yrs. 6 mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) O. O. Magee M. D.

dec 30 21 (Address) Pocatello Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. **PLACE OF BURIAL OR REMOVAL** Mountain View — **DATE OF BURIAL** Dec 31 1921

20. **UNDERTAKER** Schumacher Bros — **ADDRESS** City

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH 36350

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 28

Primary Registration District No. 2161

File No. 46

County of Bannock

City of Pocatello (No. ~~Da~~ Anaconda Mont St.)

Registered No. 3731

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Robert F. Rinkel

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Feb. (Month) 8 (Day) 1905 (Year)

7. AGE: 16 Yrs. 10 Mos. 20 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Student

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Anaconda

10. NAME OF FATHER: Howard Mendenhall

11. BIRTHPLACE OF FATHER (State or Country): Penn.

12. MAIDEN NAME OF MOTHER: Lizzie Johnson

13. BIRTHPLACE OF MOTHER (State or Country): Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Fred R. Howard.

(Address) 225 So 4 Ave.

15. Filed Dec 31 1921 J. R. Young Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 28 (Day) 19 21 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....

that I last saw h..... alive on ..... 19.....

and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) M. W. Freeman M. D.

12 24 1921 (Address) Des Lodge Mont

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence Anaconda Mont

19. PLACE OF BURIAL OR REMOVAL: Pocatello Mt View Cem. DATE OF BURIAL: Jan 1 1922

20. UNDERTAKER: McTavish Undertaking Co. ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 6[illegible] M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 2170
File No. 36351
Registered No. 137

RECEIVED
JAN 10 1922
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Bannock
City of Mecan (St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Adelbert F Lott
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: May 22 1860 (Month) (Day) (Year)

7. AGE: 61 Yrs. 6 Mos. 28 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farming
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: John Lott

11. BIRTHPLACE OF FATHER (State or Country): U.S.

12. MAIDEN NAME OF MOTHER: Clarissy Roffey

13. BIRTHPLACE OF MOTHER (State or Country): U.S.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Lena Covington
(Address) Mecan, Ida

15. Filed 1/4 1922 C Thomas Local Registrar
Dr Ford

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec 20 1921 (Month) (Day) (Year)
~~Nov 30~~

17. I HEREBY CERTIFY, That I attended deceased from Nov 30 1921, to Dec 20 1921, that I last saw h~~im~~ alive on Dec 19 19..., and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia (Uncomplicated)

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Jabez Nash M. D.
Dec 21 1921 (Address) Pocatello

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mecan, Ida. DATE OF BURIAL: 12/23 1921

20. UNDERTAKER: E Edmundson ADDRESS: Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
JAN 10 1922
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 73
Primary Registration District No. 21V-0
File No. 36352
Registered No. 136

County of Bannock
City of Ida Falls (If outside limits, give township.) St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Glenn Strahle

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Nov (Month) 4 (Day) 1909 (Year)

7. AGE: 12 Yrs. 0 Mos. 12 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Byron Strahle

11. BIRTHPLACE OF FATHER (State or Country): ?

12. MAIDEN NAME OF MOTHER: Eliza Holden

13. BIRTHPLACE OF MOTHER (State or Country): ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Byron Strahle
(Address) Ida Falls

15. Filed 1/24 1922 C. E. Jennard Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 16 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 12, 1921 to Nov. 16 1921 that I last saw h[illegible] alive on Nov. 16, 1921 and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Suppuration appendicitis.

(Duration) ..... Yrs. ..... mos. 6 ds.

Contributory (Secondary) General peritonitis

(Duration) ..... yrs. ..... mos. 2 ds.

(Signed) John O. Mellor M. D.

11/18 1921 (Address) Ida Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Idaho Falls, Ida — DATE OF BURIAL: 11/18 1921

20. UNDERTAKER: C. E. Dunwoody — ADDRESS: Ida Falls

Dr Mellon

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JAN 10 1922 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 21V-0
File No. 36353
Registered No. 13V-

1. PLACE OF DEATH
County of Bannock
City of Ida Falls (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Parke Telford
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Infant

6. DATE OF BIRTH: April 4 (Month) (Day) 1920 (Year)

7. AGE: 1 Yrs. 7 Mos. 27 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work \
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Idaho Falls

10. NAME OF FATHER J. L. Telford

11. BIRTHPLACE OF FATHER (State or Country) Ut

12. MAIDEN NAME OF MOTHER LaVina Parke

13. BIRTHPLACE OF MOTHER (State or Country) Ut

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. L. Telford
(Address) City

15. Filed 1/14 19 22 W. H. Townsend Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec 1 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 26, 1921, to Nov 26 1921, that I last saw him alive on Nov 26 1921, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Probably Pneumonia. He died very Suddenly unattended
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Chronic enteritis.
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. Ross Hatch M. D.
19..... (Address) Idaho Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Idaho Falls	1/3 19 22
20. UNDERTAKER	ADDRESS
C. E. Summerday	Ida Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

DeHatch

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36354
Registered No. 134

RECEIVED JAN 10 1922 BUREAU OF VITAL STATISTICS

Registration District No. 73
Primary Registration District No. 2 1 N-0

1. PLACE OF DEATH
County of Bonneville
City of Ida Falls (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Raymond McPoulter
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Oct (Month) 5 (Day) 1899 (Year)

7. AGE: 22 Yrs. 1 Mos. 28 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farming
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ogden - Utah

10. NAME OF FATHER: Frank Poulter

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Mary McGill

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Frank Poulter
(Address) City

15. Filed 1/4 1922 W. Freeman Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. (Month) 3 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1 1921, to Dec 3 1921, that I last saw h.im alive on Dec 3 1921, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Diabetes mellitus

(Duration) ..... Yrs. ..... mos. 15 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. Ray Hatch M. D.
19..... (Address) Idaho Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Idaho Falls Ida — DATE OF BURIAL: 12/6 1921

20. UNDERTAKER: C. C. Dunwoody — ADDRESS: Ida Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

H. Hatch

FORM V. S. No. 5-25 M. 1-19

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 2140
File No. 36357
Registered No. 131

1. PLACE OF DEATH
County of Bannock
City of Idaho Falls (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Martha Freeman
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH: June (Month) 20 (Day) 1843 (Year)

7. AGE: 78 Yrs. 6 Mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: at Home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ill

10. NAME OF FATHER: James Hale

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Lucy Clemmens

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs J. E. Canfield
(Address) Menan Ida

15. Filed 1/4 19 22 W. Freeman Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 28 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at 6 P.M.
The CAUSE OF DEATH* was as follows:
Uremia -
No medical attendance
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) ..... M. D.
1/4 19 22 (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Idaho Falls Ida
DATE OF BURIAL: 12/29 1921

20. UNDERTAKER: C. E. Linwood
ADDRESS: Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36358

Registered No. 130

1. PLACE OF DEATH

County of Bonneville

City of Idaho Falls

Registration District No. 73

Primary Registration District No. 21V-0

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mabel Janett Bundte

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: May (Month) 29 (Day) 1914 (Year)

7. AGE: 7 Yrs. 6 Mos. 26 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho Falls

10. NAME OF FATHER: Charles Bundte

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Mary Robs

13. BIRTHPLACE OF MOTHER (State or Country): Switz.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Charles Bundte

(Address) City

15. Filed 1/4 1922 C. E. Kinnard Local Registrar

SUMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

D. E. Kinnard

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 25 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 14 1921, to Dec 25 1921 that I last saw her alive on Dec 16 1921 and that death occurred on the date stated above, at 19 M.

The CAUSE OF DEATH* was as follows:

Diphtheria

(Duration) ..... Yrs. ..... mos. 10 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. E. Kinnard M. D.

1/4 1922 (Address) Idaho Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Idaho Falls Ida — DATE OF BURIAL: 1/26 1922

20. UNDERTAKER: C. E. Dunwoody — ADDRESS: Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bonneville

City of Idaho Falls

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 73

Primary Registration District No. 21V-0

(No. Union St.)

File No. 16359

Registered No. 129

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Kenneth Kendrick

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Jan (Month) 2 (Day) 1921 (Year)

7. AGE: Yrs. 10 Mos. 2 4 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Idaho Falls

10. NAME OF FATHER: Geo Kendrick

11. BIRTHPLACE OF FATHER (State or Country): Va.

12. MAIDEN NAME OF MOTHER: Mandy Stotts

13. BIRTHPLACE OF MOTHER (State or Country): Kan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Geo Kendrick

(Address) Union Ida.

15. Filed 1/4 1922 W. Simmons Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 25 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 10-20- 1921, to 10-25- 1921

that I last saw h..... alive on ..... 19.....,

and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

[redacted] Hemorrhage

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. C. Hollister, M. D.

19..... (Address) Idaho Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence Unknown

19. PLACE OF BURIAL OR REMOVAL: Union Idaho

DATE OF BURIAL: Oct 26 1921

20. UNDERTAKER: Cliff Hayes

ADDRESS: Idaho Falls

Dr. Hollister

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JAN 1 1922 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bonneville Registration District No. 73

City of Idaho Falls (No. 444 Jonas St.) Primary Registration District No. 21 W-0

File No. 36360

Registered No. 122

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Infant Parkinson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Dec 13, 1921 (Month) (Day) (Year)

7. AGE: ....Yrs. ....Mos. 8 ds.

IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Neo.

(b) General nature of industry, business or establishment in which employed (or employer): /

9. BIRTHPLACE (State or Country): Idaho Falls Ida

10. NAME OF FATHER: Walter Parkinson

11. BIRTHPLACE OF FATHER (State or Country): Nebr.

12. MAIDEN NAME OF MOTHER: Ada Monie

13. BIRTHPLACE OF MOTHER (State or Country): Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Walter Parkinson

(Address) Idaho Falls Ida.

15. Filed 1/4 19 22 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec 22, 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 16 - 1921, to Dec 22 - 1921, that I last saw h.... alive on .... 19...., and that death occurred on the date stated above, at .... M.

The CAUSE OF DEATH* was as follows:

Premature Infant

.... (Duration) .... Yrs. .... mos. .... ds.

Contributory (Secondary)

.... (Duration) .... yrs. .... mos. .... ds.

(Signed) J. C. Hollister M. D.

19.... (Address) Idaho Falls Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .... yrs. .... mos. .... days. In the State .... yrs. .... mos. .... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rose Idaho Falls Ida | DATE OF BURIAL: Dec 24 19 21

20. UNDERTAKER: Cliff Haines Idaho | ADDRESS: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JAN 10 1922 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 21V-0

File No. 36361
Registered No. 127

1. PLACE OF DEATH

County of Bonneville

City of Idaho Falls (No. 620 Iowa St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Marcus G. Brainard

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widower

6. DATE OF BIRTH: Nov. (Month) 13 (Day) 1831 (Year)

7. AGE: 90 Yrs. 1 Mos. 12 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio.

10. NAME OF FATHER: Datus A Brainard.

11. BIRTHPLACE OF FATHER (State or Country): N. Y.

12. MAIDEN NAME OF MOTHER: Fay.

13. BIRTHPLACE OF MOTHER (State or Country): Dont know.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C A Brainard

(Address) Idaho Falls

15. Filed 1/4 1922 Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. (Month) 29 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....

that I last saw h..... alive on ..... 19.....

and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Uremia - No medical assistance

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Consumed - Registered M. D.

1/4 1922 (Address) Idaho Falls Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rose Hill Cem. Idaho Falls

DATE OF BURIAL: Jan 1 1922

20. UNDERTAKER: Cliff C Hayes

ADDRESS: Idaho Falls

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED JAN 10 1922 BUREAU OF VITAL STATISTICS

Registration District No. 73
Primary Registration District No. 2 1 V-0
File No. 36362
Registered No. 126

1. PLACE OF DEATH
County of Bonneville
City of Idaho Falls (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Orlando E Vaun

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widower

6. DATE OF BIRTH: ..... (Month) 1 (Day) 94 (Year)

7. AGE: 67 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher.
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Mo.

10. NAME OF FATHER: Wm Vaun

11. BIRTHPLACE OF FATHER (State or Country): mo.

12. MAIDEN NAME OF MOTHER: Janis Moore

13. BIRTHPLACE OF MOTHER (State or Country): Germany.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Orlando Martin Vaun
(Address) Idaho Falls Ida.

15. Filed 1/14 1922 W Durand Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: November 15 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 3 1921 to Nov. 12 1921 that I last saw him alive on Nov 12 1921, and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Cancer of Stomach

(Duration) 3 Yrs. ..... mos. ..... ds.

Contributory (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Jabez West M. D.
1/31 1921 (Address) Idaho Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rose Hill Cemetery — DATE OF BURIAL: Nov. 19 1921

20. UNDERTAKER: Cliff Hayne — ADDRESS: Idaho Falls Ida

Dr West.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bonneville — Registration District No. 73

City of Idaho Falls (Not in Co. 19 + Boyce St.) — Primary Registration District No. 21V-0

File No. 36363

Registered No. 12V—

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Albert W. Thiel

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: May (Month) 9 (Day) 1[illegible] (Year)

7. AGE: 6 Yrs. ... Mos. ... ds. IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: No.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ryby Ida.

10. NAME OF FATHER: Albert Thiel

11. BIRTHPLACE OF FATHER (State or Country): England.

12. MAIDEN NAME OF MOTHER: Florence Andrews.

13. BIRTHPLACE OF MOTHER (State or Country): Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Albert Thiel
(Address) Idaho Falls Ida.

15. Filed 1/4 1922 W. Townsend Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 28 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 26 1921, to Nov 28 1921 that I last saw him alive on Nov 27 1921 and that death occurred on the date stated above, at ... M.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

abortive [illegible]

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) John W Nisbet M. D.

12/31/1921 (Address) Idaho Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Grant Cem. DATE OF BURIAL: Nov. 30 1921

20. UNDERTAKER: Cliff Hamm ADDRESS: Idaho Falls Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

for West

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 73

Primary Registration District No. 21 V-0

File No. 36364

Registered No. 124

County of Bonneville

City of Idaho Falls (No. Spencer Hosp. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Gertrude Marshall

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Sept (Month) 10 (Day) 1921 (Year)

7. AGE: Yrs. 3 Mos. ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: ✓
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho Falls

10. NAME OF FATHER: Mike Marshall

11. BIRTHPLACE OF FATHER (State or Country): Michigan

12. MAIDEN NAME OF MOTHER: Gertie Lunsburg

13. BIRTHPLACE OF MOTHER (State or Country): Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mike Marshall
(Address) Idaho Falls Ida

15. Filed 1/4 1922 (Signature) Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: NOV (Month) 21 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 10 1921, to NOV 21 1921, that I last saw h[illegible] alive on NOV 21 1921, and that death occurred on the date stated above, at 3:30 P.M.

The CAUSE OF DEATH* was as follows:

Tuberculosis

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) [signature] M. D.

Jan 3 1922 (Address) Ida Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rose Hill Cemetery — DATE OF BURIAL: Nov 22 1921

20. UNDERTAKER: Cliff C Hayes — ADDRESS: Idaho Falls Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 21V-0
File No. 36365
Registered No. 123

1. **PLACE OF DEATH**
County of Bonneville
City of Idaho Falls
(No. Spencer Hosp. St.)

If death occurs away from usual residence, give facts called for under special information.

2. **FULL NAME** Naman Cazer

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. **SEX** Male
4. **COLOR OR RACE** White
5. **SINGLE, MARRIED, WIDOWED OR DIVORCED** (Write the word.) Single

6. **DATE OF BIRTH** Sept. 6, 1915 (Month) (Day) (Year)

7. **AGE** 6 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. **OCCUPATION**
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. **BIRTHPLACE** (State or Country) Idaho Falls

10. **NAME OF FATHER** Naman Cazer

11. **BIRTHPLACE OF FATHER** (State or Country) Ohio

12. **MAIDEN NAME OF MOTHER** Margaret O'Hara

13. **BIRTHPLACE OF MOTHER** (State or Country) Colorado

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**
(Informant) Naman Cazer
(Address) Idaho Falls Ida

15. Filed 1/4 1922 (Signature) Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH** Nov. 27 1921 (Month) (Day) (Year)

17. **I HEREBY CERTIFY, That I attended deceased from** Nov. 26 1921, to Nov 27 1921 **that I last saw h.. alive on** Nov 27 1921, **and that death occurred on the date stated above, at** 3 9 M.
The CAUSE OF DEATH* was as follows:

Hemorrhage

(Duration) Yrs. mos. 3 ds.
Contributory (Secondary) Meningitis
(Duration) yrs. mos. 1 ds.

(Signed) H D Spencer M. D.
Jan 7 1922 (Address) Ida Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. **LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)**
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. **PLACE OF BURIAL OR REMOVAL** Rose Hill Cemetery | **DATE OF BURIAL** Nov. 30 1921

20. **UNDERTAKER** Cliff Hayes | **ADDRESS** Idaho Falls Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JAN 11 1922 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH 13

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 21
Primary Registration District No. 21-0
File No. 36366
Registered No. 122

1. PLACE OF DEATH
County of Bonneville
City of Idaho Falls
(No. Beecher Hosp., St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Dora Leota Bray.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Oct 1 (Month) (Day) 21 (Year)

7. AGE: 8 days (Yrs. Mos. ds.)
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho Falls

10. NAME OF FATHER: Geo E Bray.

11. BIRTHPLACE OF FATHER (State or Country): Ill

12. MAIDEN NAME OF MOTHER: Dora L. Candle

13. BIRTHPLACE OF MOTHER (State or Country): Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Geo. E. Bray.
(Address) Idaho Falls R. 3. B. 6

15. Filed 1/4 1922 W. Fenwick Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct 7st (Month) (Day) 21 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 7 1921, to Oct 7 1921, that I last saw h[illegible] alive on Oct 7 1921, and that death occurred on the date stated above, at 1 P M.
The CAUSE OF DEATH* was as follows:

Premature Birth

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) H. D. Snow M. D.

Jan 3 1922 (Address) H. D. Snow

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Idaho Falls Ida. DATE OF BURIAL: Oct 10 1921

20. UNDERTAKER: Cliff Rogers ADDRESS: Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

BYRNS-YORK CO., PRINTERS & BINDERS, BOISE 51088

Mr. Powers

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JAN 10 1922 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36368
Registered No. 120

1. PLACE OF DEATH
County of Bonneville Registration District No. 73
City of Idaho Falls Ida (If outside city limits, Primary Registration District No. 42 V-0
write Rural and name Precinct. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Scott Gibson.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Sept. 21 (Month) (Day) 1900 (Year)

7. AGE: 21 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer,
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kansas

10. NAME OF FATHER: Louis W. Gibson

11. BIRTHPLACE OF FATHER (State or Country): Ill.

12. MAIDEN NAME OF MOTHER: Mary E. Spain.

13. BIRTHPLACE OF MOTHER (State or Country): Iowa,

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Louis W. Gibson
(Address) 367 Sherman ave, Salt Lake, Utah

15. Filed 1/4 19 22 [illegible] Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 31 (Day) 19 21 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Accident in saw mill. Dead
from Hemorrhage on way to hospital
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) J. H. Spencer M. D.
Jan 3 1922 (Address) Idaho Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Salt Lake Utah | DATE OF BURIAL: July 19 21

20. UNDERTAKER: Jeff Hayes | ADDRESS: Idaho Falls

Dr. Spencer

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 73

County of Bonneville

Primary Registration District No. 21-6

City of Idaho Falls (No. 258 Lava St.)

File No. 36370

Registered No. 11

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jno a alcorn

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

RECEIVED JAN 1924 BUREAU OF STATISTICS

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	married

6. DATE OF BIRTH. Dec (Month) 31 (Day) 1853 (Year)

7. AGE 68 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Butcher
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Penn

10. NAME OF FATHER James alcorn

11. BIRTHPLACE OF FATHER (State or Country) Penn

12. MAIDEN NAME OF MOTHER Thea Fee

13. BIRTHPLACE OF MOTHER (State or Country) Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Henrietta alcorn
(Address) Idaho Falls

15. Filed Jan 4 1922 W Tennant Local Registrar
per Jamison

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 10 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 6 1921 to Jan 10 1921 that I last saw h living on Jan 10 1921 and that death occured on the date stated above, at 5P. M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 2 Yrs. mos. ds.

Contributory (Secondary) Hemiplegia - Nephritis

(Duration) 2 yrs. mos. ds.

(Signed) H. [illegible] M. D.

1/15 1921 (Address) Idaho Falls Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Rose Hill Idaho Falls	1/13 1921

20. UNDERTAKER	ADDRESS
Cliff Hayes	Idaho Falls.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

BYRNE - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bonneville — Registration District No. 73

City of Idaho Falls — Primary Registration District No. 21-9

(No. Yards & Idaho Falls St.)

File No. 36371

Registered No. 117

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs. Emma W Goldman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: May 9 1871 (Month) (Day) (Year)

7. AGE: 44 Yrs. 8 Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Home wife

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ill

10. NAME OF FATHER: Henry Gumaud

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Josephine Eigh

13. BIRTHPLACE OF MOTHER (State or Country): Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Goldman

(Address) Idaho Falls

15. Filed 1/4 1922 — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: November 6 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 6 1921, to Nov 6 1921 that I last saw h.. alive on Nov 7 1921 and that death occurred on the date stated above, at 6 M.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(Duration) ? Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Emma Goldman M. D.

1/4 1922 (Address) Idaho Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rose Hill Idaho Falls — DATE OF BURIAL, 1922

20. UNDERTAKER: Cliff Hayes — ADDRESS: Idaho Falls

Dr Kinnaird

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36372
Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Bear Lake
City of St Charles Ida
(No. ..... St.)

Registration District No. .....
Primary Registration District No. 55-

RECEIVED
JAN 10 1922
BUREAU OF VITAL STATISTICS

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Carl Conrad Anderson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH. July (Month) 11 (Day) 1896 (Year)
7. AGE: 25 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): Halmstad Sweden
10. NAME OF FATHER: Christian Anderson
11. BIRTHPLACE OF FATHER (State or Country): Berbe Sweden
12. MAIDEN NAME OF MOTHER: Johannah Severena Person
13. BIRTHPLACE OF MOTHER (State or Country): Sweden
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Bert Bunderson
(Address) St Charles Id.
15. Filed Dec 26 1921 John Mattson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 24 (Day) 1921 (Year)
17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
St Charles Amusement Hall
fell on him killing him
instantaly. Dec 24 21 7 PM
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) ..... M. D.
19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: St Charles Id. DATE OF BURIAL: Dec 26 1921
20. UNDERTAKER ..... ADDRESS .....

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24854

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36373

Registered No. 51

Registration District No. 13

Primary Registration District No. 2079

1. PLACE OF DEATH

County of Fremont

City of St Maries (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED JAN 1 1922 BUREAU OF VITAL STATISTICS

2. FULL NAME Fisher A. Sawyer

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Widowed

6. DATE OF BIRTH

..... (Month) ..... (Day) 1 (Year)

7. AGE

About 57 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE

(State or Country) .....

10. NAME OF FATHER .....

11. BIRTHPLACE OF FATHER

(State or Country) .....

12. MAIDEN NAME OF MOTHER .....

13. BIRTHPLACE OF MOTHER

(State or Country) .....

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C.A. Robbins

(Address) St. Maries, Ida

15. Filed Dec. 31 1921 H.E. Hasel Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51083

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

December (Month) 31st (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 22 1921 to Dec 31 1921 that I last saw him alive on Dec 31 1921, and that death occurred on the date stated above, at 7:15 A.M.

The CAUSE OF DEATH* was as follows: Purulent Leptomeningitis "Traumatic".

(Duration) ..... Yrs. ..... mos. 12 ds.

Contributory (Secondary) Head injury (when thrown from horse)

(Duration) ..... yrs. ..... mos. 12 ds.

(Signed) C.A. Robbins M. D.

12/31 1921 (Address) St. Maries, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. 12 days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? Near Emida, Ida

Former or usual residence Emida, Idaho.

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Not Buried	1- 2 1922

20. UNDERTAKER	ADDRESS
[illegible] & Co	St Maries

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36374

Registered No. 50

RECEIVED JAN 1922 BUREAU OF STATISTICS

1. PLACE OF DEATH

Registration District No. 32

Primary Registration District No. 2049

County of Benewah

City of St Maries (or) ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Richard L Cardwell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.)
Male	White	Widowed

6. DATE OF BIRTH: Aug. (Month) 5 (Day) 1851 (Year)

7. AGE: 70 Yrs. 4 Mos. 21 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Tenn.

10. NAME OF FATHER Richard Cardwell

11. BIRTHPLACE OF FATHER (State or Country) Tenn.

12. MAIDEN NAME OF MOTHER Sally Acuff.

13. BIRTHPLACE OF MOTHER (State or Country) Tenn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mary V. Cardwell
(Address) St Maries Idaho

15. Filed Dec. 26 1921 A E Brown Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. (Month) 26 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 26 1921, to Dec 26 1921, that I last saw him alive on Dec 26 1921, and that death occurred on the date stated above, at 6 15 A M.

The CAUSE OF DEATH* was as follows:

Myocarditis

..... (Duration) Unknown mos. ..... ds.

Contributory (Secondary) Chronic Bronchitis Pleurisy

2 months (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C A Cabins M. D.

12/26/1921 (Address) St. Maries, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? Unknown

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Sandy Creek.	Dec 28 1921
20. UNDERTAKER	**ADDRESS**
A E Brown Co	St Maries

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Benewah

City of St Maries Ida (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 0 2 7

Primary Registration District No. 2049

File No. 36375

Registered No. 41

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Richard Charles Rodgers

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	white	single

6. DATE OF BIRTH: Oct (Month) 18 (Day) 1901 (Year)

7. AGE: 20 Yrs. 2 Mos. 3 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: student

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Washington

10. NAME OF FATHER: Charles E. Rodgers

11. BIRTHPLACE OF FATHER (State or Country): Tipton, Iowa

12. MAIDEN NAME OF MOTHER: Ellen J. Scott

13. BIRTHPLACE OF MOTHER (State or Country): Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) P. E. Rodgers

(Address) Waverly - Wash

15. Filed Dec 21 1921 — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 21 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 17 1921 to Dec 21 1921 that I last saw him alive on Dec 21 1921, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Hyperthyroidism

(Duration) ..... Yrs. 4 mos. ..... ds.

Contributory (Secondary) —

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C B Smith M. D.

Dec 1921 (Address) St Maries Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Rockford Cemetery Waverly Wash	on arrival

20. UNDERTAKER shipping — ADDRESS St Maries Ida

Whitehead & Menge

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36376

Registered No. 47

1. PLACE OF DEATH

County of Benewah. Registration District No. 32

City of St Maries Ida. (If outside limits of city or village, give township.) Primary Registration District No. 2049

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Rosina Streit

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

RECEIVED JAN 19 1922 BUREAU OF VITAL STATISTICS

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
female	white	married

6. DATE OF BIRTH: July (Month) 8 (Day) 1860 (Year)

7. AGE: 61 Yrs. 5 Mos. 12 ds. IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: house wife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Switzerland

10. NAME OF FATHER: not known

11. BIRTHPLACE OF FATHER (State or Country): Switzerland

12. MAIDEN NAME OF MOTHER: not known

13. BIRTHPLACE OF MOTHER (State or Country): Switzerland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mary Sergent
(Address) St Maries Ida

15. Filed Dec. 22 1921 — H E Hunt, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 20 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 20 1921, to Dec 20 1921, that I last saw her alive on Dec 20 1921, and that death occurred on the date stated above, at 9-30 A.M.

The CAUSE OF DEATH* was as follows:

Cardiac failure and Coma.

(Duration) 3 Yrs. ... mos. ... ds.

Contributory (Secondary): Failure of Heart

(Duration) 10 yrs. ... mos. ... ds.

(Signed) O. D. Platt M. D.

Dec 20 1921 (Address) St Maries, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs ... mos ... days. In the State ... yrs ... mos ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Woodlawn	12-22 1921

20. UNDERTAKER	ADDRESS
Mitchell & Murphy	St Maries Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED JAN 10 1922 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Benewah Registration District No. 82

City of St Maries Primary Registration District No. 3049

No. ..... St.)

File No. 36377

Registered No. 47

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Rose Anna Iller

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): married

6. DATE OF BIRTH: Sept. (Month) 30 (Day) 1864 (Year)

7. AGE: 37 Yrs. 2 Mos. 7 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Wendle Studer

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Caroline Seigerst

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Alfred Iller

(Address) St Maries Ida

15. Filed 12-12 1921

H E Trent
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 12 (Month) 7 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 3 1921 to Dec 7 1921 that I last saw her alive on Dec 7 1921, and that death occurred on the date stated above, at 9 P.M.

The CAUSE OF DEATH* was as follows: Chronic Pneumonia

(Duration) ..... Yrs. ..... mos. 30 ds.

Contributory (Secondary) Pregnancy

(Duration) ..... yrs. 9 mos. ..... ds.

(Signed) Owen D. Platt M. D.

Dec 12 1921 (Address) St Maries Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Woodlawn Cem. DATE OF BURIAL: 12-12 1921

20. UNDERTAKER: Mitchell Mercogen ADDRESS: St Maries

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

36379

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 31

Primary Registration District No.

(No. ....., ... St.)

File No. 1

Registered No. 45

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Desmet

City of Benewah

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Samuel Ohler

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1860 (Year)

7. AGE: 61 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Farmer

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): Washington

10. NAME OF FATHER: Not known

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) .....

15. Filed Dec 17 1921

J. E. Belcan
Local Registrar

SYMS - YORK CO., PTRS. & STNRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. 16 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,

that I last saw h.....alive on ..... 191...,

and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Chronic Enteritis

.....(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

.....(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Dr Barbeau M. D.

19..... (Address) Desmet Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Jehova, Wash — DATE OF BURIAL: Dec 19 1921

20. UNDERTAKER: C. Thulen — ADDRESS: Jehova

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED JAN 10 1922 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH. 36380

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 116

County of Bingham

Primary Registration District No. 2195

City of Aberdeen (No. ..... St.)

File No. 4

Registered No. 63

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Winfield Scott Marvel

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. Oct 24 1880 (Month) (Day) (Year)

7. AGE: 41 Yrs. 1 Mos. 12 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: George Marvel

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: Sarah Mann

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lucille Marvel

(Address) Aberdeen Ida

15. Filed Dec 9 191 21 M. Cunningham Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 6 (Day) 191 21 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 29 191 21, to Dec 6 191 21, that I last saw him alive on Dec 6 191 21, and that death occured on the date stated above, at 11:45 P.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ..... Yrs. ..... mos. 7 ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) M. C. McKinnon M. D.

Dec 9 19 21 (Address) Aberdeen Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: I.O.O.F. Cemetery Aberdeen Ida — DATE OF BURIAL: Dec 10 191 21

20. UNDERTAKER: Friends — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

EVANS - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36382
Registered No.

1. PLACE OF DEATH
County of Bonner — Registration District No. 78
City of Sand Point — Primary Registration District No. 2155
(No. On Ranch Sand Point, Rd St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Steven McCrea
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Male	White	Widowed

6. DATE OF BIRTH — May (Month) 27 (Day) 1844 (Year)

7. AGE — 79 Yrs. ... Mos. ... ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Carpenter
(b) General nature of industry, business or establishment in which employed (or employer): Retired

9. BIRTHPLACE (State or Country): Canada

10. NAME OF FATHER: Steven McCrea

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Elizabeth Johnson

13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jessie Lovejoy
(Address) Sand Point, Ida.

15. Filed Jan 6 1922 — Floyd Wendle, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH — Dec (Month) 26 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12-26 1921 to 12-25 1921
that I last saw him alive on 12-25 1921
and that death occurred on the date stated above, at 4:30 P.M.
The CAUSE OF DEATH* was as follows:
Chronic Catarrhal Pneumonia
& Senility.
(Duration) Many Years. Yrs. ... mos. ... ds.
Contributory (Secondary)
(Duration) ... yrs. ... mos. ... ds.
(Signed) E. J. Anderson M. D.
Dec 30, 1921. (Address) Sand Point, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Sand Point, Ida	Dec 28, 1921.

20. UNDERTAKER	ADDRESS
J. H. Pugh	Sand Point

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JAN 10 1922 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36383

Registered No.

1. PLACE OF DEATH

Registration District No. 78

Primary Registration District No. 2155

County of Bonner

City of Sandpoint (No. City Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Thos. Kelly.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Unknown (Write the word.)

6. DATE OF BIRTH: Unknown (Month) 1 (Day) (Year)

7. AGE: ....Yrs....Mos....ds.

IF LESS than 1 day how many....hrs. or....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Woodsman

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Unknown

10. NAME OF FATHER: "

11. BIRTHPLACE OF FATHER (State or Country): "

12. MAIDEN NAME OF MOTHER: "

13. BIRTHPLACE OF MOTHER (State or Country): "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) City Hospital

(Address) Sandpoint, Ida.

15. Filed Jan 6 1922 Floyd Weadle Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. (Month) 6 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1921, to Dec-6 1921, that last saw h.im alive on Dec-5 1921, and that death occurred on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis & Valvular heart disease

(Duration) 2 Yrs. mos. ds.

Contributory (Secondary) /

(Duration) yrs. mos. ds.

(Signed) Floyd Weadle M. D.

1-5 1922 (Address) Sandpoint, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death....yrs....mos....days. In the State....yrs....mos....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Sandpoint Ida. DATE OF BURIAL: Dec. 6. 1921

20. UNDERTAKER: B. N. Pugh, ADDRESS: Sandpoint Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36384
Registered No.

RECEIVED
JAN 10 1922
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Bonner Registration District No. 78
City of Sandpoint (or Glengarry) Ida. St.) Primary Registration District No. 2155
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John R. Anderson, Sr.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M.	White	Married

6. DATE OF BIRTH: Oct. (Month) 26 (Day) 1853 (Year)

7. AGE: 68 Yrs. Mos. ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ontario

10. NAME OF FATHER: John Anderson

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: McKenzie

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John R. Anderson, Jr.
(Address) Glengarry, Idaho.

15. Filed Jan 6 1922 Floyd Wendle Local Registrar

SUNS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. (Month) 13 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased ~~from~~ at different times in 1920 and 1921; that I last saw h[illegible] alive on Dec 8 1921 and that death occurred on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:
Chronic Interstitial Nephritis
(Duration) 6 Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) Floyd Wendle M. D.
1-6 1922 (Address) Sandpoint Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Glengarry, Idaho.	1/15 1921
20. UNDERTAKER	ADDRESS
B. N. Pugh,	Sandpoint, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED JAN 10 1922 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 78

County of Bonner

Primary Registration District No. 2155

File No. 36385

City of Sandpoint (802 Pine St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Margaret Feeder

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widowed (Write the word.)

6. DATE OF BIRTH: April (Month) 15 (Day) 1871 (Year)

7. AGE: 50 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer): At Home

9. BIRTHPLACE (State or Country): Kansas

10. NAME OF FATHER: John Kennedy

11. BIRTHPLACE OF FATHER (State or Country): Scotland

12. MAIDEN NAME OF MOTHER: Mary Scott

13. BIRTHPLACE OF MOTHER (State or Country): Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Grace Feeder
(Address) Sandpoint, Ida.

15. Filed Dec-19 1921 Floyd Wendle Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. (Month) 17 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 16 1921, to Dec 17 1921, that I last saw her alive on Dec 16 1921, and that death occurred on the date stated above, at 9A M.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

(Duration) 9 Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) W. P. Wallentine M. D.

Dec, 19 1921 (Address) Sandpoint, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Leeds, N. Dak. DATE OF BURIAL 19

20. UNDERTAKER: B. H. Pugh ADDRESS: Sandpoint, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 26386

Registered No.

1. PLACE OF DEATH

County of Bonner Registration District No. 78.

City of Sand Point (No.) Primary Registration District No. 2155.

(St.) Priest River, Ida

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lem Floyd Carpenter

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

RECEIVED JAN 10 1922 BUREAU OF VITAL STATISTICS STATE OF IDAHO

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Sept. 19, 1919 (Month) (Day) (Year)

7. AGE: 2 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: At home.

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mont

10. NAME OF FATHER: Floyd Carpenter

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Bessie Everett

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Floyd Carpenter

(Address) Priest River, Ida

15. Filed 1-6 1922 Floyd Wendle Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. 19, 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....

that I last saw h..... alive on ..... 19.....

and that death occurred on the date stated above, at 12:20 P.M.

The CAUSE OF DEATH* was as follows:

Due to burn and Shock
From Falling in to
Scalding water

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Floyd Wendle M. D.

Dec 21, 1921. (Address) Sand Point, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Ames Iowa | DATE OF BURIAL: Dec. 27, 1921.

20. UNDERTAKER: L. V. Finch | ADDRESS: Sand Point, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 78

Primary Registration District No. 2153

File No. 36387

Registered No.

County of Bonner

City of Sandpoint

(If outside limits of city or village give township)

Sandpoint Ida. on N.P. Train No 2

(St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Aaron L. New

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	White	Married

6. DATE OF BIRTH: March (Month) 28 (Day) 1869 (Year)

7. AGE: 52 Yrs. ... Mos. ... ds.

IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Merchant

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ill

10. NAME OF FATHER: Lewis New

11. BIRTHPLACE OF FATHER (State or Country): Europe

12. MAIDEN NAME OF MOTHER: Caroline Openheimer

13. BIRTHPLACE OF MOTHER (State or Country): Europe

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Aaron L. New

(Address) Chicago, Ill

15. Filed Dec-9 1921 Floyd G Wendle

Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec- (Month) 8 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sudden death enroute on 19..., to ... 19..., that I last saw him alive on ... 19..., and that death occurred on the date stated above, at 11 P. M.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

Diagnosis from statements of person present at time of death (Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary) ... (Duration) ... yrs. ... mos. ... ds.

(Signed) Floyd G Wendle M. D.

Dec 9 1921 (Address) Sandpoint, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Chicago, Ill.	19...

20. UNDERTAKER	ADDRESS
B. H. Pugh	Sandpoint, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36388
Registered No.

RECEIVED JAN 10 1922 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
Registration District No. 79
Primary Registration District No. 21 St.
County of Boundary
City of Leonia (If outside city limits, give township) St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Esther Buhl Wooden

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): June

6. DATE OF BIRTH: June (Month) 4 (Day) 1920 (Year)

7. AGE: 1 Yrs. 6 Mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Waterhole county Canada (Alberta)

10. NAME OF FATHER: Darrel Wooden

11. BIRTHPLACE OF FATHER (State or Country): Oklahoma.

12. MAIDEN NAME OF MOTHER: Ruth Ester Thomson

13. BIRTHPLACE OF MOTHER (State or Country): Kootenai County Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. A. Ralston
(Address) Leonia Idaho

15. Filed: Dec. 8th. 1921 E E Fry Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 7 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Accidental burning.

..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E. E. Saunders M. D.
Coroner
..... 19..... (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. 3 mos. ..... days. In the State ..... yrs. 3 mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence Short. River Alberta

19. PLACE OF BURIAL OR REMOVAL: To Ephrata Wash.
DATE OF BURIAL: Dec 10 1921

20. UNDERTAKER
ADDRESS Ephrata Wn

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 79.
Primary Registration District No. 2156.
File No. 36389
Registered No.

1. PLACE OF DEATH
County of Boundary
City of Idaho
(No. St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Dorthy Evelyn Wooden

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH: Oct (Month) 8 (Day) 1918 (Year)

7. AGE: 3 Yrs. 1 Mos. 29 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Spirit River Alberta Canada

10. NAME OF FATHER: K. Darrel Wooden

11. BIRTHPLACE OF FATHER (State or Country): Oklahoma

12. MAIDEN NAME OF MOTHER: Ruth Esler Thompson

13. BIRTHPLACE OF MOTHER (State or Country): Kootenai County Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R. Paulson
(Address) Lenia Idaho

15. Filed Dec. 9th. 1921. E E Tr. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 7 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Accidental Burning
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) E. E. Saunders M. D.
19..... (Address) Carrie

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. 3 mos. ..... days. In the State ..... yrs. 3 mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Ephrata Wash — DATE OF BURIAL: Dec 10 1921

20. UNDERTAKER — ADDRESS: Ephrata Wn

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36390

Registered No.

1. PLACE OF DEATH. Registration District No. 79.

County of Boundary Primary Registration District No. 215.

City of Moyie Springs (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John E Thompson

RECEIVED JAN 19 1922 BUREAU OF STATISTICS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: April (Month) 3 (Day) 1863 (Year)

7. AGE: 58 yrs. 8 mos. 7 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry business, or dstablishment in which employed (or employer): Farm

9. BIRTHPLACE (State or Country): Wisc.

10. NAME OF FATHER: Eric Thompson

11. BIRTHPLACE OF FATHER (State or Country): Norway

12. MAIDEN NAME OF MOTHER: Martha Elerson

13. BIRTHPLACE OF MOTHER (State or Country): Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J E Thompson
(Address) Bonners Ferry Ida

15. Filed Dec. 11th 1921. E E Fry Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec (Month) 10 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191..., that I last saw h..... alive on ..... 191..., and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Malignant Cancer
Pulmonary Tuberculosis

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E. E. Saunders M. D.

19.... (Address) Coroner

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Paradise Cemetery	12/13 1921
20. UNDERTAKER	**ADDRESS**
J.E. Thompson	Bonners Ferry Ida

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

RECEIVED

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 39.
Primary Registration District No. 3156.
File No. 36391
Registered No.

1. PLACE OF DEATH.
County of Boundary
City of Bonners Ferry (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Edith Wilma Turner

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
F	W	Single

6. DATE OF BIRTH: June (Month) 2 (Day) 1916 (Year)

7. AGE: 5 yrs. 4 mos. 11 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Ida

10. NAME OF FATHER J. W. Turner

11. BIRTHPLACE OF FATHER (State or Country) Indiana

12. MAIDEN NAME OF MOTHER Willie Mabel Chambers

13. BIRTHPLACE OF MOTHER (State or Country) Minn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J W Turner
(Address) Bonners Ferry Ida.

15. Filed Dec. 14th 1921. E E Frye Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec (Month) 13 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 11 1921, to Dec. 13 1921, that I last saw h er alive on Dec. 11 1921, and that death occurred on the date stated above, at 4 A M.

The CAUSE OF DEATH* was as follows:
Acute articular rheumatism
.....
.....
..... (Duration) ..... yrs. ..... mos. 4 ds.
Contributory (Secondary) Myocarditis
..... (Duration) ..... yrs. ..... mos. 1 ds.

(Signed) R W Borrell M. D.
12/14 1921 (Address) Bonners Ferry Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Bonners Ferry Ida	12/14 1921
20. UNDERTAKER C R Stookey	ADDRESS Bonners Ferry

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SDRS. 19760

Form V. S. No. 5 20M.1-16-12

RECEIVED JAN 10 1922 BUREAU OF VITAL STATISTICS STATE OF IDAHO

CERTIFICATE OF DEATH

State of Idaho.
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 79

County of Boundary Primary Registration District No. 2186

File No. 36392

City of Bonners Ferry Ida (No. ....., ... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Albert French

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Aug (Month) 15 (Day) 1847 (Year)

7. AGE: 74 yrs. 4 mos. 2 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry business, or dstablishment in which employed (or employer): Lumber

9. BIRTHPLACE (State or Country): Mich

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Chas McCarthy

(Address) Libby Mont

15. Filed Dec. 18th 1921 E E Fry Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec (Month) 17 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Heart failure (Instantaneous death)

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E E Dennedy M. D.

19.... (Address) Carmen

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence. Libby Mont

19. PLACE OF BURIAL OR REMOVAL: Bonners Ferry — DATE OF BURIAL: 12/19 1921

20. UNDERTAKER: O B Cooley — ADDRESS: Bonners Ferry

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 1004
File No. 36393
Registered No.

1. PLACE OF DEATH
County of Canyon
City of Nampa (No. St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charles Gilman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Male	White	Single

6. DATE OF BIRTH: Dec (Month) 18 (Day) 1917 (Year)

7. AGE: 7 Yrs. 10 Mos. 24 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: In School
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: J. E. Gilman

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER: Mary Feeney

13. BIRTHPLACE OF MOTHER (State or Country): Nebraska

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): J. E. Gilman
(Address): Nampa Idaho

15. Filed Dec 12 1921 Pearle Dodds Local Registrar

SUNS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 9 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 9 1921, to ..... 19.....
that I last saw h.. alive on Nov 9 1921
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows: Was dying at my visit - Lungs full of fluid Probably a fulminating Pneumonia -
..... (Duration) ..... Yrs. ..... mos. 1 ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) J. H. Murray M. D.
11/10/1921 (Address) Nampa Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Star Cemetery	11/11/1921

20. UNDERTAKER	ADDRESS
Fred H. Robinson	Nampa Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. .....
Primary Registration District No. 1006
File No. 36394
Registered No. .....

1. PLACE OF DEATH
County of Canyon
City of Nampa.
(No. 25 - 12 st South St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charles H Sherman
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widower

6. DATE OF BIRTH: Jan (Month) 3 (Day) 1859 (Year)

7. AGE: 62 Yrs. 11 Mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): California

10. NAME OF FATHER: Charles Sherman

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Gertrude Daly
(Address) Nampa Idaho

15.
Filed Jan 4 1922 Pearle Dodds
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 11 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Ms attending Physician:
was taking treatment from Chiropractor

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Pearle Dodds Registrar ~~M. D.~~

..... 19..... (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Boise Idaho — DATE OF BURIAL: Dec 12 1921

20. UNDERTAKER: Summers & Kelly — ADDRESS: Boise Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36395
Registered No.

1. PLACE OF DEATH

County of Canyon
City of Nampa
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No.
(No. 624 9th Ave. So. St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Rosilda Scovell

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Fem	White	Married

6. DATE OF BIRTH: Sept (Month) 13 (Day) 1863 (Year)

7. AGE: 58 Yrs. 2 Mos. 28 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kansas

10. NAME OF FATHER: J. Trosper

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. S. Scovell
(Address) Nampa Ida

15. Filed June 5 1922 Rosa Turner Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 11 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 11 1921, to ——— 19..
that I last saw h[illegible] alive on Dec 11 1921
and that death occurred on the date stated above, at 9 P.M.
The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) one hour Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) D. H. Murray M. D.
12/12 1921 (Address) Nampa Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Kohlerlawn Cem	12-13 1921
20. UNDERTAKER	**ADDRESS**
Fred K Robinson	Nampa Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

M.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36396

Registered No.

Registration District No.

Primary Registration District No. 1056

1. PLACE OF DEATH

County of Canyon

City of Nampa

(No. 520 - 19 ave S St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Pearl Parks

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Fem	white	

6. DATE OF BIRTH: Oct (Month) 21 (Day) 21 (Year)

7. AGE: Yrs. 1 Mos. 21 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER J. E. Parks

11. BIRTHPLACE OF FATHER (State or Country) Texas

12. MAIDEN NAME OF MOTHER Mary Averard

13. BIRTHPLACE OF MOTHER (State or Country) Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. E. Parks
(Address) Nampa Ida

15. Filed Jan 4 1922 Frank Davis Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 8 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1 1921, to Dec 8 1921, that I last saw her alive on Dec 8 1921, and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Congenital Weakness of Respiratory Organs

(Duration) Yrs. 1 mos. 21 ds.

Contributory (Secondary) Malnutrition

(Duration) yrs. mos. ds.

(Signed) F. H. Proctor M. D.

12/9/1921 (Address) Nampa Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Kohlerdawn Cem	12-13-1921
20. UNDERTAKER	ADDRESS
Ind & Robinson	Nampa Ida

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

P

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Canyon

City of Nampa

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 7

Primary Registration District No. 1006

(No. ..... St.)

File No. 36397

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Harriett S. Whitted

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widow

6. DATE OF BIRTH: May (Month) 8 (Day) 1843 (Year)

7. AGE: 78 Yrs. 7 Mos. 23 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Jw Jacobs

11. BIRTHPLACE OF FATHER (State or Country): Penn

12. MAIDEN NAME OF MOTHER: Nancy Shoup

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs R. D. Tippen

(Address) Nampa Ida

15. Filed Jan 4 1922 Jan 3 1922 Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 31 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12-28 1921, to 12-31 1921 that I last saw her alive on 12-30 1921 and that death occurred on the date stated above, at 3-30 P.M.

The CAUSE OF DEATH* was as follows:

Acute Peritonitis

..... (Duration) ..... Yrs. ..... mos. 3 ds.

Contributory (Secondary) Occlusion of bowels

..... (Duration) ..... yrs. ..... mos. ½ ds.

(Signed) H. C. Robinson M. D.

1-4 1922 (Address) Nampa

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF ~~BURIAL~~ OR REMOVAL: Mankato Kansas

DATE OF BURIAL ..... 19.....

20. UNDERTAKER: Fred K Robinson

ADDRESS: Nampa Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36398
Registered No.

1. PLACE OF DEATH
County of Canyon
City of
(No. , St.)
Registration District No.
Primary Registration District No. 1054
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Infant Male Smith
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.):

6. DATE OF BIRTH: Dec (Month) 13 (Day) 21 (Year)

7. AGE: Yrs. Mos. ds.
IF LESS than 1 day how many 2 hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: A. Smith

11. BIRTHPLACE OF FATHER (State or Country): Mo.

12. MAIDEN NAME OF MOTHER: Pearl Webb

13. BIRTHPLACE OF MOTHER (State or Country): Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Arthur Webb
(Address) Nampa Ida

15.
Filed Jan 4 1922
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 13 (Day) 21 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 13 1921, to Dec 13 1921, that I last saw him alive on Dec 13 1921, and that death occurred on the date stated above, at 1130 P.M.

The CAUSE OF DEATH* was as follows:

Asphyxia neonatorum 2 hrs
(Duration) Yrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) Marion D. Finch M. D.
Dec 14 1921 (Address) Nampa Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Kohlerlawn
DATE OF BURIAL: 12/14 1921

20. UNDERTAKER: Frank Robins
ADDRESS: Nampa Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 1556
File No. 36400
(No. ....., ... St.)
Registered No. .....

1. PLACE OF DEATH
County of Canyon
City of Nampa
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Hiram Steadman Roberts

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH: July (Month) 6 (Day) 1829 (Year)

7. AGE: 92 Yrs. 5 Mos. 7 ds.
IF LESS than 1 day, how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business or establishment in which employed (or employer): Farmer.

9. BIRTHPLACE (State or Country): Bangor Maine

10. NAME OF FATHER: Hiram S. Roberts

11. BIRTHPLACE OF FATHER (State or Country): Hanover England

12. MAIDEN NAME OF MOTHER: Mary Harding

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. H. Stanford
(Address) Nampa Idaho

15. Filed Jan 4 1922 Dave Doar Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 13 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9 a.m. 12 Dec 13 1921, to 9 a.m. 12 Dec 13 1921, that I last saw him alive on Dec 13 1921, and that death occurred on the date stated above, at 8 A. M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) 12 Yrs. ..... mos. ..... ds.

Contributory (Secondary) Arterio Sclerosis

(Duration) years Yrs. ..... mos. ..... ds.

(Signed) Leo H Chilton M. D.

12/15 1921 (Address) Nampa Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Nampa Idaho
DATE OF BURIAL: 12-16 1921

20. UNDERTAKER: Fred E. Robinson
ADDRESS: Nampa Ida

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

Omitted

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36402
Registered No. 11

1. PLACE OF DEATH. Registration District No. 82
County of Cariboo Primary Registration District No. 2159
City of ..... St.)
If death occurs away from usual residence, give facts called for under special information.

RECEIVED
NOV 30 1921
BUREAU OF VITAL STATISTICS

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Thomas Jefferson Woodland

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	W	Single

6. DATE OF BIRTH: May 19, 1850
(Month) (Day) (Year)

7. AGE: 71 yrs. 8 mos. 25 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Do not know

11. BIRTHPLACE OF FATHER (State or Country): Do not know

12. MAIDEN NAME OF MOTHER: Do not know

13. BIRTHPLACE OF MOTHER (State or Country): Do not know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H.S.Woodland
(Address) Arimo, Idaho

15.
Filed Oct.14,1921 191
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Oct.14,1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sep.12 1921, to Sep.30,1921 191, that I last saw him alive on Sep.30,1921 191, and that death occurred on the date stated above, at 5:20 M.

The CAUSE OF DEATH* was as follows:

Chronic Cystitis

(Duration) 10 yrs. mos. ds.

Contributory (Secondary) None

(Duration) yrs. mos. ds.

(Signed) Eric Kaestlin M. D.

Oct 14 1921 (Address) Soda Springs

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Willard, Ut.	Oct.17,1921
20. UNDERTAKER	**ADDRESS**
Woodland	Malad, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

BYNS - YORK CO., PTRS. & BORS. 19750

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36404
Registered No. 359

1. PLACE OF DEATH
County of Cassia
City of Burley
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 117
Primary Registration District No. 2196
(No. ..... St.)

2. FULL NAME Bola Tokundi Kohus

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH. July (Month) 4 (Day) 1893 (Year)

7. AGE 28 Yrs. 5 Mos. 4 ds. IF LESS than 1 day how many .... hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work In School
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Afghanistan

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (State or Country) "

12. MAIDEN NAME OF MOTHER "

13. BIRTHPLACE OF MOTHER (State or Country) "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Token from Naturalization Papers
(Address) Burley Ida.

15. Filed Jan. 5th 1921. W. J. Patterson Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. (Month) 8 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 2 1921 to Dec 8 1921
that I last saw him alive on Dec 8 1921
and that death occurred on the date stated above, at .....M.

The CAUSE OF DEATH* was as follows:

Pneumonia

.....(Duration) ..... Yrs..... mos. ..... ds.

Contributory (Secondary)

.....(Duration) ..... Yrs..... mos. ..... ds.

12/9 1921. (Signed) T. H. Cutler M. D.
(Address) Burley

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs....mos....days. In the State....yrs....mos....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Burley Ida. DATE OF BURIAL Dec. 9- 1921

20. UNDERTAKER L. R. Talboy ADDRESS Burley Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36405
Registered No. 560

1. PLACE OF DEATH
County of Cassia. Registration District No. 117
City of Burley. Primary Registration District No. 2196
If death occurs away from usual residence, give facts called for under special information. (No. ..... St.)

RECEIVED JAN 10 1922 IDAHO BUREAU OF VITAL STATISTICS

2. FULL NAME Delva Nadine Lee

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Single

6. DATE OF BIRTH. Oct. (Month) 15 (Day) 1918 (Year)

7. AGE 3 Yrs. 1 Mos. 20 ds. IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Arizona

10. NAME OF FATHER Chester A. Lee.

11. BIRTHPLACE OF FATHER (State or Country) Texas.

12. MAIDEN NAME OF MOTHER Roney Lee

13. BIRTHPLACE OF MOTHER (State or Country) Texas.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chester A. Lee.
(Address) Burley Ida.

15. Filed Jan. 5 1922 Dr. J. C. Portman Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. (Month) 6 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 5 1921 to Dec. 6 1921
that I last saw her alive on Dec. 6 1921
and that death occurred on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Diphtheritic Laryngitis

(Duration) .... Yrs. .... mos. .... ds.

Contributory (Secondary)

(Duration) .... Yrs. .... mos. .... ds.

(Signed) G. P. Smith M. D.
12/7 1921 (Address) Burley Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Burley Ida. DATE OF BURIAL Dec. 7 1921

20. UNDERTAKER None. ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-12 M. 6-15-17.

Cutler

CERTIFICATE OF DEATH

36406

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 117
Primary Registration District No. 2196
File No. 561
Registered No.

1. PLACE OF DEATH
County of Cassia
City of Burley
If death occurs away from usual residence, give facts called for under special information.
(No. 236, So. Albion Ave. St.)
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME James McCune

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Dec. 15 1921.
(Month) (Day) (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many 2 hrs. or 30 min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE
(State or Country) Burley Ida.

10. NAME OF FATHER Frank McCune

11. BIRTHPLACE OF FATHER
(State or Country) Iowa

12. MAIDEN NAME OF MOTHER Grace Montgomery

13. BIRTHPLACE OF MOTHER
(State or Country) Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Frank McCune
(Address) Burley Ida. General Delivery

15. Filed Jan. 5th 1922. Dr. J. E. Patterson
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. 15 1921.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 15 1921. to Dec. 15 1921.
that I last saw him alive on Dec. 15 1921.
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Premature

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) J. H. Cutler M. D.
19.... (Address) Burley

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs....mos....days. In the State....yrs....mos....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Pella Idaho. DATE OF BURIAL 12.16. 1921.

20. UNDERTAKER T. P. Tollefsrud ADDRESS Burley Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

36407

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 562
Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

RECEIVED JAN 10 1922 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Cassia Registration District No. 117
City of Burley Primary Registration District No. 2196
(Or Town ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John A. Beamis

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Sing'l

6. DATE OF BIRTH. Unknown (Month) 1 (Day) ..... (Year)

7. AGE: 43 Yrs. ? Mos. ? ds. IF LESS than 1 day how many .... hrs. or .....min.?'

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Joe. Beamis
(Address): Burley Ida.

15. Filed Jan. 5th 1922 H. J. Pattison Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. 22 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..... to .....191...
that I last saw h.....alive on .....191....
and that death occurred on the date stated above, at .....M.
The CAUSE OF DEATH* was as follows:
Tuberculosis
.....(Duration) ..... Yrs..... mos. ..... ds.
Contributory (Secondary) .....
.....(Duration) ...3... Yrs..... mos. ..... ds.
(Signed) L.B. Galloway Coroner ~~M. D.~~
12/26/1921 (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Burley Ida. DATE OF BURIAL: Dec. 26. 1921

20. UNDERTAKER: L.B. Galloway. ADDRESS: Burley Ida.

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

Registration District No. 117

Primary Registration District No. 2196

J. C. Patterson,
State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36408
Registered No. 363

1. PLACE OF DEATH
County of Cassia
City of Burley
If death occurs away from usual residence, give facts called for under special information.
(No. 1108 N. Miller Ave. St.)
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Jesse Thomas Lindmarsh

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Aug. 26. 1 (Month) (Day) (Year)

7. AGE: 66 Yrs. 4 Mos. 1 ds.
IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE
(State or Country) Manchester England

10. NAME OF FATHER: Thomas Lindmarsh

11. BIRTHPLACE OF FATHER
(State or Country) England

12. MAIDEN NAME OF MOTHER: Matilda Seyweska

13. BIRTHPLACE OF MOTHER
(State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. N. P. Jensen
(Address) Brant Alberta Canada

15. Filed Jan. 5 1922
Dr. J. C. Patterson
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Dec. (Month) 27 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 1st 1921 to Dec. 27 1921
that I last saw h. alive on Dec. 26 1921
and that death occurred on the date stated above, at 3:30 P. M.

The CAUSE OF DEATH* was as follows:
Carcinoma of liver
(Duration) Yrs. 9 mos. ds.
Contributory (Secondary)
(Duration) Yrs. mos. ds.

(Signed) J. C. Patterson M. D.
12-28 1921 (Address) Burley, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Burley Ida — DATE OF BURIAL: 12/30/ 1921

20. UNDERTAKER: L. D. Talboy — ADDRESS: Burley

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

Form V. S. No. 5. 12½M.7-24-11 RECEIVED JAN 4 1922 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36409
Registered No.

1. PLACE OF DEATH. Registration District No. 90
County of Clearwater Primary Registration District No. 2168
City of Orofino, (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs. Herman Hanson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed
6. DATE OF BIRTH: About (Month) 1 (Day) 1856 (Year)
7. AGE: About 65 yrs. ✓ mos. ✓ ds. IF LESS than 1 day how many ..... hrs. or ..... min.
8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife Formerly
(b) General nature of industry business or establishment in which employed (or employer): Keeping House
9. BIRTHPLACE (State or Country): Norway
10. NAME OF FATHER: Unknown
11. BIRTHPLACE OF FATHER (State or Country): Unknown
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (State or Country): Unknown,
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. W. Atteberry
(Address) Orofino, Idaho.
15. Filed Jany 1 1922 J. M. Faulk Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: December (Month) 3rd (Day) 1921 (Year)
17. I HEREBY CERTIFY, That I attended deceased from June 5, 1920 to Dec. 3rd 1921, that I last saw her alive on Dec. 2nd 1921 and that death occurred on the date stated above, at 4:15 A.M.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

Unknown (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) Insanity

Unknown (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John W. Givens M. D.

Dec 3rd 1921 (Address) Orofino, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.) over

At place of death 1 yrs. 5 mos. 29 ds. In the State 1 yrs. 5 mos. 29 ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence Lewiston, Idaho.

19. PLACE OF BURIAL OR REMOVAL: Grave #8 Row #5 In New addition Cemetery The Northern Idaho Unitarian Orofino, Idaho
DATE OF BURIAL: Dec 6 1921

20. UNDERTAKER: Wayne Johnson
ADDRESS: Orofino, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36410
Registered No.

1. PLACE OF DEATH. Registration District No. 90
County of Clearwater Primary Registration District No. 168
City of Orofino, (If not in city give township) St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME H. M. Hoverson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH: January — (Month) (Day) 1860 (Year)

7. AGE: about 61 yrs. 11 mos. ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher
(b) General nature of industry business or establishment in which employed (or employer): Stock Raising, Farming, etc.,

9. BIRTHPLACE (State or Country): Norway,

10. NAME OF FATHER: Hoverson

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown,

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. W. Atteberry
(Address) Orofino, Idaho,

15.
Filed January 1, 1922 J. McFamily Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: December 9th 1921 ~~1911~~
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from August 5th ~~1911~~ 1920, to December 9th ~~1911~~ 1921
that I last saw him alive on December 8th ~~1911~~ 1921
and that death occurred on the date stated above, at 3 20 A M.

The CAUSE OF DEATH* was as follows:

Epilepsy
Unknown
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Insanity
(Duration) Unknown yrs. ..... mos. ..... ds.
(Signed) John W. Givens M. D.
Dec. 9th 1921 (Address) Orofino, Idaho,

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 1 yrs. 7 mos. 5 ds. In the State about 6 yrs. 6 mos. ..... ds.
Where was disease contracted, If not at place of death? .....
Former or usual residence Eagle, Idaho,

19. PLACE OF BURIAL OR REMOVAL: Grave # 9 Row # 5 The New Add. The Northern Idaho Sanitarium
DATE OF BURIAL: Dec. 12 1921 ~~1911~~

20. UNDERTAKER: P. M. Johnson, Orofino, Idaho
ADDRESS: Orofino, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

FORM V. S. No. 5-12 M. 6-15-17

RECEIVED JAN 10 1922 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3641
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Clearwater
City of Orofino
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 40
Primary Registration District No. 2168
(No. ....., ... St.)

2. FULL NAME Lilly May Lashley

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH. Sept. 24 1904 (Month) (Day) (Year)
7. AGE: 17 Yrs. 2 Mos. 19 ds. IF LESS than 1 day how many .... hrs. or .....min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Ida
10. NAME OF FATHER: William Lashley
11. BIRTHPLACE OF FATHER (State or Country): Wisconsin
12. MAIDEN NAME OF MOTHER: Lyra Hinkle
13. BIRTHPLACE OF MOTHER (State or Country): Ten
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Walter L. Lashley
(Address) Orofino
15. Filed January 4 1922 J. M. Stanley Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec 13 1921 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from — 191.. to — 191..
that I last saw h..alive on ..... 191....
and that death occurred on the date stated above, at 11:30 A. M.
The CAUSE OF DEATH* was as follows:

Accidental shot with
303 Savage rifle while hunting.

(Duration) ..... Yrs..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... Yrs..... mos. ..... ds.
(Signed) J. C. Bullock Coroner M. D.
12/14 1921 (Address) Orofino

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the ,State....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Weisman Cemetery, Orofino — DATE OF BURIAL: Dec. 15 1921
20. UNDERTAKER: W. L. Shaw — ADDRESS: Orofino

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-12 M. 6-15-17.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

RECEIVED JAN 10 1922 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 30412
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Clearwater
City of Orofino
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 90
Primary Registration District No. 2168
..... St.)

2. FULL NAME Joe C. Pollock

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. ? (Month) 1 (Day) ..... (Year)

7. AGE: 4 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many .... hrs. or ..... min.?'

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Ida

10. NAME OF FATHER: Evart Pollock

11. BIRTHPLACE OF FATHER (State or Country): Oklahoma

12. MAIDEN NAME OF MOTHER: Stranger

13. BIRTHPLACE OF MOTHER (State or Country): South Dakota

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Evart Pollock
(Address) Orofino Ida

15. Filed Jany 4 1922 J M Daily Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 29 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 24 1921 to 1921
that I last saw him alive on Dec 29 1921
and that death occurred on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:
Fracture of Skull Instant death
Accidentally Killed by
Block of wood
..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
..... (Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) Earle W. Hammond M. D.
12/29 1922 (Address) Orofino Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the State....yrs.....mos....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Orofino Ida — DATE OF BURIAL: Dec 31 1921

20. UNDERTAKER: W A Shaw — ADDRESS: Orofino

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36415
Registered No.

RECEIVED JAN 10 1922 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH. Registration District No. 90
County of Gleenwater Primary Registration District No. 2168
City of Orofino (If outside city limits, write the name of township.) St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Susie M. Jett.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH: About (Month) (Day) 1850 (Year)

7. AGE: About 71 yrs. mos. ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Formerly Housewife & Chiropractioner
(b) General nature of industry business or establishment in which employed (or employer): Housekeeping & Chiropractic

9. BIRTHPLACE (State or Country): Madison Co., Arkansas.

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Unknown.

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. M. Johnson
(Address) Orofino, Ida.

15.
Filed January 6 1922 J. M. Faul Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: December 24th 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 27, 1920 to Dec 24, 1921
that I last saw her alive on Dec. 24 1921
and that death occurred on the date stated above, at 7:45 P. M.

The CAUSE OF DEATH* was as follows:
Arterio Sclerosis
Unknown
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Insanity
(Duration) Unknown yrs. ..... mos. ..... ds.
(Signed) John W. Owens M. D.
Dec. 24 1921 (Address) Orofino, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.) About
At place of death 1 yrs. 7 mos. 28 ds. In the State 22 yrs. - mos. - ds.
Where was disease contracted, if not at place of death?
Former or usual residence Idaho, Idaho.

19. PLACE OF BURIAL OR REMOVAL: Grave #10 Row #5 New Add. The Northern Idaho Sanitarium, Cin
DATE OF BURIAL: 12/24/1921

20. UNDERTAKER: P. M. Johnson
ADDRESS: Orofino, Idaho.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 76

Primary Registration District No. 2153

File No. 36414

County of Custer

City of Mackay (No. ....., ... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
JAN 10 1922
BUREAU OF VITAL

2. FULL NAME Victor William Bailey

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	WH	Single

6. DATE OF BIRTH: 6 (Month) 25 (Day) 1918 (Year)

7. AGE: 3 Yrs. 5 Mos. 12 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Mackay Idaho

10. NAME OF FATHER: Victor William Bailey

11. BIRTHPLACE OF FATHER (State or Country): Hailey, Idaho

12. MAIDEN NAME OF MOTHER: Flora Hosford

13. BIRTHPLACE OF MOTHER (State or Country): Challis, Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Victor W. Bailey

(Address) Mackay Ida

15. Filed 12/29 1921 Rose Mowatt
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 12 (Month) 6 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12/6 1921, to 12/6/21 1921, that I last saw h.im alive on 12/6/21 19....., and that death occurred on the date stated above, at 5 A M.

The CAUSE OF DEATH* was as follows:

Cerebral Convulsions -
(Epilepsy)

(Duration) 3 Yrs. ..... mos. ..... ds.

Contributory (Secondary) Respiratory Failure -

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F. P. Richards - M. D.

12/7 1921 (Address) Mackay Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL ..... 19.....
20. UNDERTAKER	ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED
JAN 10 1922
BUREAU OF VITAL STATISTICS

Form V. S. No. 5. 10M. 6-20-11. **CERTIFICATE OF DEATH**

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. **PLACE OF DEATH.** Registration District No. 24

County of Elmore — Primary Registration District No. 2021

File No. 36415

City of King Hill (No. ....., ... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. **FULL NAME** Susan Charlotte Davidson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. **SEX**: Female

4. **COLOR OR RACE**: White

5. **SINGLE, MARRIED, WIDOWED OR DIVORCED.** (Write the word.): Widow

6. **DATE OF BIRTH**: Feb. 19 (Month) 1840 (Year)

7. **AGE**: 81 yrs. 9 mos. 16 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. **OCCUPATION**
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business or establishment in which employed (or employer) .....

9. **BIRTHPLACE** (State or Country): Penn.

10. **NAME OF FATHER**: Joseph E Hare

11. **BIRTHPLACE OF FATHER** (State or Country): —

12. **MAIDEN NAME OF MOTHER**: Susan Ramsey

13. **BIRTHPLACE OF MOTHER** (State or Country): —

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**

(Informant) Mrs G F Turner

(Address) King Hill Idaho

15.

Filed Dec 7 1921 J. W. Davis Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH**: Dec. (Month) 7th (Day) 1921 (Year)

17. **I HEREBY CERTIFY**, That I attended deceased from Dec 1st 1919, to Dec. 6th 1921, that I last saw her alive on Dec. 6th 1921, and that death occurred on the date stated above, at 2 A M.

The **CAUSE OF DEATH*** was as follows:

Senility

..... (Duration) 3 yrs. ..... mos. ..... ds.

Contributory (Secondary) Valvular

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. W. Davis M. D.

Dec 7th 1921 (Address) Glenns Ferry Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and 2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. **LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)**

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19. **PLACE OF BURIAL OR REMOVAL**: Modrawy Missouri — **DATE OF BURIAL** 191

20. **UNDERTAKER**: J M Pinkham — **ADDRESS**: Glenns Ferry

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

RECEIVED JAN 1 1922 BUREAU OF VITAL STATISTICS

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 27

Registrar's Registration District No. 2119

File No. 36416

Registered No. 71

1. PLACE OF DEATH

County of Franklin

City of Preston (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Martha Kershaw

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH In the Spring (Month) ..... (Day) 1834 (Year)

7. AGE 87 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) England

10. NAME OF FATHER Roger Robertshaw

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Disely Wells

(Address) Preston Ida

15. Filed Jan 4 1922 A. P. Cutler Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 23 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 17 1921 to Dec 23 1921, that I last saw her alive on Dec 23 1921, and that death occurred on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:

Uremic poisoning

..... (Duration) ..... Yrs. ..... mos. 14 ds.

Contributory (Secondary) Dry Gangrene

..... (Duration) ..... yrs. 6 mos. ..... ds.

(Signed) A. P. Cutler M. D.

1-3 1922 (Address) Preston Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Preston Ida | DATE OF BURIAL Dec 27 1921

20. UNDERTAKER W. A. Steadmore | ADDRESS Preston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED JAN 10 1922 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36418

Registered No. 68

1. PLACE OF DEATH.

County of Franklin Registration District No. 21

City of Preston Primary Registration District No. 2119

(If not in incorporated limits, write "Not in ....." St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Almira Norton

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Aug (Month) 5 (Day) 1856 (Year)

7. AGE: 65 Yrs. 4 Mos. 12 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION

(a) Trade, profession or particular kind of work... House Keeper

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Utah

10. NAME OF FATHER John Mangham

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER Maria Davenport

13. BIRTHPLACE OF MOTHER (State or Country) Michigan Genesee Co

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John M Boothe

(Address) Weston Ida.

15. Filed Jan 4 1922 A. R. Cutler Jr. Local Registrar

BYNS - YORK CO., PTRS. & ENGS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 17 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 31 1921, to Dec 17 1921, that I last saw her alive on Dec 17 1921, and that death occured on the date stated above, at 2 P M.

The CAUSE OF DEATH* was as follows:

Gastritis

(Duration) ..... Yrs. ..... mos. 17 ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Thos B Holden M. D.

19 ..... (Address) Preston Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Weston, Ida.

DATE OF BURIAL: 12-20 1921

20. UNDERTAKER: G. A. Lundquist

ADDRESS: Logan, Utah

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

RECEIVED JAN 1922

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36419

Registered No. 67

1. PLACE OF DEATH.

Registration District No. 21

Primary Registration District No. 3119

County of Franklin

City of Preston (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Nels Nielsen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
male	white	

6. DATE OF BIRTH.

Jan (Month) 12 (Day) 1884 (Year)

7. AGE

37 Yrs. 11 Mos. 7 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... laborer

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country) Denmark

10. NAME OF FATHER Christen Nielsen

11. BIRTHPLACE OF FATHER

(State or Country) Denmark

12. MAIDEN NAME OF MOTHER Hanna Madsen

13. BIRTHPLACE OF MOTHER

(State or Country) Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wilford Nielsen

(Address) Think to let you.

15.

Filed Jan 4 1922. A. R. Cutler

Local Registrar

SYMS - YORK CO., PTRS. & ENGS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec (Month) 7 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 23 1921, to Dec 7 1921, that I last saw h... alive on Dec 7 1921 and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Fracture of right Thigh

(Duration) ..... Yrs. 1 mos. ..... ds.

Contributory (Secondary) Blood Poison

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J B Holder M. D.

19..... (Address) Preston Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Weston Idaho	12-10 1921
20. UNDERTAKER	ADDRESS
✓	✓

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
JAN 10 1922
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Fremont — Registration District No. 99

City of St. Anthony, Idaho — Primary Registration District No. 2177 — St.)

File No. 36420

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John B. Taylor

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Jan. (Month) 20 (Day) 1921 (Year)

7. AGE: Yrs. 9 Mos. 18 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Leon Taylor

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Eliza Ann Kinegar

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15. Filed Dec 10 1921 — W. R. Wirt — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 7 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19....., that I last saw h..... alive on ..... 19....., and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Burned to death

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. R. Wirt M. D.

..... 19..... (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Pashen Cemetery — DATE OF BURIAL: Nov 10th 1921

20. UNDERTAKER: W. M. Hansen — ADDRESS: St. Anthony, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
JAN 16 1922
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36421
Registered No.

1. PLACE OF DEATH
County of Fremont
City of St. Anthony (St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 99
Primary Registration District No. 2177

2. FULL NAME Zillah Anderson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: July (Month) 2nd (Day) 1912 (Year)

7. AGE: 9 Yrs. 4 Mos. 22 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): St. Anthony Idaho

10. NAME OF FATHER: Valentine Andersow

11. BIRTHPLACE OF FATHER (State or Country): Dannmark

12. MAIDEN NAME OF MOTHER: Kathrine Nelsow

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Valentine Andersow
(Address)

15. Filed Dec 10 1921
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 24 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 14 1921, to Nov. 24 1921, that I last saw h— alive on —— 19—, and that death occurred on the date stated above, at 10 P M.

The CAUSE OF DEATH* was as follows:
Diabetes Mellitus

(Duration) 9 Yrs. 6 mos. 7 ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. 7 ds.

(Signed) J. E. Whelton M. D.
Nov 24 1921 (Address) St Anthony Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Milford Cemetery
DATE OF BURIAL: Nov 28th 1921

20. UNDERTAKER: W. M. Hansen
ADDRESS: St. Anthony

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36422
Registered No.

RECEIVED
JAN 10 1922
BUREAU OF VITAL STATISTICS

Registration District No. 99
Primary Registration District No. 2177

1. PLACE OF DEATH
County of Fremont
City of St. Anthony (If outside limits, St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Clarence Main
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: February (Month) 9th (Day) 1917 (Year)

7. AGE: 4 Yrs. 9 Mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) St. Anthony, Idaho

10. NAME OF FATHER Carry C. Main

11. BIRTHPLACE OF FATHER (State or Country) Illinois

12. MAIDEN NAME OF MOTHER Lilly Jones

13. BIRTHPLACE OF MOTHER (State or Country) Nebraska

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) F F Main
(Address) .....

15. Filed Dec 10 1921 W. A. Wood
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: November 24th (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11/23/1921, to 11/24/1921 that I last saw him alive on 11/24/1921, and that death occurred on the date stated above, at 9:30 A.M.
The CAUSE OF DEATH* was as follows:

Diphtheria

(Duration) one Yrs. one mos. 5 ds.
Contributory (Secondary) none
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Jno R Gray M. D.
11/25 1921 (Address) St Anthony Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Milford — DATE OF BURIAL: Nov 25th 1921

20. UNDERTAKER: W M Hansen — ADDRESS: St. Anthony, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36423

Registration District No. 04
Primary Registration District No. 2 / 7

RECEIVED
JAN 10 1922
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Fremont
City of St. Anthony (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Cathrine Nilson Anderson

Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: July (Month) 10 (Day) 1885 (Year)

7. AGE: 36 Yrs. 3 Mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Henry Nilson

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Adrena Barlow

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Valentine Anderson
(Address) St. Anthony Idaho

15. Filed Nov 10 1921 W. Burns Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 15th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 12th 1921, to Sept 12th 1921, that I last saw h[illegible] alive on Sept 12th 1921, and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Diabetic Coma.
(Duration) ..... Yrs. ..... mos. 1 ds.
Contributory (Secondary) Diabetes Mellitus
(Duration) several yrs. ..... mos. ..... ds.
(Signed) M. M. Farnsworth M. D.
19..... (Address) St. Anthony Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Wilford Cemetery | DATE OF BURIAL: Oct 17th 1921

20. UNDERTAKER: W. M. Hansen | ADDRESS: St. Anthony, Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JAN 26 1922 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36424
Registered No.

1. PLACE OF DEATH
County of Fremont — Registration District No. 99
City of St. Anthony — Primary Registration District No. 217
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Darrell Bates
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: May 18 (Month) (Day) 1897 (Year)

7. AGE: 24 Yrs. 4 Mos. 24 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Chapin Idaho

10. NAME OF FATHER: John Nyrum

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Mary Elliott

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. D. E. Bates
(Address)

15. Filed ..... 1921 — W. D. Cox, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 10 (Month) 13 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 1917, to 10/17 1921, that I last saw h.. alive on 10/17 1921, and that death occurred on the date stated above, at 5 M.

The CAUSE OF DEATH* was as follows:
[redacted] Cerebral hemorrhage

(Duration) ..... Yrs. 6 mos. — ds.
Contributory (Secondary) Epilepsy
(Duration) 16 yrs. — mos. — ds.

(Signed) J. Hockaday M. D.
10/14 1921 (Address) St. Anthony Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Riverside Cemetery — DATE OF BURIAL: Oct 17 1921

20. UNDERTAKER: W. M. Hansen — ADDRESS: St. Anthony Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
JAN 10 1922
BUREAU OF VITAL STATISTICS

Registration District No. 99
Primary Registration District No. 2177
File No. 26425
Registered No.

1. PLACE OF DEATH
County of Fremont
City of St. Anthony (If outside limits, give township) St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Margaret Broom Jenkins
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH: November — 1858 (Month) (Day) (Year)

7. AGE: 63 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): South Wales, England

10. NAME OF FATHER: William Broom

11. BIRTHPLACE OF FATHER (State or Country): South Wales, England

12. MAIDEN NAME OF MOTHER: Elizabeth Jones

13. BIRTHPLACE OF MOTHER (State or Country): South Wales England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Geo W. Jenkins
(Address) St. Anthony, Idaho.

15. Filed Nov 10 1921
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 8 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct Oct 7 1921 to Oct 8 1921
that I last saw her alive on Oct 8 1921,
and that death occurred on the date stated above, at M.
The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

(Duration) Yrs. mos. 1st ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) J. Frank Watkins M. D.
Oct 1921 (Address) St Anthony Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL, CREMATION OR REMOVAL: Parker Cemetery — DATE OF BURIAL: 10/11 1921
20. UNDERTAKER: H. M. Hansen — ADDRESS: St. Anthony Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 99
Primary Registration District No. 2177
File No. 26426
Registered No.

RECEIVED JAN 16 1922 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Fremont
City of St. Anthony (No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Amy Booth Meredith
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: April (Month) 8th (Day) 1867 (Year)

7. AGE: 54 Yrs. 6 Mos. — ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: William H. Booth

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Mary Simmons

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A. Meredith
(Address)

15. Filed Jan 10 1922 — W. Clark, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 8 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 15 1920, to Oct 8 1921, that I last saw her alive on March 20 1921, and that death occurred on the date stated above, at M.
The CAUSE OF DEATH* was as follows: Myocarditis

(Duration) Yrs. 8 mos. — ds.
Contributory (Secondary): Senility
None (Duration) — yrs. mos. ds.

(Signed) J. E. Melton M. D.
8-1-1922 (Address) St. Anthony, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Riverview Cemetery St. Anthony — DATE OF BURIAL: 10/11 1921

20. UNDERTAKER: W. M. Hanson — ADDRESS: St. Anthony Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

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FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 99
Primary Registration District No. 2177
File No. 36427
Registered No.

RECEIVED
JAN 10 1922
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Fremont
City of St. Anthony (St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Robert Herbert Lachey

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: September (Month) 13 (Day) 1920 (Year)

7. AGE: 1 Yrs. — Mos. 21 ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): St. Anthony Idaho

10. NAME OF FATHER: Herbert D. Lachey

11. BIRTHPLACE OF FATHER (State or Country): Boise Idaho

12. MAIDEN NAME OF MOTHER: Ruth Long

13. BIRTHPLACE OF MOTHER (State or Country): Nebraska

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): W. W. Lachey
(Address):

15. Filed Nov 10 1921 — W. Dewitt, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 5th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 27th 1921, to Oct 5th 1921, that I last saw h.m alive on Oct 4th 1921 and that death occurred on the date stated above, at ... M.

The CAUSE OF DEATH* was as follows:
Catarrhal dysentery
(Duration) ... Yrs. ... mos. 10 ds.
Contributory (Secondary) —
(Duration) ... yrs. ... mos. ... ds.

(Signed) M. M. Hansbarger M. D.
10/5 1921 (Address) St. Anthony Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: DATE OF BURIAL: Oct 8th 1921

20. UNDERTAKER: W M Hansen — ADDRESS: St. Anthony, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. ____
Primary Registration District No. 6
File No. 26428
Registered No. ____

1. PLACE OF DEATH
County of Gem
City of Emmett
(No. ____ St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sarah Helen Foster
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: widow (Write the word.)

6. DATE OF BIRTH: Apr (Month) 30 (Day) 1844 (Year)

7. AGE: 77 Yrs. 5 Mos. 9 ds.
IF LESS than 1 day how many ____ hrs. or ____ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer): ____

9. BIRTHPLACE (State or Country): Penn.

10. NAME OF FATHER: Phillip Shaw

11. BIRTHPLACE OF FATHER (State or Country): Not Known

12. MAIDEN NAME OF MOTHER: Rebecca Machlen

13. BIRTHPLACE OF MOTHER (State or Country): Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C M Foster
(Address) Glenns Ferry Idaho

15. Filed 12/15 1921 J L Reynolds Local Registrar

SYMS-YORK CO. PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 8 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12/3 1921, to 12/7 1921
that I last saw her alive on 12/7 1921,
and that death occurred on the date stated above, at 1 a M.
The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ____ Yrs. ____ mos. 3 ds.
Contributory (Secondary) Influenza
(Duration) ____ yrs. ____ mos. 2 ds.

(Signed) R N Cummings M. D.
12/10 1921 (Address) Emmett

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients or Recent Residents.)
At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days
Where was disease contracted if not at place of death? ____
Former or usual residence ____

19. PLACE OF BURIAL OR REMOVAL: Emmett Idaho
DATE OF BURIAL: 12/10 1921

20. UNDERTAKER: O D Buckmun
ADDRESS: Emmett Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36429

Registered No.

Registration District No. 6

Primary Registration District No. 6

1. PLACE OF DEATH

County of Gem

City of Emmett

If death occurs away from usual residence, give facts called for under special information.

(No. ..... St.)

2. FULL NAME Lew Evan Wallace

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Infant (Write the word.)

6. DATE OF BIRTH: Dec (Month) 10 (Day) 1920 (Year)

7. AGE: — Yrs. 11 Mos. 23 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: R. H. Wallace

11. BIRTHPLACE OF FATHER (State or Country): Kansas

12. MAIDEN NAME OF MOTHER: Georgia Fulghum

13. BIRTHPLACE OF MOTHER (State or Country): Arkansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) R H Wallace

(Address)

15. Filed 12/16 1921 J. L. Reynolds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 3 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 27 1921, to Dec 2 1921 that I last saw h[illegible] alive on Dec 2 1921 and that death occurred on the date stated above, at 12 [illegible] M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... Yrs. ..... mos. 6 ds.

Contributory (Secondary) Influenza

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) R N Cummings M. D.

12/5 1921 (Address) Emmett Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Emmett Ida — DATE OF BURIAL: 12/4 1921

20. UNDERTAKER: C. D. Buckmun — ADDRESS: Emmett Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. .....
Primary Registration District No. .....
File No. 36430
Registered No. .....

1. PLACE OF DEATH
County of Gem
City of Emmett
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Bernice Elizabeth Slate
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Infant

6. DATE OF BIRTH: Aug. (Month) 8 (Day) 1921 (Year)

7. AGE: — Yrs. 4 Mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: W. J. Slate

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Margaret Davison

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. J. Slate
(Address) Emmett, Idaho

15. Filed 12/16 1921 J. L. Reynolds Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 10 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Baby died suddenly during the night, no Physician
Cause Pneumonia
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) J. L. Reynolds M. D.
19..... (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Emmett Idaho	12/11 1921
20. UNDERTAKER C. O. Buckenmeyer	ADDRESS Emmett Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Gem

City of Emmett

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No. 6

(No. ..... St.)

File No. 36431

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Henry E. Cooke

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	white	Married

6. DATE OF BIRTH Sept (Month) 11 (Day) 1853 (Year)

7. AGE 68 Yrs. 3 Mos. 19 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Wisconsin

10. NAME OF FATHER Hawley Cooke

11. BIRTHPLACE OF FATHER (State or Country) New York

12. MAIDEN NAME OF MOTHER Not known

13. BIRTHPLACE OF MOTHER (State or Country) " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Lee M. Laughlin

(Address) Emmett Idaho

15. Filed 1/3 1922 J. L. Reynolds Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 30 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 30 1921, to and Visit Only that I last saw h— alive on Dec 30 1921 and that death occurred on the date stated above, at 10 ½ M.

The CAUSE OF DEATH* was as follows:

Aortic regurgitation

(Duration) 2 yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. L. Reynolds M. D.

1/3 1922 (Address) Emmett Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Emmett Idaho

DATE OF BURIAL 1/1 1922

20. UNDERTAKER C. D. Buckner

ADDRESS Emmett Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Gem

City of Emmett

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No. 6

(No. , St.)

File No. 26432

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Solomon B. Callender

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): married

6. DATE OF BIRTH: Nov 20 (Month) (Day) 1856 (Year)

7. AGE: 65 Yrs. 1 Mos. 1 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Solomon Callender

11. BIRTHPLACE OF FATHER (State or Country): Penn

12. MAIDEN NAME OF MOTHER: Sarah Skenrider

13. BIRTHPLACE OF MOTHER (State or Country): Not Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. J. Callender

(Address) Boise Idaho

15. Filed 12/24/21 19

F. L. Reynolds
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 21 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 13 1921, to Dec 21 1921, that I last saw h— alive on Dec 20 1921, and that death occurred on the date stated above, at 4 P M.

The CAUSE OF DEATH* was as follows:

Heart trouble

Fatty degeneration of heart

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) F. L. Reynolds M. D.

12/24 1921 (Address) Emmett Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Emmett Idaho

DATE OF BURIAL: 12/26 1921

20. UNDERTAKER: O. Buckner

ADDRESS: Emmett Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1

1. PLACE OF DEATH

County of Gem

City of Emmett

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No. 4

(No. ..... St.)

File No. 26434

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Spear

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): married

6. DATE OF BIRTH: March 3rd (Month) (Day) 1874 (Year)

7. AGE: 47 Yrs. 9 Mos. 4 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Crafford Co Ark

10. NAME OF FATHER: James Spear

11. BIRTHPLACE OF FATHER (State or Country): Kentucky

12. MAIDEN NAME OF MOTHER: Mary Nelson

13. BIRTHPLACE OF MOTHER (State or Country): Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant): Minnie Spear

(Address): Emmett Ida.

15.

Filed 12/14 1921

J L Reynolds
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 6 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 24 1921, to Dec 6 1921, that I last saw him alive on Dec 5 1921, and that death occurred on the date stated above, at 2-45 P.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) [redacted] Yrs. mos. 12 ds.

Contributory (Secondary): Influenza

(Duration) yrs. mos. 4 ds.

(Signed) J L Reynolds M. D.

12/7 1921 (Address) Emmett Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Emmett Idaho

DATE OF BURIAL: 12/9 1921

20. UNDERTAKER: C D Bucknum

ADDRESS: Emmett Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36435
Registered No.

1. PLACE OF DEATH
County of Elmore
City of Emmett
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No. 6
(No. , St.)

2. FULL NAME Anna Marion Beutler

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Infant (Write the word.)

6. DATE OF BIRTH: Aug 7 1921 (Month) (Day) (Year)

7. AGE: — Yrs. 4 Mos. — ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Ed Beutler

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Anna Stanley

13. BIRTHPLACE OF MOTHER (State or Country): Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Ed Beutler
(Address):

15. Filed 12/9 1921 J. C. Rasmussen Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec 7 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 22 1921, to Dec 6 1921, that I last saw h[illegible] alive on Dec 6 1921, and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:
Whooping Cough
Pneumonia
(Duration) Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) Burton O'Clark, M. D.
Dec 7 1921 (Address) Emmett Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Emmett Idaho | DATE OF BURIAL: 12/8 1921

20. UNDERTAKER: C. D. Buckman | ADDRESS: Emmett Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED JAN 12 1922 BUREAU OF VITAL STATISTICS

Registration District No. 21

Primary Registration District No.

File No. 36436

Registered No.

1. PLACE OF DEATH

County of Gooding

City of Hagerman (No.) St.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Orville Johnson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number. W C Sandless

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Indian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word.): Single

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1 (Year)

7. AGE: 60 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15. Filed July 1 1922 R N Greene Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 29 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 16 1921, to ..... 19....., that I last saw h.. alive on June 16 1921, and that death occurred on the date stated above, at 11 a M.

The CAUSE OF DEATH* was as follows:

Tuberculosis

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) R N Greene M. D.

June 29 1921 (Address) Hagerman

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR ~~REMOVAL~~: Hagerman DATE OF BURIAL: June 30 1921

20. UNDERTAKER: None ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PR... & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

Registration District No. 21

Primary Registration District No.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36437

Registered No.

1. PLACE OF DEATH

County of Gooding

City of Hagerman (No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Bessie Mildred Cook

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: June (Month) 7 (Day) 1902 (Year)

7. AGE: 19 Yrs. Mos. 18 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Walter Cook

11. BIRTHPLACE OF FATHER (State or Country): Mo

12. MAIDEN NAME OF MOTHER: Kate Johnston

13. BIRTHPLACE OF MOTHER (State or Country): Ark.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Mrs R. G. Finch
(Address): Hagerman

15. Filed June 26 1921 R N Greene Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 25 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 1921, to June 25 1921, that I last saw h.r alive on June 25 1921, and that death occurred on the date stated above, at 11:45 A.M.

The CAUSE OF DEATH* was as follows:

Tuberculosis

(Duration) 1 Yrs. 6 mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. 16 ds.

(Signed) R N Greene M. D.

June 26 1921 (Address) Hagerman

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death? at place death

Former or usual residence —

19. PLACE OF BURIAL OR REMOVAL: Hagerman Cemetery — DATE OF BURIAL 1921

20. UNDERTAKER: A E Thompson — ADDRESS Gooding

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36438
Registered No.

1. PLACE OF DEATH
County of Gooding
City of Wagerman
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 21
Primary Registration District No.
(No. St.)

RECEIVED
JAN 10 1922
BUREAU OF VITAL STATISTICS

2. FULL NAME William Hendrickson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6. DATE OF BIRTH: Oct (Month) 13 (Day) 1862 (Year)

7. AGE: 58 Yrs. 10 Mos. 2 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: James Hendrickson

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Martha J Langley

13. BIRTHPLACE OF MOTHER (State or Country): Tenn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Wm Hendrickson
(Address) Wagerman

15. Filed Sept 12 1921 R W Greene Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 11 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1 1921 to Sept 3 1921, that I last saw h. alive on Sept 3 1921, and that death occurred on the date stated above, at 3 P M.

The CAUSE OF DEATH* was as follows:
Endocarditis
about 1 or 8 years
(Duration) Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) R W Greene M. D.
Sept 12 1921 (Address) Wagerman

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death? Teton Idaho
Former or usual residence Teton Idaho

19. PLACE OF BURIAL OR REMOVAL: Wagerman
DATE OF BURIAL 19

20. UNDERTAKER
ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 21
Primary Registration District No.
File No. 36439
Registered No.

RECEIVED
JAN 10 1922
BUREAU OF VITAL STATISTICS
STATE OF IDAHO

1. PLACE OF DEATH
County of Gooding
City of Wagerman (No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Allie Otis Moore

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Aug (Month) 12 (Day) 1883 (Year)

7. AGE: 38 Yrs. 1 Mos. 3 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Coultonville Ill

10. NAME OF FATHER: William Osborn

11. BIRTHPLACE OF FATHER (State or Country): Ill

12. MAIDEN NAME OF MOTHER: Mary Bennett

13. BIRTHPLACE OF MOTHER (State or Country): Ill

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jas B Moore
(Address) Wagerman

15. Filed Sept 16 1921 R H Greene Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 13 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 3 1920 to Sept 15 1921 that I last saw h[illegible] alive on Sept 15 1921, and that death occurred on the date stated above, at 4:40 P M.
The CAUSE OF DEATH* was as follows:
Arthritis Deformans
with Nephritis
(Duration) 3 Yrs. mos. ds.
Contributory (Secondary) Nephritis
(Duration) yrs. mos. ds.
(Signed) R H Greene M. D.
Sept 16 1921 (Address) Wagerman

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF ~~BURIAL~~ OR REMOVAL: Coultonville Ill — DATE OF BURIAL: Sept 20 1921

20. UNDERTAKER: A V Thompson — ADDRESS: Gooding

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 24

Primary Registration District No.

File No. 36440

Registered No.

County of Goodding

City of Goodding (St.)

If death occurs away from usual residence, give facts called for under special information.

JAN 10 1922
BUREAU OF VITAL STATISTICS

2. FULL NAME Robert H Houston

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	white	Married

6. DATE OF BIRTH: Dec (Month) 22 (Day) 1868 (Year)

7. AGE: 53 Yrs. 0 Mos. 9 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farming
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: Samuel H Houston

11. BIRTHPLACE OF FATHER (State or Country): Penn.

12. MAIDEN NAME OF MOTHER: Mary E. Woods

13. BIRTHPLACE OF MOTHER (State or Country): Penn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Carolyn Smith
(Address)

15. Filed 1-9-1922 F F Cayman Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 31st (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 25 1921 to Dec 31 1921, that I last saw h[illegible] alive on 12/31 1921, and that death occurred on the date stated above, at 12 P M.

The CAUSE OF DEATH* was as follows:

Locomotar ataxia

(Duration) 2 Yrs. mos. ds.

Contributory (Secondary) Chronic

(Duration) yrs. mos. 7 ds.

(Signed) J H Cromwell M. D.

1/3 1922 (Address) Goodding Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Goodding DATE OF BURIAL: Jan 2 1922

20. UNDERTAKER: A E Thompson ADDRESS: Goodding

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED JAN 10 1922 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36442
Registered No. 31

1. PLACE OF DEATH. Registration District No. 103
County of Idaho Primary Registration District No. 1001
City of Grangeville (No. 1063 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Gideon J Williams

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH. Dec (Month) 21 (Day) 1921 (Year)

7. AGE: 70 Yrs. 1 Mos. 28 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Engineering
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE Monroe Madison Co (State or Country) Tenesee

10. NAME OF FATHER William Williams

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Wm. T. Williams
(Address) Grangeville

15. Filed Jan 1 1922 G S Stockton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 20 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1 1921, to Dec 20 1921, that I last saw h[illegible] alive on Dec 19 1921, and that death occured on the date stated above, at 12 A. M.

The CAUSE OF DEATH* was as follows:

Carcinoma of rectum

(Duration) one year mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) G S Stockton M. D.

12/24/1921 (Address) Grangeville

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mt Idaho — DATE OF BURIAL: Dec 22d 1921

20. UNDERTAKER: E L Hanson — ADDRESS: Grangeville

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & ENGS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36443
Registered No. 30

1. PLACE OF DEATH.

Registration District No. 103

County of Idaho

Primary Registration District No. 2181

City of Mt-Idaho (No.) ..... St.)

RECEIVED
JAN 10 1922
BUREAU OF VITAL STATISTICS

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Elsebeth Hindman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. Oct (Month) 2 (Day) 1840 (Year)

7. AGE: 73 Yrs. 2 Mos. 12 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Andrew ?

11. BIRTHPLACE OF FATHER (State or Country): Virginia

12. MAIDEN NAME OF MOTHER: Sarah Loring

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Chas N Hindman
(Address) Mt Idaho, Idaho

15. Filed Jan 1 1922 G S Stockton Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 15 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 15 1921, to Dec 15 1921, that I last saw her alive on Dec 14 1921, and that death occured on the date stated above, at 3 a. M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G. S. Stockton M. D.

12/15 1921 (Address) Grangeville Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mt Idaho — DATE OF BURIAL: 12-15-1921

20. UNDERTAKER: E S Hancock — ADDRESS: Grangeville

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED JAN 10 1922 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 103
Primary Registration District No. 1031
File No. 36444
Registered No. 29

1. PLACE OF DEATH.
County of Idaho
City of Grangeville (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Samfsson Neal

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	White	Married

6. DATE OF BIRTH. Nov (Month) 12 (Day) 1836 (Year)

7. AGE 85 Yrs. ..... Mos. 25 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Farmer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Kentuckey

10. NAME OF FATHER Albert - Neal

11. BIRTHPLACE OF FATHER (State or Country) Louisana

12. MAIDEN NAME OF MOTHER ~~Eatmon~~ Sarah Garner

13. BIRTHPLACE OF MOTHER Missouri (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Lena Neal
(Address) Grangeville Idaho

15. Filed Jan 1 1922 G S Stockton Local Registrar

SYMS - YORK CO., PTRS. & SONS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 7 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1 1921, to Dec 7 1921, that I last saw him alive on Dec 5 1921, and that death occured on the date stated above, at 6 P. M.
The CAUSE OF DEATH* was as follows:

Senile decay

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Arteria - Sclerosis
(Duration) 2 yrs. ..... mos. ..... ds.
(Signed) G S Stockton M. D.
12/7 1921 (Address) Grangeville Ida

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Prairie View — DATE OF BURIAL: Dec 9 1921

20. UNDERTAKER: E B Hancock — ADDRESS: Grangeville Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JAN 10 1922 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36446
Registered No. 3

1. PLACE OF DEATH
County of Jefferson Registration District No. 98
City of Grant Primary Registration District No. 2176
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jeneria Wilson
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): single

6. DATE OF BIRTH: Apr 17 1917 (Month) (Day) (Year)

7. AGE: 4 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: no
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Bruce Wilson

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Louise Leek

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Bruce Wilson
(Address) Grant Ida

15. Filed 1-10 1922 Ray Fisher Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 28 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 28 1921 to June 28 1921
that I last saw her alive on June 28 1921
and that death occurred on the date stated above, at 11 A M.
The CAUSE OF DEATH* was as follows:

Oedema of Glottis

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Earl D. Jones M. D.
6 29 1921 (Address) Roberts Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Grant — DATE OF BURIAL: 6-29 1921

20. UNDERTAKER: Cliff C. Hayes — ADDRESS: Ida Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
JAN 10 1922
BUREAU OF VITAL STATISTICS

Registration District No. 98
Primary Registration District No. 2176
File No. 36447
Registered No. 4

1. PLACE OF DEATH
County of Jefferson
City of Home (or Town) St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Thomas Dudley Walker
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): single

6. DATE OF BIRTH: Sept 27 1921 (Month) (Day) (Year)

7. AGE: ....Yrs. ....Mos. 1 ds.
IF LESS than 1 day how many ....hrs. or ....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Ida

10. NAME OF FATHER: John H. Walker

11. BIRTHPLACE OF FATHER (State or Country): Mo.

12. MAIDEN NAME OF MOTHER: Achsah E. Walker

13. BIRTHPLACE OF MOTHER (State or Country): Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Achsah E Walker
(Address) Homer Ida

15. Filed Jan 10 1922
Ray H Fisher
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept 28 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....19...., to ....19....
that I last saw h.... alive on ....19....,
and that death occurred on the date stated above, at 11 A M.
The CAUSE OF DEATH* was as follows:

Premature Birth

....(Duration) ....Yrs. ....mos. ....ds.

Contributory (Secondary)

....(Duration) ....yrs. ....mos. ....ds.

(Signed) Earl D Jones M. D.
Sept 29 1921 (Address) Roberts

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Roberts — DATE OF BURIAL: Sept 29 1921

20. UNDERTAKER — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36448

Registered No.

1. PLACE OF DEATH.
County of Jerome
City of Jerome
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 23
Primary Registration District No. 1017-2017
(No. ....., ... St.)

2. FULL NAME unnamed White

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Infant

6. DATE OF BIRTH: DEC (Month) 22 (Day) 1921 (Year)

7. AGE: ..... yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Jerome Idaho

10. NAME OF FATHER: Edward B White

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Mattie Marie Stucker

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. E. B. White
(Address) Jerome Idaho

15. Filed Jan 3 1922 E. D. Pifer M. D. Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: DEC (Month) 22 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 22 1921, to Dec 22 1921 that I last saw h— alive on ..... 191—, and that death occurred on the date stated above, at —M.

The CAUSE OF DEATH* was as follows:

Still born.
(Hydrocephalus - Spina Bifida)

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E. D. Pifer M. D.
1/3 1922 (Address) Jerome Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Jerome Cemetary — DATE OF BURIAL: Dec 23 1921

20. UNDERTAKER: D. A. Stevenson — ADDRESS: Jerome Idaho

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 23
Primary Registration District No. 1017-2017
File No. 36450
Registered No.

1. PLACE OF DEATH
County of Jerome
City of Jerome
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John T Illman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Sept 3 (Month) 1855 (Day) 1 (Year)

7. AGE: 66 Yrs. 2 Mos. 23 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Tenn.

10. NAME OF FATHER: Bardy M. Tillman

11. BIRTHPLACE OF FATHER (State or Country): Tenn.

12. MAIDEN NAME OF MOTHER: Elizabeth Sutton

13. BIRTHPLACE OF MOTHER (State or Country): Tenn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) B. M. Tillman
(Address) Jerome.

15. Filed Nov 27 1921 E. D. Pipes M.D. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 26 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1908 to Nov 26 1921 that I last saw h.. alive on Nov 26 1921, and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Chronic inflamation of Colon with Chronic Mucous Colitis
(Duration) 20 Yrs. mos. ds.
Contributory (Secondary) Acute obstruction of Bowel
(Duration) yrs. mos. 3 ds.

(Signed) E. D. Pipes M. D.
Nov 27 1921 (Address) Jerome Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Jerome Cemetary — DATE OF BURIAL: Nov 28 1921

20. UNDERTAKER: D & L Harrison — ADDRESS: Jerome Idaho

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36451
Registered No. 1867

1. **PLACE OF DEATH**

County of Kootenai
City of Coeur d'Alene (No. 15 Post Falls, Ida., St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 30
Primary Registration District No. 1051

BUREAU OF VITAL STATISTICS

2. **FULL NAME** James Mc Nair

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.)
Male	White	Widowed

6. **DATE OF BIRTH** Feb (Month) 1 (Day) 1850 (Year)

7. **AGE** 71 Yrs. 10 Mos. 13 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. **OCCUPATION**
(a) Trade, profession or particular kind of work: President Post Falls Lbr Co
(b) General nature of industry, business or establishment in which employed (or employer):

9. **BIRTHPLACE** (State or Country) Scotland

10. **NAME OF FATHER** James Mc Nair

11. **BIRTHPLACE OF FATHER** (State or Country) Scotland

12. **MAIDEN NAME OF MOTHER** Catherine Allen

13. **BIRTHPLACE OF MOTHER** (State or Country) Scotland

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**
(Informant) Christine Stephens
(Address) Post Falls Ida

15. Filed Jan 4 1922 D P Brennan Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH** 12 (Month) 13 (Day) 1921 (Year)

17. **I HEREBY CERTIFY, That I attended deceased from** Oct 2 1921, to Dec 4 1921
that I last saw h... alive on Dec 10 1921
and that death occurred on the date stated above, at 2 P. M.
The CAUSE OF DEATH* was as follows:

Mitral Insufficiency
Valvular Heart Disease,
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Chronic Gastritis
..... (Duration) 15 yrs. ..... mos. ..... ds.
(Signed) H. L. McCauley M. D.
12/17 1921 (Address) Post Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. **PLACE OF BURIAL OR REMOVAL** Greenwood. **DATE OF BURIAL** Dec 17 1921

20. **UNDERTAKER** Trumbull Undertaking Co **ADDRESS** Spokane Wash.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

[redacted] no
[redacted] EALTH
[redacted] m of Vital Statistics

Registration District No. 30
Primary Registration District No. 1057
File No. 36452
Registered No. [redacted] 47

1. PLACE OF DEATH
County of Kootenai
City of Rathdrum (Ward) BURIAL NO. STATE (St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Frank M. Martin
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widower

6. DATE OF BIRTH: April (Month) 2 (Day) 1850 (Year)

7. AGE: 71 Yrs. 7 Mos. 17 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Pa.

10. NAME OF FATHER: A C. Martin

11. BIRTHPLACE OF FATHER (State or Country): Pa.

12. MAIDEN NAME OF MOTHER: Margret McCormick

13. BIRTHPLACE OF MOTHER (State or Country): Pa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A. M. Martin
(Address) Post Falls Id

15. Filed Jan 5, 1922 D D Drennan Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Novbr 19 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 22 1921, to Novb. 19 1921, that I last saw h[illegible] alive on Nov. 18. 1921 and that death occurred on the date stated above, at 8.00 A. M.
The CAUSE OF DEATH* was as follows:
Arteria Sclerosis
(Duration) 5 Yrs. mos. ds.
Contributory (Secondary) Chronic Nephritis
(Duration) yrs. 3 mos. ds.
(Signed) Frank Ware M. D.
11/20 1921 (Address) Rathdrum, N. Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. 2 mos. 28 days. In the State 40 yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence Post Falls, Idaho

19. PLACE OF BURIAL OR REMOVAL: Rathdrum Ida
DATE OF BURIAL: 11-20 1921
20. UNDERTAKER: C. Cassedy
ADDRESS: Rathdrum

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
JAN 10 1922
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 30
Primary Registration District No. 1067

File No. 36453
Registered No. 1683

1. PLACE OF DEATH

County of Kootenai
City of Rathdrum (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Wallace B. Green

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
male	white	Single

6. DATE OF BIRTH Febry 5 1921
(Month) (Day) (Year)

7. AGE Yrs. 9 Mos. 23 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Charles S. Green

11. BIRTHPLACE OF FATHER (State or Country) Minn.

12. MAIDEN NAME OF MOTHER Elizabeth Roberts

13. BIRTHPLACE OF MOTHER (State or Country) Minn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Charles S. Green
(Address) Rathdrum, Idaho

15.
Filed ..... 19 .....
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Novbr. 28 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 27 1921 to Nov. 28 1921 that I last saw him alive on Nov. 28 1921 and that death occurred on the date stated above, at 8.00 P. M.

The CAUSE OF DEATH* was as follows:
Laryngeal Diphtheria
.....
.....
(Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Frank J. Kenny M. D.
11/30 1921 (Address) Rathdrum, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Rathdrum Idg	11/30 1921

20. UNDERTAKER C. Cassedy ADDRESS Coeur d'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Kootenai
City of
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No.
(No. Near, Post Falls St.)

File No. 36454
Registered No. 1004

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME August Belde

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: April (Month) 10 (Day) 1895 (Year)

7. AGE: 26 Yrs. 7 Mos. 21 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Julius Belde

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Martina Folk

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Julius Belde
(Address) Post Falls, Ida.

15. Filed Jan 5, 1922 D D Drennan Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 1 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....19...., to ....19....,
that I last saw h..... alive on ....19....,
and that death occurred on the date stated above, at 1:30 M.
The CAUSE OF DEATH* was as follows:
Chest Crushed in
Runaway (accidental)
(Duration) ....Yrs....mos....ds.
Contributory (Secondary)
(Duration) ....yrs....mos....ds.
(Signed) P B Mooney Coroner M. D.
12/3 1921 (Address) Coeur d'Alene Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death....yrs....mos....days. In the State 19 yrs....mos....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: St Thomas Cemetery
DATE OF BURIAL: 12/5 1921

20. UNDERTAKER: P B Mooney
ADDRESS: Coeur d'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-A—25 M. 1-19. RECEIVED JAN 10 1922 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 30
Primary Registration District No. 1001
File No. 36455
Registered No. 1005

1. PLACE OF DEATH

County of Kootenai
City of Coeur d'Alene (No. 712 Sherman St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Augustus C. May

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M.	W.	married

6. DATE OF BIRTH 12 (Month) 22 (Day) 1872 (Year)

7. AGE 50 Yrs. 11 Mos. 20 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Contractor and
(b) General nature of industry, business or establishment in which employed (or employer): builder

9. BIRTHPLACE (State or Country) Minn.

10. NAME OF FATHER Henry May

11. BIRTHPLACE OF FATHER (State or Country) Germany

12. MAIDEN NAME OF MOTHER Albertina —

13. BIRTHPLACE OF MOTHER (State or Country) Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. A. C. May
(Address) 1212 Sherman Ave

15. Filed Jan. 5 1921 D D Drenna Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. (Month) 12 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 16 1916, to Dec. 12 1921, that I last saw h[illegible] alive on Dec. 10 1921, and that death occurred on the date stated above, at 6 30 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(Duration) 5 Yrs. ..... mos. ..... ds.

Contributory (Secondary) Cerebral Embolism

(Duration) 2 yrs. ..... mos. ..... ds.

(Signed) J. Dwyer M. D.

12/14/21 (Address) Coeur d'Alene Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Forest Cem. C'dAlene — **DATE OF BURIAL** 12-15-21

20. UNDERTAKER C. Carrad — **ADDRESS** C'dAlene Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 30
Primary Registration District No. 1057
File No. 36456
Registered No. 1061

1. PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene (No. Fourth St.)
If death occurs away from usual residence, give facts called for under special information.

RECEIVED JAN 10 1922 BUREAU OF VITAL STATISTICS

2. FULL NAME Edna Marie Peck

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: May (Month) 8 (Day) 1915 (Year)

7. AGE: 6 Yrs. 7 Mos. 6 ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business or establishment in which employed (or employer) —

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER E. J. Peck

11. BIRTHPLACE OF FATHER (State or Country) Colo

12. MAIDEN NAME OF MOTHER Ellen Jones

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. J. Peck
(Address) Coeur d'Alene Ida

15. Filed Jan 5 1922 D. D. Drenna Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 12 (Month) 14 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 11 1921, to Dec 14 1921, that I last saw h[illegible] alive on Dec 14 1921, and that death occurred on the date stated above, at 2.35 A.M.
The CAUSE OF DEATH* was as follows:

General peritonitis

(Duration) Yrs. mos. 1 ds.
Contributory (Secondary) Ruptured appendicial abscess.
(Duration) Yrs. mos. 1 ds.

(Signed) Alexander Barclay M. D.
12 14 1921 (Address) Coeur d Alene.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State 6 yrs. ... mos. ... days
Where was disease contracted if not at place of death? —
Former or usual residence —

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetery — DATE OF BURIAL: 12/15 1921

20. UNDERTAKER: [illegible] — ADDRESS: Coeur d'Alene

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3645
Registered No. 1057

RECEIVED
JAN 10 1922
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Kootenai
Registration District No. 30
Primary Registration District No. 1057
City of Post Falls Idaho
If death occurs away from usual residence, give facts called for under special information.
(No. ..... St.)

2. FULL NAME Charles Kamps

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. ~~SINGLE~~, MARRIED, ~~WIDOWED OR DIVORCED~~. (Write the word.): married

6. DATE OF BIRTH: May (Month) 23 (Day) 1875 (Year)

7. AGE: 46 Yrs. 6 Mos. 21 ds.
IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Box Manufacturing
(b) General nature of industry, business, or establishment in which employed (or employer): Employee

9. BIRTHPLACE (State or Country): Wisconsin

10. NAME OF FATHER: John Kamps.

11. BIRTHPLACE OF FATHER (State or Country): Germany.

12. MAIDEN NAME OF MOTHER: Rose Kamps.

13. BIRTHPLACE OF MOTHER (State or Country): Germany.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Katharine E. Kamps
(Address) Post Falls Idaho

15. Filed Jan 5 1922, D. D. Brennan, Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 14th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 14 1920 to Dec 14 1921 that I last saw him alive on Dec 14 1921 and that death occurred on the date stated above, at 4:30 P. M.

The CAUSE OF DEATH* was as follows:

Apoplexy (Cerebral Hemorrhage)

(Duration) .... Yrs. .... mos. 1 ds.

Contributory (Secondary) ....

(Duration) .... Yrs. .... mos. .... ds.

(Signed) F. L. McCauley M. D.

Dec 15 1921 (Address) Post Falls, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death? -
Former or usual residence Post Falls Idaho

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetery — DATE OF BURIAL: Dec 19 1921

20. UNDERTAKER: P. E. McCauley — ADDRESS: Coeur d'Alene Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 30
Primary Registration District No. 1057
File No. 36458
Registered No. 1008

1. PLACE OF DEATH

County of Kootenai
City of Coeur d'Alene (No. 3-4 Lacrosse Street.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED JAN 4 1922 BUREAU OF VITAL STATISTICS

2. FULL NAME Sarah Bell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: April 10 1860 (Month) (Day) (Year)

7. AGE: 61 Yrs. 8 Mos. 7 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Home Maf
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Scotland

10. NAME OF FATHER: Charles Bell

11. BIRTHPLACE OF FATHER (State or Country): Scotland

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Frank Bell
(Address) Coeur d'Alene Ida.

15. Filed Jan 5 1922 D. D. Drennan Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec 17 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 1 1921, to Dec 17 1921, that I last saw h[illegible] alive on Dec 15 1921, and that death occurred on the date stated above, at 6:30 P.M.

The CAUSE OF DEATH* was as follows:
Gastric Carcinoma

(Duration) Yrs. 6 mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) W. H. Kaedeen M. D.
12/19 1921 (Address) Coeur d'Alene Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State 10 yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: G. Thomas Cem. DATE OF BURIAL: 12/20/1921

20. UNDERTAKER: [illegible] Coeur d'Alene ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY; PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED JAN 14 1922 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 30
Primary Registration District No. 1051
File No. 36459
Registered No. 1609

1. PLACE OF DEATH
County of Kootenai
City of Coeur d'alene (No. 1137 Seventh St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sarah D Tomlinson
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: July (Month) 18 (Day) 1991 (Year)

7. AGE: 0 Yrs. 5 Mos. 4 ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Coeur d'alene Ida.

10. NAME OF FATHER: Fremont Tomlinson

11. BIRTHPLACE OF FATHER (State or Country): Ind.

12. MAIDEN NAME OF MOTHER: Nettie Battoms

13. BIRTHPLACE OF MOTHER (State or Country): Mich

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Fremont Tomlinson
(Address) Coeur d'alene Ida

15. Filed Jan 6 1922 D D Brennan Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 23 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 21 1921, to Dec. 23 1921 that I last saw h[illegible] alive on Dec. 22 1921 and that death occurred on the date stated above, at 8 a M.
The CAUSE OF DEATH* was as follows:
Marasmus.

(Duration) Yrs. 5 mos. [illegible] ds.
Contributory (Secondary) ... (Duration) ... yrs. ... mos. ... ds.

(Signed) John D Wood M. D.
Dec 23 1921 (Address) Coeur d'Alene Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State — yrs. 5 mos. ... days
Where was disease contracted if not at place of death? ...
Former or usual residence ...

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetery — DATE OF BURIAL: 12-24-1921

20. UNDERTAKER: [illegible] Mortuary — ADDRESS: Coeur d'Alene Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED JAN 10 1922 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 80
Primary Registration District No. 1051
File No. 36460
Registered No. 1670

1. PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene (No. 1019 Fifth St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Archibald R Mathews

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6. DATE OF BIRTH: Nov (Month) 28th (Day) 1845 (Year)

7. AGE: 76 Yrs. 1 Mos. — ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Canada

10. NAME OF FATHER: Richard Mathews

11. BIRTHPLACE OF FATHER (State or Country): Canada.

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R. A. Mathews
(Address) Coeur d'Alene Ida.

15. Filed Jan 5 1922 D D Drenna Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 28 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 26 1921 to Dec. 27 1921
that I last saw h.. alive on Dec. 27 1921
and that death occurred on the date stated above, at 1 P M.
The CAUSE OF DEATH* was as follows:
Lobar Pneumonia.

(Duration) ... Yrs. ... mos. 5 ds.
Contributory (Secondary)
(Duration) ... yrs. ... mos. 1 ds.

(Signed) John O Wood M. D.
Dec. 28 1921 (Address) Coeur d'Alene Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State 12 yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetery | DATE OF BURIAL: 12/29/1921
20. UNDERTAKER: W S Mooney | ADDRESS: Post Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Kootenai Registration District No. 30

City of Coeur d'Alene (No. 516 Sherman St.) Primary Registration District No. 1051

File No. 36461

Registered No. 7011

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Carl Wilding

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M.	W.	Widowed

6. DATE OF BIRTH: Oct. (Month) 3 (Day) 1860 (Year)

7. AGE: 61 Yrs. 2 Mos. 1 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER: Carl Larson

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Agnes Ruble
(Address) 1417 So 46 st Tacoma Wash

15. Filed Jan 5 1921 D D Brennan Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. (Month) 4 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 20 1921, to Dec 4 1921, that I last saw h.. alive on Dec 4 1921 and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows: Septic Peritonitis, Appendicitis

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D D Brennan M. D.

12/6 1921 (Address) Coeur d Alene Idg

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Forest - Cem. C'Dale — DATE OF BURIAL: 12-6 1921

20. UNDERTAKER: Carsley — ADDRESS: C'd Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED JAN 10 1922 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 64

County of Latah

Primary Registration District No. 2144

File No. 36463

City of Troy (No. ..... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Catherine Arnot

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Fem-	White	Married

6. DATE OF BIRTH: December (Month) 12 (Day) 1849 (Year)

7. AGE: 72 Yrs. ..... Mos. 9 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Delphi Indiana

10. NAME OF FATHER: John Wingard

11. BIRTHPLACE OF FATHER (State or Country): Penn.

12. MAIDEN NAME OF MOTHER: Catharine Swoberger

13. BIRTHPLACE OF MOTHER (State or Country): Penn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Mrs. Fred Arnberg
(Address): Troy Idaho

15. Filed Dec 21 1921 Lucy M. Pickerd Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: December (Month) 20 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Deceased, Sesue Shortly after
death, Cause of death, based
on history, Acute Heart Failure

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. Armstrong M. D.
12/21 1921 (Address) Moscow Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Moscow Idaho	Dec 23 1921

20. UNDERTAKER	ADDRESS
John J. Pickerd	Troy Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. RECEIVED JAN 10 1922 BUREAU OF VITAL STATISTICS

Registration District No. 68

County of Latah

Primary Registration District No.

File No. 36464

City of Juliaetta, (If not in incorporated place, give township.) St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Zachariah Lay

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH: March (Month) 16" (Day) 1856 (Year)

7. AGE: 65 Yrs. 8 Mos. 12 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Retired Farmer

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: Nathan Lay

11. BIRTHPLACE OF FATHER (State or Country): North Carolina

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country): Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) mollie graves

(Address) Juliaetta Idaho

15. Filed Dec 1 1921 R. T. Pepper Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 28" (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,

that I last saw h... alive on ..... 191...,

and that death occured on the date stated above, at about 3 & 7 am M.

The CAUSE OF DEATH* was as follows:

Old ages

No Physician in attendance

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

..... 19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Juliaetta Cemetery

DATE OF BURIAL: Dec. 1" 1921

20. UNDERTAKER: J. E. Bracelore

ADDRESS: Juliaetta Idaho.

Iron number, 65

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

BYMS - YORK CO., PTRS. & BORS. 24658

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Latah
City of Moscow (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

RECEIVED JAN 10 1922 BUREAU OF VITAL STATISTICS

Registration District No. 61
Primary Registration District No. 1011
File No. 36465
Registered No. 25

2. FULL NAME Arthur G. Paul.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Dec 26 1887 (Month) (Day) (Year)

7. AGE: 34 Yrs. ..... Mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: August Paul

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Elizabeth Eckhardt

13. BIRTHPLACE OF MOTHER (State or Country): Ill

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chas Paul
(Address) Moscow

15. Filed 12/31 1921 M Hawthorne Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec 30 [redacted] 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 29 1921, to Dec 29 1921, that I last saw him alive on Dec 29 1921, and that death occurred on the date stated above, at 12:05 A.M.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Ex Hemiplegia Cerebral
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) W M Hawthorne M. D.
12/31 1921 (Address) Moscow Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Moscow — DATE OF BURIAL: 1/1 1922

20. UNDERTAKER: Gem City — ADDRESS: Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36466

Registered No. 10

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Latah — Registration District No. 201

City of Moscow — Primary Registration District No. 1011

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Annie J Graham.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Dec (Month) 2 (Day) 1857 (Year)

7. AGE: 64 Yrs. ..... Mos. 23 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Canada

10. NAME OF FATHER: — Eaton

11. BIRTHPLACE OF FATHER (State or Country): ?

12. MAIDEN NAME OF MOTHER: ?

13. BIRTHPLACE OF MOTHER (State or Country): ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J W Graham
(Address) Moscow Idaho

15. Filed 12/26 1921 M Hoaritners
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 25th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 15 1921, to Dec 25 1921, that I last saw her alive on Dec 21 1921, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) one Yrs. ..... mos. ..... ds.

Contributory (Secondary) Cancer of Face

(Duration) several yrs. ..... mos. ..... ds.

(Signed) J. U. Clarke M. D.

12/26 1921 (Address) Moscow

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Moscow — DATE OF BURIAL: 12/26 1921

20. UNDERTAKER: Neal Bros — ADDRESS: Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 61
Primary Registration District No. 1911
File No. 36467
Registered No. 69

1. PLACE OF DEATH
County of Latah
City of Moscow (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Kenneth David Boyd

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W Sutz
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: S (Write the word.)

6. DATE OF BIRTH: May (Month) 14 (Day) 1913 (Year)

7. AGE: 8 Yrs. 7 Mos. 7 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Ira R Boyd

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Jessie S. Farnsworth

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ira R Boyd
(Address) Moscow

15. Filed 12/22 19.....
M Hawthorne
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 21 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 20, 1921, to Dec 21 1921, that I last saw h[im] alive on Dec 21 1921, and that death occurred on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:
Acute Dilatation of Heart.
(Duration) ..... Yrs. ..... mos. 1 ds.
Contributory (Secondary) Bronchopneumonia
(Duration) ..... yrs. ..... mos. 1 ds.

(Signed) M Armstrong M. D.
12-21 1921 (Address) Moscow Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Moscow	12/23/21

20. UNDERTAKER: Glen Price — ADDRESS: Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Latah
City of Moscow
If death occurs away from usual residence, give facts called for under special information.

RECEIVED JAN 10 1922 BUREAU OF VITAL STATISTICS

Registration District No. 61
Primary Registration District No. 2141
(No. ..... St.)

File No. 36468
Registered No. 71

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Franklin Garvin.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Oct (Month) 28 (Day) 1867 (Year)

7. AGE: 54 Yrs. 2 Mos. 1 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wis.

10. NAME OF FATHER: George R. Garvin

11. BIRTHPLACE OF FATHER (State or Country): VERmont

12. MAIDEN NAME OF MOTHER: Mary J. Brown

13. BIRTHPLACE OF MOTHER (State or Country): Vermont

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs J. F. Garvin
(Address) Viola Idaho

15. Filed Jan 1 1922 M Hoaruthers Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 12/29/1921
(Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 23 1921, to Dec 29 1921, that I last saw h~~im~~ alive on Dec 29 1921, and that death occurred on the date stated above, at 11:55 M.

The CAUSE OF DEATH* was as follows:

Cancer of Stomach

(Duration) Since Yrs. — mos. — ds.

Contributory (Secondary) Pneumonia

(Duration) ..... yrs. ..... mos. 7 ds.

(Signed) E. K. Wolf M. D.
1/11 1922 (Address) Pullman Wn

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Viola — DATE OF BURIAL: 1/11 1922

20. UNDERTAKER: Glen Pace — ADDRESS: Moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

Form V. S. No. 5 20M.1-16-12

FILED JAN 10 1922 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 61

County of Latah Summary Registration District No. 2141

City of ..... (No. ....., ... St.)

File No. 36468

Registered No. 68

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Jessie M. Emmons

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Married

6. DATE OF BIRTH: August 18 1884 (Month) (Day) (Year)

7. AGE: 37 yrs. 4 mos. 2 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) South Dakota

10. NAME OF FATHER Chas. E. Acland

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER Mary McIntosh

13. BIRTHPLACE OF MOTHER (State or Country) Wisconsin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. F. Emmons
(Address) Garfield, Wash.

15. Filed Dec 30 1921 M Hawthorn Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec (Month) 20 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 15 1921, to Dec 20 1921, that I last saw h[illegible] alive on Dec 20 1921, and that death occurred on the date stated above, at 7 A M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ..... yrs. ..... mos. 5 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Garfield Nash M. D.

Dec 1921 (Address) Garfield Wash

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Garfield, Wash. DATE OF BURIAL: Dec 22 1921

20. UNDERTAKER: L. L. Bunning ADDRESS: Colfax, Wn.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-18

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 47 — 36470

File No. 71

Registered No. 167

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Lemhi

City of Nezperce Idaho (No. Route 3 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Don Quinton Swartz

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Dec 15 (Month) (Day) 1921 (Year)

7. AGE ..... Yrs. ..... Mos. 13 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work... Infant
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Nezperce Idaho Rout 3

10. NAME OF FATHER Lee Clyde Swartz

11. BIRTHPLACE OF FATHER (State or Country) Kansas

12. MAIDEN NAME OF MOTHER Frederika Ann Westa

13. BIRTHPLACE OF MOTHER (State or Country) Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Nezperce Idaho
(Address) Lee Clyde Swartz

15. Filed 12-29 1921 Albert Huff Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 12-27 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12-14 1921, to 12-27 1921, that I last saw him alive on 12-17 1921, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Influenza

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) W Taylor M. D.

12-28 1921 (Address) Nezperce Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Nezperce Cemetery — DATE OF BURIAL: 12-28 1921

20. UNDERTAKER: Albert Huff — ADDRESS: Nezperce Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

BYRD - RICH CO., PTRS. & STRS. 24655

FORM V. S. No. 5-A—25 M. 1-19.

RECE JAN BUR ST

CERTIFICATE OF DEATH

Registration District No. 16

Primary Registration District No. 1016

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36474

Registered No. 20

1. PLACE OF DEATH

County of Kootenai

City of Wallace (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ina M Beager

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
F	W	married (Write the word.)

6. DATE OF BIRTH

Dec 14 (Month) 1866 (Day) 1 (Year)

7. AGE

55 Yrs. 3 Mos. 3 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business or establishment in which employed (or employer) on Ranch

9. BIRTHPLACE (State or Country) Pennsylvania

10. NAME OF FATHER James Bruder

11. BIRTHPLACE OF FATHER (State or Country) Pennsylvania

12. MAIDEN NAME OF MOTHER Madalin Millar

13. BIRTHPLACE OF MOTHER (State or Country) Penn^a

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C F Beager

(Address) .....

15. Filed Dec 17 1921 J. L. Brown Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

12 (Month) 16 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12-15-1921, to 12-16-1921 that I last saw h. ~~alive~~ Dead on 12-16-1921, and that death occurred on the date stated above, at 7.45 P.M.

The CAUSE OF DEATH* was as follows:

Endocarditis.

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Diabetes.

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Herbert C Deane M. D.

19..... (Address) Shoshone Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Bratle Wash	19.....

20. UNDERTAKER O J Brennan ADDRESS Shoshone Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 16
Primary Registration District No. 1016
File No. 36475
Registered No. 19

1. PLACE OF DEATH
County of Lincoln
City of Shoshone (No. ..., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Kate Sills

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.)
F	W	Widow

6. DATE OF BIRTH Feb 27 1847
(Month) (Day) (Year)

7. AGE 74 Yrs. 10 Mos. 3 ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Ireland

10. NAME OF FATHER Martin Kelly

11. BIRTHPLACE OF FATHER (State or Country) Ireland

12. MAIDEN NAME OF MOTHER Mary Hannigan

13. BIRTHPLACE OF MOTHER (State or Country) Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Matthews Sills
(Address) Shoshone

15. Filed 12-12 1921 H. Sievers
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 12 — 11 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan-10 1921, to Dec 11 1921
that I last saw h... alive on Dec 10 1921
and that death occurred on the date stated above, at 8a M.

The CAUSE OF DEATH* was as follows:
Coma malignant trouble of bowel.
(Duration) ... Yrs. ... mos. ... ds.
Contributory (Secondary) Senility
(Duration) 5 yrs. ... mos. ... ds.

(Signed) H. H. Dill M. D.
12/12 1921 (Address) Shoshone Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Shoshone	19...
20. UNDERTAKER D. F. Brennan	ADDRESS Shoshone

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

36476

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
JAN 10 1922
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH. Registration District No. 17
County of Lincoln Primary Registration District No.
City of Richfield (If outside limits, give township.) St.)
File No. 1
Registered No. 8
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Baby Huffington

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH: Dec (Month) 1 (Day) 1921 (Year)

7. AGE: X yrs. X mos. 1 ds.
IF LESS than 1 day how many 3 hrs. or 30 mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Lincoln Co Ida

10. NAME OF FATHER: Melvin H. Huffington

11. BIRTHPLACE OF FATHER (State or Country): Cherokee Co Kans

12. MAIDEN NAME OF MOTHER: Goldie Shelly

13. BIRTHPLACE OF MOTHER (State or Country): Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Melvin H. Huffington
(Address) Richfield Ida R.F.D.

15. Filed Jan 7 1922 O.E. Bloom Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec (Month) 2nd (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1 1921, to Dec 2 1921, that I last saw him alive on Dec 2 1921, and that death occurred on the date stated above, at 3:40 A.M.

The CAUSE OF DEATH* was as follows:
Premature Birth
(6th Month)

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

19 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Home	Dec 2 1921

20. UNDERTAKER	ADDRESS
none	—

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

BVMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JAN 14 1922 VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Madison Registration District No. 100

City of Sunny Dell (No.) (St.) Primary Registration District No. 2178

File No. 36477

Registered No. 91

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Preston Burr

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH: December 14 1869 (Month) (Day) (Year)

7. AGE: 52 Yrs. 11 Mos. 9 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Postmaster
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Payson, Utah

10. NAME OF FATHER: John Atlantic Burr

11. BIRTHPLACE OF FATHER (State or Country): Atlantic Ocean Near coast of Africa

12. MAIDEN NAME OF MOTHER: Martha Angeline Hancock

13. BIRTHPLACE OF MOTHER (State or Country): Iowa USA

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs J. P. Burr
(Address) Sunny Dell Idaho

15. Filed 11-25 1921 — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 23 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 10-13-1921, to 11-22-1921, that I last saw h.IM alive on 11-22-1921, and that death occurred on the date stated above, at 2:10 A M.

The CAUSE OF DEATH* was as follows:
Myocarditis

(Duration) 1 yr Yrs. mos. ds.
Contributory (Secondary) Osteitis deformans
(Duration) 23 yrs. mos. ds.

(Signed) Lorin A. Rich M. D.
11/23 1921 (Address) Rexburg Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Archer — DATE OF BURIAL: Nov. 25 1921

20. UNDERTAKER — ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36478
Registered No. 92
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Independence
City of Madison Co
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 100
Primary Registration District No. 2178
(No. ..... St.)

2. FULL NAME Edw. O. Carlson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH. Sept. 27. 1844.
(Month) (Day) (Year)

7. AGE: 77 Yrs. 2 Mos. 19 ds.
IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER: Carl Nelson

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Sophia Olsen

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Walter Scott
(Address): Lovell

15. Filed 12/27 1921.. G. G. Espe
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Dec (Month) 16 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..... to ..... 191.....
that I last saw h.....alive on ..... 191....
and that death occurred on the date stated above, at ....., ...M.

The CAUSE OF DEATH* was as follows:
Worried dead from old age. - and Weakness
(Duration) ..... Yrs..... mos. ..... ds.

Contributory (Secondary)
(Duration) ..... Yrs..... mos. ..... ds.

(Signed) W. Ross Conner M. D.
19.. (Address) Lovell Wyoming

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lovell — DATE OF BURIAL: Dec 19. 1921.

20. UNDERTAKER: Lovell Wyoming — ADDRESS: Lovell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-25 M. 1-16-18

RECEIVED JAN 11 1922 BUREAU OF STATISTICS

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 100

County of Madison Primary Registration District No. 2178

City of Rexburg (Ward) ..... St.)

File No. 36479

Registered No. 93

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Joseph Fielding Brown

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Sept. (Month) 9th (Day) 1921 (Year)

7. AGE: -- Yrs. 3 Mos. 16 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Joseph Brown

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Sarah Jane Wood

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Joseph Brown
(Address) Rexburg Ida.

15. Filed 12-25 1921 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. (Month) 25 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 1921, to Dec 25 1921, that I last saw him alive on Dec 25 1921, and that death occured on the date stated above, at 7:30 M.

The CAUSE OF DEATH* was as follows:
Broncho-Pneumonia

(Duration) ..... Yrs. ..... mos. 3 ds.
Contributory (Secondary) Pertussis
(Duration ..... yrs. 1½ mos. ..... ds.

(Signed) Farley Nelson M. D.
12-27 1921 (Address) Rexburg Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rexburg, Ida. | DATE OF BURIAL: 12/27 1921

20. UNDERTAKER: David R Young | ADDRESS: Rexburg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

STUB - YORK CO., PTRS. & STRS. 24654

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JAN 1 1922 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 100
Primary Registration District No. 2178

File No. 36480
Registered No. 14

1. PLACE OF DEATH
County of Madison
City of Rexburg (No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Joseph Thornick

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Male	White	Married (Write the word.)

6. DATE OF BIRTH: August (Month) 19 (Day) 1848 (Year)

7. AGE: 73 Yrs. 4 Mos. 6 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: John Thornick

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Ann Bott

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Huber Thornick
(Address) Rexburg Idaho

15. Filed 12-26 1921
G. H. Esplin
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 12 (Month) 25 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That ~~I attended deceased from~~ 12-25-21 ~~19~~ to 12-25-21 ~~19~~ that I last saw him ~~alive on~~ ~~19~~ and that death occurred on the date stated above, at 6:20 P.M.

The CAUSE OF DEATH* was as follows: Dilatation of heart (?)

Contributory (Secondary) Partial Paralysis

(Duration) Yrs. mos. ds.

(Duration) yrs. mos. ds.

(Signed) Lorin A. Rich M. D.

12/26 1921 (Address) Rexburg Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Bloomington Ida. | DATE OF BURIAL: Dec 29 1921

20. UNDERTAKER: David R Young | ADDRESS: Rexburg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

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FORM V. S. No. 5-25 M. 1-19.

RECEIVED
JAN 1 1922
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 100
Primary Registration District No. 2178
File No. 36481
Registered No. 95

1. PLACE OF DEATH
County of Madison
City of Rexburg (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Oscar U. Engdahl
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH: February (Month) 10 (Day) 1863 (Year)

7. AGE: 58 Yrs. 10 Mos. 17 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Contractor & Builder
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER: Not Known

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Not Known

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) O U Engdahl
(Address) Rexburg Ida

Filed 12-28 1921 G. L. Espe Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 12 (Month) – 27 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12-22- 1921, to 12-27- 1921, that I last saw h.IM alive on 12-22- 1921, and that death occurred on the date stated above, at 2. P. M.
The CAUSE OF DEATH* was as follows:
Pernicious Anemia
(Duration) Yrs. 3 mos. – ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) Louis A. Ricks M. D.
12/28 1921 (Address) Rexburg Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Sugar City	Jan. 1 1922
20. UNDERTAKER David R. Young	ADDRESS Rexburg, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

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FORM V. S. No. 5-25 M. 1-19.

RECEIVED JAN 14 1922 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 19
Primary Registration District No. 2015
File No. 36482
Registered No. 44

1. PLACE OF DEATH
County of Minidoka
City of Rupert
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary F Jones

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widow

6. DATE OF BIRTH: Dec (Month) 10 (Day) 1839 (Year)

7. AGE: 82 Yrs. 11 Mos. 19 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House Wife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Tennessee

10. NAME OF FATHER: H Grigsby

11. BIRTHPLACE OF FATHER (State or Country): Tennessee

12. MAIDEN NAME OF MOTHER: Mary F Grigsby

13. BIRTHPLACE OF MOTHER (State or Country): Tennessee

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Arthur Jones
(Address) Rupert Idaho

15. Filed 12-22 1921 E. E. Ehmsen Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 29 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 23 1921 to Nov. 29 1921 that I last saw her alive on Nov 29 1921 and that death occurred on the date stated above, at 9 a M.

The CAUSE OF DEATH* was as follows:

Erysipelas Facial

(Duration) ..... Yrs. ..... mos. 11 ds.

Contributory (Secondary) —

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Leland Frazier M. D.

19..... (Address) Rupert, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Portland Oregon | DATE OF BURIAL ..... 19.....

20. UNDERTAKER | ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

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FORM V. S. No. 5-25 M. 1-19.

RECEIVED JAN 10 1922 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 19

Primary Registration District No. 2015

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36483

Registered No. 78

1. PLACE OF DEATH

County of Minidoka

City of Rupert (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Geisler

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Fem

4. COLOR OR RACE White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.) Child

6. DATE OF BIRTH May (Month) 31 (Day) 1921 (Year)

7. AGE Yrs. Mos. ds. 3

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Rupert Idaho

10. NAME OF FATHER Joe Geisler

11. BIRTHPLACE OF FATHER (State or Country) Switzerland

12. MAIDEN NAME OF MOTHER Agnes Rosenau

13. BIRTHPLACE OF MOTHER (State or Country) Austria

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Joe Geisler

(Address) Rupert Idaho

15. Filed Dec 22 1921 E. A. Edlefsen Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 31 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 31 1921, to June 3 1921, that I last saw her alive on June 3 1921 and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Premature Birth

(Duration) ..... Yrs. ..... mos. 3 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J B Kennaff M. D.

6/21 1921 (Address) Rupert

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Catholic Cemetery — **DATE OF BURIAL** June 10 19..

20. UNDERTAKER W. G. Goodman — **ADDRESS** Rupert Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

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FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36484

Registered No. 76

RECEIVED
JAN 10 1922
BUREAU OF VITAL STATISTICS

Registration District No. 19
Primary Registration District No. 2015

1. PLACE OF DEATH
County of Kootenai
City of Rupert (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Grace Crumley

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: April (Month) 25 (Day) 1873 (Year)

7. AGE: 48 Yrs. 6 Mos. 9 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House Wife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: John V. McDonald

11. BIRTHPLACE OF FATHER (State or Country): Penn

12. MAIDEN NAME OF MOTHER: Elizabeth Flaught

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John V McDonald
(Address) Spokan Wash

15.
Filed 12-22 1921
E H Elmore
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 4 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 22 1921, to Nov 4 1921, that I last saw h.er alive on Nov 4 1921, and that death occurred on the date stated above, at 9:10 P.M.

The CAUSE OF DEATH* was as follows:
Nephritis

(Duration) 5 Yrs. ? mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J B Kennagy M. D.
12/21 1921 (Address) Rupert Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Spokan Wash
DATE OF BURIAL: 12/28 1921

20. UNDERTAKER: W. C. Goodman
ADDRESS: Rupert Idaho

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36485
Registered No. 47

1. PLACE OF DEATH

RECEIVED JAN 10 1922 BUREAU OF VITAL STATISTICS

County of Minidoka Registration District No. 19
Primary Registration District No. 2010
City of Rupert (Ward) St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Infant Named Smith

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Infant

6. DATE OF BIRTH: Dec 14 (Month) (Day) 1921 (Year)

7. AGE: ....Yrs....Mos....ds.
IF LESS than 1 day how many 13 hrs. or ....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Minidoka

10. NAME OF FATHER: Laural H Smith

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Lyona Stewart

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Laurel H Smith
(Address) American Falls Idaho

15. Filed Dec 18 1921 E H Eberson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. (Month) 15 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 14 1921, to Dec. 16 1921, that I last saw h.. alive on Dec. 15 1921, and that death occurred on the date stated above, at 1:30 P.M.
The CAUSE OF DEATH* was as follows:
Atelectasis
"Blue baby"
(Duration) ....Yrs....mos....ds.
Contributory (Secondary)
(Duration) ....yrs....mos....ds.
(Signed) E H Eberson M. D.
12-16 1921 (Address) Rupert Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rupert Cemetary — DATE OF BURIAL: Dec 15 1921
20. UNDERTAKER: Denis Keleu — ADDRESS: Rupert Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36486

Registered No. 48

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Minidoka

City of Rupert (No. St.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED JAN 10 1922 BUREAU OF VITAL STATISTICS

Registration District No. 19

Primary Registration District No. 2013

2. FULL NAME Margaret Richards

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word.): Widowed

6. DATE OF BIRTH: Nov (Month) 14 (Day) 1834 (Year)

7. AGE: 87 Yrs. Mos. 9 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House Wife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): South Wales

10. NAME OF FATHER: Evan Morgan

11. BIRTHPLACE OF FATHER (State or Country): Wales

12. MAIDEN NAME OF MOTHER: Mary Morgan

13. BIRTHPLACE OF MOTHER (State or Country): Wales

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Elias Richards
(Address) Malad Idaho

15. Filed 12-22 1921 E. H. Elmore Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 24 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 23 1921 to Nov 24 1921 that I last saw h[illegible] alive on Nov 24 1921 and that death occurred on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows: Cerebral Hemorrhage

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed) [signature] M. D.

12-22-1921 (Address) Rupert Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Malad Idaho — DATE OF BURIAL: Nov 26 1921

20. UNDERTAKER — ADDRESS: Malad Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

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FORM V. S. No. 5-25 M. 1-19.

RECEIVED JAN 10 1922 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 92 — 36487
Primary Registration District No. 2170
File No. 6
Registered No. 37

1. PLACE OF DEATH

County of Nez Perce

City of Southwick (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Marion [illegible]

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Child

6. DATE OF BIRTH ✓
Oct 26 1918
(Month) (Day) (Year)

7. AGE ✓
3 Yrs. 1 Mos. 14 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry, business or establishment in which employed (or employer): At Home

9. BIRTHPLACE ✓
(State or Country) Idaho

10. NAME OF FATHER ✓
Geo [illegible]

11. BIRTHPLACE OF FATHER ✓
(State or Country) Washington

12. MAIDEN NAME OF MOTHER ✓
Madolin Wright

13. BIRTHPLACE OF MOTHER ✓
(State or Country) West Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A. M. Marion
(Address) Southwick Idaho

15.
Filed 12-31 1921
E. E. Watts
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Dec 10 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 9 1921, to Dec 10 1921, that I last saw him alive on Dec 10 1921, and that death occurred on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:

acute nephritis following Scarlet Fever

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. T. Seeley M. D.
Dec 10 1921 (Address) Leland Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Lewiston — DATE OF BURIAL: Dec 11 1921

20. UNDERTAKER — ADDRESS: Southwick

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

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FORM V. S. No. 5-25 M. 1-16-13

RECEIVED JAN 10 1922 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH.

36488

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 92 Primary Registration District No. 2170

County of Nez Perce

City of Gifford (No. ..... St.)

File No. 5

Registered No. 35

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George Dodson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): widowed

6. DATE OF BIRTH. Mar (Month) 25 (Day) 1838 (Year)

7. AGE: 83 Yrs. 9 Mos. — ds. IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: farmer retired
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Eng

10. NAME OF FATHER: John Dodson

11. BIRTHPLACE OF FATHER (State or Country): Eng

12. MAIDEN NAME OF MOTHER: Aliza Ashley

13. BIRTHPLACE OF MOTHER (State or Country): Eng

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant): Jas Dodson
(Address): Culdesac

15. Filed 12-27 1921 E. E. Watts Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 25 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from — 191—, to — 191—, that I last saw him alive on — 191—, and that death occured on the date stated above, at 10 P M.

The CAUSE OF DEATH* was as follows:
Senile Decay

(Duration) — Yrs. — mos. — ds.

Contributory (Secondary)

(Duration — yrs. — mos. — ds.

(Signed) E. E. Watts M. D.

19— (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Gifford Ida — DATE OF BURIAL: 12-27 1921

20. UNDERTAKER: W. E. Stoddard — ADDRESS: Gifford

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BOKS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 92 36489
Primary Registration District No. 2140
File No. 5
Registered No. 36

1. PLACE OF DEATH.
County of Nez Perce
City of Gifford (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William L. Howerton

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Feby (Month) 3 (Day) 1846 (Year)

7. AGE: 75 Yrs. 10 Mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mo

10. NAME OF FATHER: John Howerton

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Sooter

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) W. L. Howerton
(Address) Gifford Idaho

15. Filed 12-30 1921 E. E. Watts Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 28 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12-24 1921, to 12-27 1921, that I last saw him alive on 12-27 1921, and that death occured on the date stated above, at 9 P.M.
The CAUSE OF DEATH* was as follows:
Cerebral hemorrhage
(Duration) — Yrs. — mos. 6 ds.
Contributory (Secondary)
(Duration — yrs. — mos. — ds.
(Signed) E. E. Watts M. D.
19..... (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lookout — DATE OF BURIAL: Dec 30 1921

20. UNDERTAKER: H. E. Stoddard — ADDRESS: Gifford

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24853

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED JAN 10 1922 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 93

County of Nez Perce — Local Registration District No. 2371

File No. 36490

City of Peck (St.) — Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Rodney Williams Oglesby

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH Jan (Month) 1 (Day) 1848 (Year)

Dec — 31 — 1921

7. AGE 73 Yrs. 11 Mos. 19 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Ills Maine Iowa

10. NAME OF FATHER John W Oglesby

11. BIRTHPLACE OF FATHER (State or Country) Not Known

12. MAIDEN NAME OF MOTHER Cowden

13. BIRTHPLACE OF MOTHER (State or Country) Not Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Geo. Oglesby

(Address) Peck, Idaho

15. Filed 1-1- 1922 Daniel Lyle Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 31 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec-21-1921 to Dec-31 1921 that I last saw h[illegible] alive on Dec-29 1921 and that death occurred on the date stated above, at 2:30 P.M.

The CAUSE OF DEATH* was as follows: Nephritis — Chronic Interstitial

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Arteriosclerosis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. F. Geary M. D.

19..... (Address) Peck Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Angel Ridge Cemetary — DATE OF BURIAL 1-2 1922

20. UNDERTAKER — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY; PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JAN 10 1922 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 93
Primary Registration District No. 2378

File No. 36491

Registered No.

1. PLACE OF DEATH

County of Nez Perce

City of Peck (or Village or Township) Idaho (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Marjorie Helen Miller

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female

4. COLOR OR RACE White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.) Single

6. DATE OF BIRTH May 24 (Month) 1903 (Day) (Year)

7. AGE 18 Yrs. 4 Mos. 4 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Canon City Colo

10. NAME OF FATHER Harrison Miller

11. BIRTHPLACE OF FATHER (State or Country) Ohio

12. MAIDEN NAME OF MOTHER Effie I. Stone

13. BIRTHPLACE OF MOTHER (State or Country) Wisconsin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Harrison Miller

(Address) Peck Idaho

15. Filed Jan 3d 1922

J. M. Gray
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 28 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 25 1921 to Sept 28 1921 that I last saw h[illegible] alive on Sept 28 1921 and that death occurred on the date stated above, at 9:00 A.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage following
Purpura Hemorrhagica,

(Duration) Yrs. 3 mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Carl N Hornaday M. D.

9/29 1921 (Address) [illegible]

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL L. L. Bobo Peck Ida. | **DATE OF BURIAL** Sept 30 1921

20. UNDERTAKER C. E. Bobo | **ADDRESS** Orofino Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

Form V. S. No. 5 20M.1-16-12

RECEIVED JAN 10 1922 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
Registration District No. 93
County of Nez Perce
Primary Registration District No. 2371
File No. 36492
City of Nez Perce (No. ..... St.)
Registered No. .....
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Leslie Ferguson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Widowed

6. DATE OF BIRTH: April 30 (Month) (Day) 1847 (Year)

7. AGE: 83 yrs. 3 mos. 15 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): West Virginia

10. NAME OF FATHER: Johnson Ferguson

11. BIRTHPLACE OF FATHER (State or Country): West Virginia

12. MAIDEN NAME OF MOTHER: Sally Triplett

13. BIRTHPLACE OF MOTHER (State or Country): West Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. J. Ferguson
(Address) Deary Idaho

15. Filed 1-4 1922 Daniel Lyle Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: August (Month) 15 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 1918, to Aug 15 1921, that I last saw him alive on July 29 1921, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

(Duration) ? yrs. ..... mos. ..... ds.,

Contributory (Secondary) Senile Changes

(Duration) ? yrs. ..... mos. ..... ds.

(Signed) J. M. Hamilton M. D.

Aug 16 1921 (Address) Orofino, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Lewiston, Idaho	Aug 17 1921

20. UNDERTAKER	ADDRESS
Smith & Son	

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 26

Primary Registration District No. 2009

(No. ..... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36493

Registered No. 42

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Oneida

City of Curlew

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Andrew Jackson Mullens

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. June (Month) 5 (Day) 1838 (Year)

7. AGE 83 Yrs. 6 Mos. 0 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kentucky

10. NAME OF FATHER: Jimmie Mullens

11. BIRTHPLACE OF FATHER (State or Country): Ky

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) D. F. Lannin (67 Curlew)
(Address) Curlew Idaho

15. Filed Jan 4 1922 — R. M. Mauer M. D. Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: December (Month) 5 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 4, 1921, to Dec 5, 1921, that I last saw him alive on Dec 4th 1921, and that death occured on the date stated above, at 6.30 P.M.

The CAUSE OF DEATH* was as follows:

Senile Pneumonia

(Duration) ..... Yrs. ..... mos. 1 ds.

Contributory (Secondary) Arteriosclerosis

(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) C. E. Gardleigh M. D.

19..... (Address) Snowville Utah

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 8 yrs. 3 mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Snowville Utah — DATE OF BURIAL: Dec 7 1921

20. UNDERTAKER: Jos J Larkin — ADDRESS: Snowville Utah

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 26
Primary Registration District No. 2069
File No. 36494
Registered No. 43

1. PLACE OF DEATH
County of Oneida
City of Malad
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Joshua J Thomas
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	W White	Widower

6. DATE OF BIRTH: Dec (Month) 9 (Day) 1920 (Year)

7. AGE: Yrs. 11 Mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Malad Ida

10. NAME OF FATHER Joshua Thomas

11. BIRTHPLACE OF FATHER (State or Country) Malad Ida

12. MAIDEN NAME OF MOTHER Mary Jones

13. BIRTHPLACE OF MOTHER (State or Country) S Carolina Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Archie W Thomas
(Address) Malad Ida

15. Filed Jan 4 1922 — R T Maher M D — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 5 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 28 1921, to Dec 5 1921, that I last saw him alive on Dec 5 1921, and that death occurred on the date stated above, at 11 9 M.
The CAUSE OF DEATH* was as follows:
Meningitis (Cerebral)
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) J F Fullmer M. D.
12-6 1921 (Address) Malad

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Malad Ida	12-7 1921

20. UNDERTAKER	ADDRESS
D E Johnson	Malad

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO. PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 26

Primary Registration District No. 2069

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36495

Registered No. 44

1. PLACE OF DEATH.

County of Owyhee

City of Murland

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Thomas Stephens

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH. Mar (Month) 20 (Day) 1836 (Year)

7. AGE: 85 Yrs. 7 Mos. 25 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or established in which employed (or employer): Farmer

9. BIRTHPLACE (State or Country): Wales

10. NAME OF FATHER: David Stephens

11. BIRTHPLACE OF FATHER (State or Country): Wales.

12. MAIDEN NAME OF MOTHER: Jane Evans

13. BIRTHPLACE OF MOTHER (State or Country): Wales

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jane S Jones.

(Address) St. John, Idaho

15. Filed Dec 4 1921

J. M. Mauer M.D. Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 15 (Day) 1921 (Year)

I HEREBY CERTIFY, That I attended deceased from March 1920, to Dec. 15 1921, that I last saw h— alive on Dec 15 1921, and that death occured on the date stated above, at 1:45 a M.

The CAUSE OF DEATH* was as follows:

Senile Decay

(Duration) 1 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Mauer M. D.

12/18 1921 (Address) Murland Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: St. John — DATE OF BURIAL: Dec 18 1921

20. UNDERTAKER: J. Guy Benson — ADDRESS

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED
JAN 10 1922
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36496

Registration District No. 130

Primary Registration District No. Homedale

Registered No.

1. PLACE OF DEATH

County of Owyhee

City of Homedale (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Helen Edith Benham

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F m

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Oct (Month) 25 (Day) 1907 (Year)

7. AGE: 13 Yrs. 1 Mos. 21 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: student

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: William J Benham

11. BIRTHPLACE OF FATHER (State or Country): Wis

12. MAIDEN NAME OF MOTHER: Gertrude M Coats

13. BIRTHPLACE OF MOTHER (State or Country): Minn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. J. Benham

(Address) Homedale Ida

15. Filed Jan 1 1921 S Hopper Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 8 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1921, to Dec 8 1921 that I last saw her alive on Dec 4 1921 and that death occurred on the date stated above, at 2 A.M.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(Duration) 1 Yrs. 10 mos. ~~10~~ ds.

Contributory (Secondary): Chorea

(Duration) yrs. 3 mos. ~~5~~ ds.

(Signed) Simeon Hopper M. D.

19..... (Address) Homedale Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill — DATE OF BURIAL: Dec 10 1921

20. UNDERTAKER: Peckham — ADDRESS: Caldwell Ida

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36497

Registered No.

RECEIVED JAN 10 1922 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Payette

City of Fruitland (St.)

Registration District No.

Primary Registration District No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Josephine Hart.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH: October (Month) 30 (Day) 1912 (Year)

7. AGE: 9 Yrs. 1 Mos. — ds. IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Fruitland Payette Co Idaho

10. NAME OF FATHER Harry W. Hart.

11. BIRTHPLACE OF FATHER (State or Country) Niagara City New York

12. MAIDEN NAME OF MOTHER Myrtle A. Royston.

13. BIRTHPLACE OF MOTHER (State or Country) Park City Alexandria Co. Nebr.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Harry W. Hart
(Address) Fruitland Idaho

15. Filed Dec 3 — 1921 C. B. Dayton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec 1st (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 7th 1921, to Dec 1st 1921, that I last saw her alive on Dec 1st 1921, and that death occurred on the date stated above, at 7:10 A.M.

The CAUSE OF DEATH* was as follows:

Rheumatic Endocarditis

(Duration) Yrs. 4 mos. 25 ds.

Contributory (Secondary) —

(Duration) — yrs. — mos. — ds.

(Signed) C. B. Dayton M. D.

Dec 2 1921 (Address) Fruitland Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Fruitland Cem | DATE OF BURIAL: Dec 4 1921

20. UNDERTAKER: Fruitland Mortuary | ADDRESS: Fruitland Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
JAN 10 1922
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36498
Registered No.

1. PLACE OF DEATH
County of Lafayette
City of Lafayette (If outside limits of city or village, write "Rural.")
Registration District No.
Primary Registration District No.
St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Robert Smith

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH: Oct (Month) 1 (Day) 1841 (Year)

7. AGE: 80 Yrs. 2 Mos. 27 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer Retired
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Peter Smith

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Mary Darley

13. BIRTHPLACE OF MOTHER (State or Country): N.J.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. R. Smith
(Address) Fruitland Ida

15.
Filed 19
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: December 22 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 16 1921, to Dec 22 1921, that I last saw him alive on Dec 22 1921, and that death occurred on the date stated above, at 1:30 P.M.

The CAUSE OF DEATH* was as follows:
Bronchopneumonia

(Duration) Yrs. mos. 7 ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) C. C. Paxton M. D.
12-22-1924 (Address) Fruitland Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Lafayette Ida	Dec 23 1921
20. UNDERTAKER	**ADDRESS**
J. A. Udall Lafayette	Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36499
Registered No. 6

Registration District No. 5
Primary Registration District No. 1009

1. PLACE OF DEATH

County of Payette

City of New Plymouth (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Florence Anderson Blayden

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Female	White	Married (Write the word.)

6. DATE OF BIRTH: March (Month) 12 (Day) 1890 (Year)

7. AGE: 31 Yrs. 6 Mos. 22 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Vermont

10. NAME OF FATHER: George H. Anderson

11. BIRTHPLACE OF FATHER (State or Country): Vermont

12. MAIDEN NAME OF MOTHER: Minnie E. Waugh

13. BIRTHPLACE OF MOTHER (State or Country): Vermont

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ethel Anderson
(Address) New Plymouth

15. Filed Oct 4 1921 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: October 4 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 5 1921, to Oct 4 1921, that I last saw h[illegible] alive on Oct 4 1921, and that death occurred on the date stated above, at 9 P.M.

The CAUSE OF DEATH* was as follows:
Chronic Nephritis

..... (Duration) ..... Yrs. 7 mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Bm Drake. M. D.

10-5 1921 (Address) New Plymouth

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: [illegible] New Plymouth — DATE OF BURIAL: Oct 5 1921

20. UNDERTAKER: J. A. & Geo. Landon — ADDRESS: Payette Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 4
Primary Registration District No. 1008
File No. 36501
Registered No. 42

RECEIVED
JAN 10 1922
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Bayette
City of Bayette (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Goldie Ella Pritchard
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Sept (Month) 23 (Day) 1911 (Year)

7. AGE: 10 Yrs. 2 Mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mont

10. NAME OF FATHER: Thos R Pritchard

11. BIRTHPLACE OF FATHER (State or Country): Wales

12. MAIDEN NAME OF MOTHER: Emma Jones

13. BIRTHPLACE OF MOTHER (State or Country): Wales

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Thomas R Pritchard
(Address) Bayette Ida

15. Filed Dec 10 1921 J C Woodward
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: December 2 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 2 1921 to Dec 2 1921
that I last saw h alive on Dec 2 1921
and that death occurred on the date stated above, at 8.45 P M.
The CAUSE OF DEATH* was as follows:
Abcess of Lung
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) J C Woodward M. D.
12/3/1921 (Address) Bayette Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Bayette Ida	Dec 4 1921
20. UNDERTAKER	ADDRESS
J F Adair	Bayette Ida

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36502

Registered No. 46

1. PLACE OF DEATH

County of Bonneville

City of Ucon (No. ..... St.)

Registration District No. 4

Primary Registration District No. 1008

If death occurs away from usual residence give facts called for under special information.

2. FULL NAME Charles A Adams

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Dec 9 (Month) 9 (Day) 1853 (Year)

7. AGE: 69 Yrs. — Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wis

10. NAME OF FATHER: Charles Adams

11. BIRTHPLACE OF FATHER (State or Country): N Y

12. MAIDEN NAME OF MOTHER: Don't Know

13. BIRTHPLACE OF MOTHER (State or Country): Don't Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) F H Morgan

(Address) McDalls Ida

15. Filed 10 Dec 11 1921. J C Woodward Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: December (Month) 9 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from remains 12-9-1921, to ..... 19....., that I last saw him alive on never 19....., and that death occurred on the date stated above, at 1.30 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) instant yrs. mos. ds.

Contributory (Secondary) none

(Duration) instant yrs. mos. ds.

(Signed) Wm T Drysdale M. D.

12-10 1921 (Address) New Plymouth Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Ontario Or — DATE OF BURIAL: 12/12 1921

20. UNDERTAKER: G C Landon — ADDRESS: Payette Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 4
Primary Registration District No. 1008

File No. 36503
Registered No. 47

1. PLACE OF DEATH
County of Payette
City of Payette
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lovey Cleveland

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	white	married

6. DATE OF BIRTH: Oct (Month) 15 (Day) 1880 (Year)

7. AGE: 40 Yrs. 1 Mos. 28 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Irvin Kinzier

11. BIRTHPLACE OF FATHER (State or Country): Indiana

12. MAIDEN NAME OF MOTHER: Eliza Gobble

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Elmer Cleveland
(Address) Payette Idaho

15. Filed 4 Dec 13 1921 J C Woodward Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: December (Month) 12 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 5 1921, to December 11 1921, that I last saw her alive on December 11 1921, and that death occurred on the date stated above, at 7 00 A.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis
~~Indefinite~~
Indefinite
(Duration) Indefinite Yrs. ..... mos. ..... ds.

Contributory (Secondary) Typhoid fever July & Aug 1921
(Duration) ..... yrs. 1½ mos. ..... ds.

(Signed) O. H. Avery M. D.
12/12/1921 (Address) Payette, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Payette Idaho	Dec 13 1921
20. UNDERTAKER	ADDRESS
Glenn C Landon	Payette Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36504
Registered No. 4

1. PLACE OF DEATH
County of Payette
City of Payette (No. ..... St.)
If death occurred away from usual residence, give facts called for under special information.

RECEIVED JAN 16 1922 BUREAU OF VITAL STATISTICS

Registration District No. 4
Primary Registration District No. 1008

2. FULL NAME F. P. Ashlock

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Widowed

6. DATE OF BIRTH: Feb (Month) 28 (Day) 1843 (Year)

7. AGE: 78 Yrs. 9 Mos. 19 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ill

10. NAME OF FATHER: Wm F. Ashlock.

11. BIRTHPLACE OF FATHER (State or Country): Don't know

12. MAIDEN NAME OF MOTHER: Patton

13. BIRTHPLACE OF MOTHER (State or Country): Ill

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. P. Ashlock
(Address) Payette Idaho

15. Filed 12 Dec 21 1921 J C Woodward Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 4 Dec (Month) 19 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 27 1921, to 4 Dec 19 1921 that I last saw h alive on 4 Dec 19 1921 and that death occurred on the date stated above, at 11 M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ..... Yrs. 2 mos. ..... ds.

Contributory (Secondary): Advanced Heart disease

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J C Woodward M. D.

12/21/1921 (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Payette Idaho	Dec 21 1921
20. UNDERTAKER	ADDRESS
Glenn C Landon	Payette Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1

1. PLACE OF DEATH

County of Payette

City of Payette

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 4

Primary Registration District No. 1008

(No. ..... St.)

File No. 36505

Registered No. 30

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William P Carpenter

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widower (Write the word.)

6. DATE OF BIRTH: June (Month) 30 (Day) 1837 (Year)

7. AGE: 84 Yrs. 6 Mos. 5 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Minister

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ind.

10. NAME OF FATHER: Don't Know

11. BIRTHPLACE OF FATHER (State or Country): Don't Know

12. MAIDEN NAME OF MOTHER: Ann Douglass

13. BIRTHPLACE OF MOTHER (State or Country): Don't Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. P. Carpenter

(Address) Payette Idaho

15. Filed Dec 26 1921. J C Woodward Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 26 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 7 1921, to Dec 25 1921, that I last saw him alive on Dec 25 1921, and that death occurred on the date stated above, at 10A M.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) ? Yrs. ? mos. ? ds.

Contributory (Secondary) Senility & Arteriosclerosis

(Duration) ? yrs. ? mos. ? ds.

(Signed) J. F. McNinch M. D.

Dec 26 1921. (Address) Payette Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence: Removed

19. PLACE OF ~~BURIAL~~ OR REMOVAL: Earleton Kansas — DATE OF ~~BURIAL~~: Dec 27 1921

20. UNDERTAKER: Glenn C Landon — ADDRESS: Payette Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 25

Primary Registration District No. 2072

File No. 36506

County of Power

City of American Falls (If outside limits of city or village, write the word "Rural") (Ward) (No. St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME not named

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

RECEIVED
JAN 10 1922
BUREAU OF VITAL STATISTICS

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH. Dec (Month) 18 (Day) 1921 (Year)

7. AGE ... Yrs. ... Mos. ... ds. IF LESS than 1 day how many 13 hrs. or ... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) American Falls Id.

10. NAME OF FATHER James A. Howell

11. BIRTHPLACE OF FATHER (State or Country) Kansas

12. MAIDEN NAME OF MOTHER Pearl Hungarter

13. BIRTHPLACE OF MOTHER (State or Country) Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James A. Howell (Rel. to deceased)

(Address) American Falls Id.

15. Filed 1-2 1922 R. A. York Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 18 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 18 1921, to Dec 18 1921, that I last saw h. alive on Dec 18 1921 and that death occured on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

Premature birth (7 months)

.....(Duration) ...Yrs. ...mos. ...ds.

Contributory (Secondary) .....

.....(Duration) ...Yrs. ...mos. ...ds.

(Signed) Richard F. York M. D.

12/19 1921 (Address) American Falls Id.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Falls Country	Dec 19 1921
20. UNDERTAKER	ADDRESS American Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOOKS. 24658

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 123

File No. 36508

County of Shoshone

Primary Registration District No.

Registered No. 38

City of Kellogg (St.)

RECEIVED JAN 10 1922 BUREAU OF VITAL STATISTICS

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Christiani Meuli

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	

6. DATE OF BIRTH: June (Month) 6 (Day) 1886 (Year)

7. AGE: 35 Yrs. 5 Mos. 25 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Italy

10. NAME OF FATHER: Jacob Meuli

11. BIRTHPLACE OF FATHER (State or Country): Switzerland

12. MAIDEN NAME OF MOTHER: Anna Schempp

13. BIRTHPLACE OF MOTHER (State or Country): Switzerland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Meuli
(Address) Kellogg Ida.

15. Filed 1/30/ 1922 E. E. Hand Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 1 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Falling under railway Coach
Apparently unavoidable accident

.....(Duration) .....Yrs.....mos.....ds.

Contributory (Secondary)

.....(Duration) .....yrs.....mos.....ds.

(Signed) Wm. Grover M. D.
acting Dep. Coroner
Dec 3 1921 (Address) Kellogg Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Kellogg, Idaho	Dec 4 1921

20. UNDERTAKER	ADDRESS
M. C. Thornhill	Kellogg Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 123
Primary Registration District No.
File No. 36509
Registered No. 39

1. PLACE OF DEATH
County of Shoshone
City of Kellogg (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Carl H. Midstaler
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M.	White	Single

6. DATE OF BIRTH
..... (Month) 1 (Day) ..... (Year)

7. AGE
33 Yrs. — Mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Painter
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Norway

10. NAME OF FATHER Midstaler

11. BIRTHPLACE OF FATHER (State or Country) Norway

12. MAIDEN NAME OF MOTHER Norvig

13. BIRTHPLACE OF MOTHER (State or Country) Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) M. C. Thornhill
(Address) Kellogg Idaho

15. Filed Dec 30 1921 E. E. Sturdy Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Dec (Month) 21 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from
..... 19....., to ..... 19.....,
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
pistol shot
.....
.....
.....(Duration) .....Yrs.....mos.....ds.
Contributory (Secondary)
.....(Duration) .....yrs.....mos.....ds.
(Signed) ..... M. D.
.....19..... (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Kellogg, Idaho	Dec 26, 1921

20. UNDERTAKER	ADDRESS
M. C. Thornhill	Kellogg Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 123
Primary Registration District No.
File No. 36510
Registered No. 40

1. PLACE OF DEATH
County of Shoshone
City of Kellogg (No. St.)
If death occurs away from usual residence, give facts called for under special information.

RECEIVED JAN 10 1927 BUREAU OF VITAL STATISTICS

2. FULL NAME Jane Garrick

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word)

6. DATE OF BIRTH: Feb (Month) 22 (Day) 1877 (Year)

7. AGE: 49 Yrs. 10 Mos. 4 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wales

10. NAME OF FATHER: Richard Roberts

11. BIRTHPLACE OF FATHER (State or Country): Wales

12. MAIDEN NAME OF MOTHER: Elizabeth Jones

13. BIRTHPLACE OF MOTHER (State or Country): Wales

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ann Lombard
(Address) Wardner

15. Filed 12/30/ 1927 E E Hardy Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 26 (Day) 1927 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 26 1927, to 1927
that I last saw h alive on 1927
and that death occurred on the date stated above, at M.
The CAUSE OF DEATH* was as follows:
Bronchial pneumonia
Death immediate
(Duration) Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) M. D.
12/30 1927 (Address) D. W. Chaney

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Keeley Idaho — DATE OF BURIAL: Dec 29 1927

20. UNDERTAKER: M C Thornton — ADDRESS: Keeley Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JAN 10 1922 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

2

1. PLACE OF DEATH

Registration District No. 123

Primary Registration District No.

File No. 36511

County of Shoshone

City of Kellogg Idaho (St.)

Registered No. 96

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Alexander Daniel McCrackin

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH: June (Month) 7th (Day) 1883 (Year)

7. AGE: 38 Yrs. 5 Mos. 4 ds. IF LESS than 1 day how many..... hrs. or.....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Physician
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Joseph R. McCrackin

11. BIRTHPLACE OF FATHER (State or Country): Pennsylvania

12. MAIDEN NAME OF MOTHER: Margaret Hughes

13. BIRTHPLACE OF MOTHER (State or Country): West Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Margaret F. McCrackin
(Address) Spokane Wn

15. Filed 1/27/ 1922 E E Hand Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 11 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..., to ..... 19...
that I last saw h... alive on ..... 19...,
and that death occurred on the date stated above, at about 6.30 P.M.

The CAUSE OF DEATH* was as follows:
Gun shot wound, Evidence conclusively, suicide.

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) William Moore M.D.
J.P. acting coroner
11/11 1921 (Address) Kellogg Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Kellogg Idaho	Nov 13, 1921

20. UNDERTAKER	ADDRESS
M.C. Thornhill	Kellogg, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

...ry item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH ...terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

...YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 123
Primary Registration District No.
File No. 36512
Registered No. 35

1. PLACE OF DEATH
County of Shoshone
City of North Fork (If outside limits, give township) (No.) (St.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED JAN 10 1922 BUREAU OF VITAL STATISTICS

2. FULL NAME Samuel Studer

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): married

6. DATE OF BIRTH: Oct (Month) 7 (Day) 1860 (Year)

7. AGE: 61 Yrs. — Mos. 22 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Austria

10. NAME OF FATHER: no information

11. BIRTHPLACE OF FATHER (State or Country): Austria

12. MAIDEN NAME OF MOTHER: no information

13. BIRTHPLACE OF MOTHER (State or Country): Austria

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jas D Studer
(Address) Kellogg

15. Filed 12/27/ 1921 E. E. Hardy Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 26 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Tuberculosis
No Doct.
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) ..... M. D.
..... 19..... (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Kingston Idaho — DATE OF BURIAL: Oct 27, 1921

20. UNDERTAKER: M. C. Thornhill — ADDRESS: Kellogg Idaho

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Teton
City of Victor
If death occurs away from usual residence, give facts called for under special information.

RECEIVED
JAN 10 1922
BUREAU OF VITAL STATISTICS

Registration District No. 77
Registration District No. 2176
File No. 36513
Registered No. one 25

2. FULL NAME Chas D Spencer

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	white	married

6. DATE OF BIRTH: March 15 1858
(Month) (Day) (Year)

7. AGE: 63 Yrs. 8 Mos. 19 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer): Farming

9. BIRTHPLACE (State or Country): Michigan

10. NAME OF FATHER: Geo. Spencer

11. BIRTHPLACE OF FATHER (State or Country): England.

12. MAIDEN NAME OF MOTHER: Nemia Sayyer.

13. BIRTHPLACE OF MOTHER (State or Country): England.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chas D Spencer.
(Address) Victor, Idaho

15. Filed Dec 15th 1921 Martha Marker
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: December 14 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 25 1921, to Dec 14 1921, that I last saw h[illegible] alive on Dec 14 1921 and that death occurred on the date stated above, at 5.40 P.M.

The CAUSE OF DEATH* was as follows:
Cancer of rectum and general collapse.

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E. V. Logan M. D.
Dec 15 1921 (Address) Victor Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Victor Cemetery	Dec 16 1921
20. UNDERTAKER	ADDRESS
[illegible]	Driggs

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
JAN 10 1922
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 77

Primary Registration District No. 2176

File No. 36514

County of Fremont

City of Lamont (No. ... St.)

Registered No. Two

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Geo. J. Simonds

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Widowed

6. DATE OF BIRTH November 12 1835
(Month) (Day) (Year)

7. AGE 86 Yrs. 0 Mos. 25 ds.

IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry, business or establishment in which employed (or employer) Farming

9. BIRTHPLACE (State or Country) New York

10. NAME OF FATHER Dont know

11. BIRTHPLACE OF FATHER (State or Country) Dont know

12. MAIDEN NAME OF MOTHER Dont know

13. BIRTHPLACE OF MOTHER (State or Country) Dont know

14. I HEREBY CERTIFY THAT THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

Informant) O. R. Simonds

(Address) Lamont, Idaho

Filed Dec 16 1921 Monta Marker

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH December 5 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 4 1921, to Dec 5 1921, that I last saw h[illegible] alive on Dec 5 1921, and that death occurred on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Cancer Liver

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary)

(Duration) ... Yrs. ... mos. ... ds.

(Signed) E. L. Sage M. D.

Dec 5 1921 (Address) Ashton

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Ashton Cemetery DATE OF BURIAL Dec 7 1921

20. UNDERTAKER ADDRESS

RESERVED FOR BINDING
WRITE WITH PENCIL OR INDELIBLE INK — THIS IS A PERMANENT RECORD
NAME should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH
ACE and OCCUPATION is very important. See instructions on back of certificate.

...S-YORK CO., PRI...

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 77
Primary Registration District No. 2176
File No. 36515
Registered No. Three

RECEIVED JAN 10 1922 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Lemhi
City of Drigg (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Thomas Robert Walker.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH December 21 1921
(Month) (Day) (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many 11½ hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Infant.
(b) General nature of industry, business or establishment in which employed (or employer) Infant

9. BIRTHPLACE (State or Country) Idaho.

10. NAME OF FATHER C Walker.

11. BIRTHPLACE OF FATHER (State or Country) Utah.

12. MAIDEN NAME OF MOTHER Hodary Wilson ~~Logan Harper~~

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C Walker
(Address) Drigg, Idaho.

15. Filed 1/12/22 19.. Martha Merker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH December 21 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 21 1921, to Dec 21 1921
that I last saw h.. alive on Dec 21 1921
and that death occurred on the date stated above, at 5.30 P. M.
The CAUSE OF DEATH* was as follows:
Premature
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Chas J Hart M. D.
Dec 1921 (Address) Driggs Idg

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Driggs Cemetery | DATE OF BURIAL 1/13/22 19..

20. UNDERTAKER C O Gray | ADDRESS Driggs

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36516
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

Registration District No. 25
Primary Registration District No. 2056
(No. ..... St.)

1. PLACE OF DEATH
County of Twin Falls
City of Twin Falls
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Grover Marshall Pugh

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write word.): Married

6. DATE OF BIRTH. (Month) 9 (Day) 1 (Year) 894

7. AGE: 27 Yrs. 8 Mos. 15 ds.
IF LESS than 1 day how many .... hrs. or .....min.?'

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) Carpenter

9. BIRTHPLACE (State or Country) N C

10. NAME OF FATHER Lee Pugh

11. BIRTHPLACE OF FATHER (State or Country) N C

12. MAIDEN NAME OF MOTHER Sara Hampton

13. BIRTHPLACE OF MOTHER (State or Country) N C

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) O E Rutter
(Address) Filer

15. Filed Nov. 28. 1921 — F. A. Newberry, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (Month) Nov. (Day) 24 (Year) 1921

17. I HEREBY CERTIFY, That I attended deceased from 11/17/1921 to 11/24/1921
that I last saw ~~him~~ alive on 11/24/1921
and that death occurred on the date stated above, at 9:30 P. M.

The CAUSE OF DEATH* was as follows:
Meningitis
(Duration) ..... Yrs. ..... mos. 3 ds.
Contributory (Secondary) Fracture of skull
(Duration) ..... Yrs. ..... mos. 7 ds.
(Signed) W. F. Pike M. D.
11/27/1921 (Address) Twin Falls Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: I.O.O.F. Cemetery Filer — DATE OF BURIAL: Nov. 26. 1921

20. UNDERTAKER: J E Drake — ADDRESS: Filer

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-12 M. 6-15-17.

RECEIVED JAN 10 1922 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36517
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Twin Falls Registration District No. 38
City of Filer Primary Registration District No. 2086
If death occurs away from usual residence, give facts called for under special information. (No. ..... St.)

2. FULL NAME N. B. Walter

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Jan (Month) 14 (Day) 1863 (Year)

7. AGE: 57 Yrs. 11 Mos. 8 ds. IF LESS than 1 day how many .... hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) Farmer

9. BIRTHPLACE (State or Country) Ohio

10. NAME OF FATHER: Cyrus Walter

11. BIRTHPLACE OF FATHER (State or Country) Ohio

12. MAIDEN NAME OF MOTHER: Hannah Beam

13. BIRTHPLACE OF MOTHER (State or Country) Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Walter
(Address) Filer

15. Filed Dec 26 1921. A. A. Newberry Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 23 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12/19 1921 to 12/23 1921 that I last saw him alive on 12/22 1921 and that death occurred on the date stated above, at 11:35 A.M.

The CAUSE OF DEATH* was as follows:

Cirrhosis of Liver

(Duration) 2 Yrs. mos. ds.

Contributory (Secondary) Interstitial Nephritis

(Duration) 2 Yrs. mos. ds.

(Signed) Eric Curry M. D.

12/24 1921 (Address) Burley Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: I.O.O.F. Cemetery — DATE OF BURIAL: Dec 26 1921.

20. UNDERTAKER: J E Drake — ADDRESS: Filer

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 36

Primary Registration District No.

File No. 36518

Registered No. 13

1. PLACE OF DEATH

County of Twin Falls

City of Murtaugh (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED JAN 10 1922 BUREAU OF VITAL STATISTICS

2. FULL NAME Lucile Hall

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: S (Write the word.)

6. DATE OF BIRTH: Dec. (Month) 4 (Day) 1921 (Year)

7. AGE: ..... Yrs. ..... Mos. 3 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work ✓

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Murtaugh, Idaho

10. NAME OF FATHER William C. Hall

11. BIRTHPLACE OF FATHER (State or Country) Tenn

12. MAIDEN NAME OF MOTHER Nellie A. Whitworth

13. BIRTHPLACE OF MOTHER (State or Country) Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W C Hall

(Address) Murtaugh Ida.

15. Filed Nov. 8 1921 J M Davis Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. (Month) 7 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov - 4 1921, to Nov - 7 1921, that I last saw h.. alive on Nov - 6 1921, and that death occurred on the date stated above, at 4P M.

The CAUSE OF DEATH* was as follows:

Spina Bifida

Brain

(Duration) ..... Yrs. ..... mos. ? ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Davis M. D.

12/8 1921 (Address) Kimberly, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls — DATE OF BURIAL ..... 19.....

20. UNDERTAKER — ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Twin Falls
City of [illegible]
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 36
Primary Registration District No.
(No. , St.)

File No. 36519
Registered No. 74

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME R Jennie Dreyden

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: fem
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWER OR DIVORCED (Write the word.): Widow

6. DATE OF BIRTH: Jan 15 (Month) (Day) 1846 (Year)

7. AGE: 73 Yrs. 11 Mos. 2 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House maid
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): ohio

10. NAME OF FATHER: James Bellville

11. BIRTHPLACE OF FATHER (State or Country): ohio

12. MAIDEN NAME OF MOTHER: Harriette Ledger

13. BIRTHPLACE OF MOTHER (State or Country): ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Kate M. Gold
(Address) 242 T" North, Twin Falls

15. Filed Dec 17 1924 J. M. Davis Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 17 (Day) 1924 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 5 1924 to Dec 17 1924 that I last saw h— alive on Dec 16 1924 and that death occurred on the date stated above, at 4:40 P.M.
The CAUSE OF DEATH* was as follows:

fractured hip

(Duration) Yrs. mos. ds.
Contributory (Secondary) old age
(Duration) yrs. mos. ds.

(Signed) J. M. Davis M. D.
12/17 1924 (Address) Kimberly Idy

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Twin Falls DATE OF BURIAL Dec 20 1924

20. UNDERTAKER J. E. Ford ADDRESS Twin Falls

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36520

Registered No. 11

RECEIVED
JAN 10 1922
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 36

Primary Registration District No.

County of Twin Falls

City of Kimberly (No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William Martin Jones

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE: American

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6. DATE OF BIRTH: January (Month) 31 (Day) 1862 (Year)

7. AGE: 59 Yrs. 10 Mos. 21 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Springfield Mo.

10. NAME OF FATHER: Wiliam Henry Jones

11. BIRTHPLACE OF FATHER (State or Country): Tenn.

12. MAIDEN NAME OF MOTHER: M. Hale

13. BIRTHPLACE OF MOTHER (State or Country): Tenn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Asthma Jones
(Address) Kimberly Idaho

15. Filed Dec. 22 1921 J M Davis Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. (Month) 21 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 5 1921, to Dec 21 1921, that I last saw him alive on Dec 21 1921 and that death occurred on the date stated above, at 7.45 P. M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) Yrs. mos. ds.

Contributory (Secondary): Asthma

(Duration) 20 yrs. mos. ds.

(Signed) J. M. Davis M. D.

(Address) Kimberly

Dec 21 1921

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Ida — DATE OF BURIAL: Dec 23 1921

20. UNDERTAKER: P. E. Grossman — ADDRESS: Twin Falls

BYNG-YORK CO., PRINTERS & BINDERS, BOISE 51087

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY; PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED JAN 10 1922 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 87

Primary Registration District No.

County of Washington

City of Weiser (No. ..... St.)

File No. 36522

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Baby Hunt

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH: Oct. (Month) 30 (Day) 1921 (Year)

7. AGE: ..... Yrs. ..... Mos. 12 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Seth Hunt

11. BIRTHPLACE OF FATHER (State or Country) Missouri

12. MAIDEN NAME OF MOTHER Maud Coats

13. BIRTHPLACE OF MOTHER (State or Country) Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ezra Hunt

(Address) .....

15. Filed Nov 12 1921 F. A. Schmidt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 10 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 6 1921, to Nov. 10 1921, that I last saw him alive on Nov. 10 1921, and that death occurred on the date stated above, at 1 P. M.

The CAUSE OF DEATH* was as follows:

Premature

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F. A. Schmidt M. D.

11-12-1921 (Address) Midvale Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mowes Creek — DATE OF BURIAL: Nov. 11 1921

20. UNDERTAKER: Northam & McCann — ADDRESS: Weiser Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY; PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. F-25 M. 1-19

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36523

1. PLACE OF DEATH

County of Washington Registration District No. 47

City of Weiser (No. St.) Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Baby Hust

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH: Oct (Month) 30 (Day) 1921 (Year)

7. AGE: — Yrs. Mos. 13 ds.

IF LESS than 1 day: how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Ida

10. NAME OF FATHER Seth Hust

11. BIRTHPLACE OF FATHER (State or Country) Missouri

12. MAIDEN NAME OF MOTHER Maud Coats

13. BIRTHPLACE OF MOTHER (State or Country) Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Carol Hust
(Address)

15. Filed Nov. 12 1921 Faschmidt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 11 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 6 1921, to Nov. 10 1921 that I last saw him alive on Nov. 10 1921, and that death occurred on the date stated above, at 6 a. M.
The CAUSE OF DEATH* was as follows:
Pneumatosis.

(Duration) ..... Yrs. ..... mos. .....

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. .....

(Signed) Fas Ahmidt M. D.
11-12 1921 (Address) Meadows Idaho

*State the Disease Causing Death; or in deaths from Violent Causes state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Meadows | DATE OF BURIAL ..... 19....

20. UNDERTAKER: Northam & McGee | ADDRESS Weiser

N. B.—Every item of information should be given if possible. This is a PERMANENT RECORD in plain terms, so that it may be properly classified. See instructions on back of certificate.

WRITE PLAINLY WITH PEN AND INK. DO NOT USE LEAD PENCIL. DO NOT FOLD. MUST BE FILED FOR BINDING.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13 (Copy)

CERTIFICATE OF DEATH. (Copy)

RECEIVED JAN 10 1922 BUREAU OF VITAL STATISTICS

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36564

Registered No. .....

1. PLACE OF DEATH.

Registration District No. 53

Primary Registration District No. .....

County of Bear Lake

City of Paris, (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME David Minson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. April (Month) 14 (Day) 1844 (Year)

7. AGE: 93 Yrs. 8 Mos. 9 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Grocery business
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Thomas Minson

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER Catherine Ward.

13. BIRTHPLACE OF MOTHER (State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Lettie Minson
(Address) Paris Idaho.

15. Filed 1—8 1922 Chas J. Schwenker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 23 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 23 1921 to Dec 23 1922 that I last saw h alive on Dec 22 1921 and that death occured on the date stated above, at 5 PM.

The CAUSE OF DEATH* was as follows:
Electric Shock
(Electrocuted)

.....(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

.....(Duration ..... yrs. ..... mos. ..... ds.

(Signed) W. D. Moore M. D.
1/16 1922 (Address) Paris Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Paris — DATE OF BURIAL: Dec 27 1921

20. UNDERTAKER: Bishop Low — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SVMS - YORK CO., PTRS. & BDRS. 24854

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 46

County of Benewah Primary Registration District No. 2323

City of Tensed (No.) (St.)

File No. 36565

Registered No. 101

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

FEB 4 - 1922
BUREAU OF VITAL STATISTICS

2. FULL NAME Samuel W. Ohler.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married.

6. DATE OF BIRTH. Mar (Month) 4 (Day) 1861 (Year)

7. AGE: 61 Yrs. 9 Mos. 11 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kentucky.

10. NAME OF FATHER: Alex. Ohler

11. BIRTHPLACE OF FATHER (State or Country): Kentucky

12. MAIDEN NAME OF MOTHER: Sophia Harris

13. BIRTHPLACE OF MOTHER (State or Country): Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Chas. S. Ohler.
(Address) Palouse, Wn

15.
Filed Dec 21 1921 H. D. Rayner Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
December (Month) 15 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 3 1921, to Dec 15 1921, that I last saw him alive on Dec 15 1921, and that death occured on the date stated above, at 11 A. M.

The CAUSE OF DEATH* was as follows:
Chronic Enteritis (Specific)

(Duration) 13 Yrs. — mos. — ds.

Contributory (Secondary) —

(Duration — yrs. — mos. — ds.

(Signed) Fred Barteau M. D.

Dec 19 21 (Address) De Smet, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death? Na
Former or usual residence —

19. PLACE OF BURIAL OR REMOVAL: Golden Rod Tekoa — DATE OF BURIAL: 12-18 1921

20. UNDERTAKER: C. L. Schulerud — ADDRESS: Tekoa Wn

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24654

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

Registration District No. 121

Primary Registration District No. 2194

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36567

Registered No. 1

1. PLACE OF DEATH

County of Bingham

City of Shelley

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Unnamed Wilson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Nov. (Month) 28 (Day) 1921 (Year)

7. AGE: ..... Yrs. ..... Mos. 3 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: J E Wilson

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Ruby Johnson

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J E. Wilson

(Address) Twin Idaho

15. Filed Dec 1 1921 Mrs Hallie E. Palmer Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 30 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 28 1921, to Nov 30 1921, that I last saw h[illegible] alive on Nov 26 1921, and that death occurred on the date stated above, at 24 M.

The CAUSE OF DEATH* was as follows:

Prematurity

(Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J E Wilson M. D.

Nov 30 1921 (Address) Shelley Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Idaho — DATE OF BURIAL ..... 19.....

20. UNDERTAKER: J E. Wilson — ADDRESS .....

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bingham — Registration District No. 121

City of Blackfoot — Primary Registration District No. 3194

(No. ..... St.)

File No. 36568

Registered No. 2

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Daisy Ann Larsen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	white	Married

6. DATE OF BIRTH: Aug (Month) 6 (Day) 1893 (Year)

7. AGE: 28 Yrs. 3 Mos. 29 ds. — IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: David A. Benson

11. BIRTHPLACE OF FATHER (State or Country): Springville Ut,

12. MAIDEN NAME OF MOTHER: Bertha M. Jensen

13. BIRTHPLACE OF MOTHER (State or Country): Brigham City Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John S Larsen
(Address) Blackfoot Rte 1

15. Filed Dec-6 1921 Mrs Nalen E. Patrick Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 12 (Month) — 5 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12/3 1921, to 12/5 1921, that I last saw h[er] alive on 12/5 1921, and that death occurred on the date stated above, at 1:30 P.M.

The CAUSE OF DEATH* was as follows:
post puerperal eclampsia

(Duration) ..... Yrs. ..... mos. 2 ds.
Contributory (Secondary) Chronic nephritis
(Duration) 7 yrs. ..... mos. ..... ds.

(Signed) J. O. Humpherys M. D.
12/6 1921 (Address) Blackfoot Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Groveland Cemetery — DATE OF BURIAL: Dec 7 1921

20. UNDERTAKER: E L Hyde — ADDRESS:

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

Registration District No. 131

Primary Registration District No. 2194

(No. ..... , ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36569

Registered No. 3

1. **PLACE OF DEATH**

County of Bingham

City of Blackfoot

If death occurs away from usual residence, give facts called for under special information.

2. **FULL NAME** Birger Christiansen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. **SEX**: Male

4. **COLOR OR RACE**: White

5. **SINGLE, MARRIED, WIDOWED OR DIVORCED** (Write the word.): Single

6. **DATE OF BIRTH**: January 24 (Month) (Day) 1913 (Year)

7. **AGE**: 5 Yrs. 10 Mos. 13 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. **OCCUPATION**

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business or establishment in which employed (or employer):

9. **BIRTHPLACE** (State or Country): Springfield Idaho

10. **NAME OF FATHER**: Simon Christiansen

11. **BIRTHPLACE OF FATHER** (State or Country): Norway

12. **MAIDEN NAME OF MOTHER**: Ingrid Paulsen

13. **BIRTHPLACE OF MOTHER** (State or Country): Norway

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**

(Informant) Simon Christiansen

(Address) Blackfoot # 1

15. Filed Dec 9 1921 Mc Nalen E Patrick
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH**: Dec. 7 (Month) (Day) 1921 (Year)

17. **I HEREBY CERTIFY, That I ~~attended deceased~~ investigated from** Dec 8 19..... to ..... 19.....

that I last saw h..... alive on ..... 19.....

and that death occurred on the date stated above, at 11:30 a M.

The CAUSE OF DEATH* was as follows: Pneumonia - Bronchial

..... (Duration) ..... Yrs. ..... mos. 8 ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) M. E. Patrick M. D.

Dec 9 1921 (Address) Co Health Officer Blackfoot Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. **PLACE OF BURIAL OR REMOVAL**: Grove City Cemetery — **DATE OF BURIAL**: Dec 9 1921

20. **UNDERTAKER**: E L Eggli — **ADDRESS**: Blackfoot,

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36570
Registered No. 4

1. PLACE OF DEATH. Registration District No. 171
County of Bingham Primary Registration District No. 2194
City of ..... (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information. Ft. Hall Reservation

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME James Freeland LaTourrette

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower
6. DATE OF BIRTH: February 3d (Month) (Day) 1856 (Year)
7. AGE: 65 yrs. 10 mos. 4 ds. IF LESS than 1 day how many ..... hrs. or ..... min?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Civil Service-Teaching
(b) General nature of industry business or establishment in which employed (or employer): & Farming
9. BIRTHPLACE (State or Country): Staten Island N.Y.
10. NAME OF FATHER: James Armour LaTourrette
11. BIRTHPLACE OF FATHER (State or Country): New York City N.Y.
12. MAIDEN NAME OF MOTHER: Margaret Ann Annesley
13. BIRTHPLACE OF MOTHER (State or Country): Ashtabula O.
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jennie L. Collins
(Address) Washington D.C.
15. Filed Dec 10 1921 Mrs Valen E. Pabst Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: December 7th 1921 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from July 30 1921, to Dec 7 1921 that I last saw him alive on Dec 5 1921 and that death occurred on the date stated above, at 10 A.M.
The CAUSE OF DEATH* was as follows:
Cardiac Valvular Disease or aortic Insufficiency
..... (Duration) — yrs. 4 mos. 7 ds.
Contributory (Secondary) Cerebral Hemorrhage
Instantly
..... (Duration) — yrs. — mos. — ds.
(Signed) Henry R. Wheeler M. D.
Dec 10 1921 (Address) Ft. Hall, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Groudland Cemetery — DATE OF BURIAL: Dec 11 1921
20. UNDERTAKER: E. J. Peck — ADDRESS: Blackfoot Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
WRITE PLAINLY, WITH UNFADING INK—THIS IS A LEGAL DOCUMENT.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 2 (94)
(No. ..... St.)

File No. 36571
Registered No. 5-

1. PLACE OF DEATH
County of Bingham
City of Blackfoot 4
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Anna Howard

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: August 9 (Month) (Day) 1921 (Year)

7. AGE: 0 Yrs. 3 Mos. 28 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Blackfoot Ida.

10. NAME OF FATHER: Leroy E. Howard

11. BIRTHPLACE OF FATHER (State or Country): Salt Lake City Ut.

12. MAIDEN NAME OF MOTHER: Hannah Gummersall

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Leroy Howard
(Address) Blackfoot Ida.

15. Filed Dec-8 1921 Mrs Nalene E. Peterson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. 7 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 7 1921 to Dec 7 1921 that I last saw h~~er~~ alive on Dec 7 1921 and that death occurred on the date stated above, at 7.30 P.M.
The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. M. Mitchell M. D.
12/8 1921 (Address) Blackfoot Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Groveland Cemetery
DATE OF BURIAL: Dec 9 1921

20. UNDERTAKER: E L Eagle
ADDRESS: Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

Registration District No. 121

Primary Registration District No. 2194

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36572

Registered No. 6

1. PLACE OF DEATH

County of Bingham

City of Blackfoot (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Quincy A Smith

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	Caucasian	Single

6. DATE OF BIRTH: June (Month) 18 (Day) 1861 (Year)

7. AGE: 60 Yrs. ..... Mos. 5 ds. 22

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): North Carolina

10. NAME OF FATHER: Not Known

11. BIRTHPLACE OF FATHER (State or Country): Not Known

12. MAIDEN NAME OF MOTHER: Not Known

13. BIRTHPLACE OF MOTHER (State or Country): Not Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Martha E. High - Bookkeeper By
asylum Records

(Address) Blackfoot, Idaho

15. Filed Dec - 11 1921 Mrs Nalas E. Pate Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: December (Month) 10 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 30, 1921, to Dec. 10, 1921 that I last saw h.im alive on Dec. 10, 1921, and that death occurred on the date stated above, at 3:45 P.M.

The CAUSE OF DEATH* was as follows:

Coma

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Arterio Sclerosis

..... (Duration) ..... yrs. 16 mos. 10 ds.

(Signed) [redacted] M. D.

12-11 1921 (Address) [redacted]

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. 6 mos. 10 days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? Don't Know

Former or usual residence Eagle, Idaho

19. PLACE OF BURIAL OR REMOVAL: Asylum Cemetery — DATE OF BURIAL: Dec. 15 1921

20. UNDERTAKER: J. A. Bailey — ADDRESS: Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36573

Registered No. 7

1. **PLACE OF DEATH**

County of Bingham

City of Blackfoot

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 121

Primary Registration District No. 21924

(No. State Asylum St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. **FULL NAME** Nellie Simpson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	Caucasian	Widow

6. **DATE OF BIRTH** December (Month) 11 (Day) 1872 (Year)

7. **AGE** 49 Yrs. Mos. 11 ds. IF LESS than 1 day how many hrs. or min.?

8. **OCCUPATION**

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business or establishment in which employed (or employer)

9. **BIRTHPLACE** (State or Country) Ogden Utah

10. **NAME OF FATHER** L. D. Wilson

11. **BIRTHPLACE OF FATHER** (State or Country) Not Know

12. **MAIDEN NAME OF MOTHER** Not. Know

13. **BIRTHPLACE OF MOTHER** (State or Country) Not Know

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**

(Informant) according to asylum Records by Martha E. Pugh - Clerk

(Address) Blackfoot Idaho

15. Filed Dec-16 1921 Mrs Nalen E. Fatz Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH** December (Month) 15 (Day) 1921 (Year)

17. **I HEREBY CERTIFY, That I attended deceased from** Sept. 3 1919 to Dec. 15 1921 that I last saw h.er alive on Dec. 15, 1921, and that death occurred on the date stated above, at 8:45 P. M.

The CAUSE OF DEATH* was as follows:

Exhaustion

(Duration) Yrs. mos. ds.

Contributory (Secondary) Psychosis Excited

(Duration) 2 yrs. 3 mos. 12 ds.

(Signed) Lee T. Nourse M. D.

12-16-1921 (Address) Blackfoot Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 2 yrs. 3 mos. 12 days. In the State 35 yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence Idaho Falls, Ida

19. **PLACE OF BURIAL OR REMOVAL** Thomas Riverside Cem

DATE OF BURIAL Dec 17 1921

20. **UNDERTAKER** E. L. Egli

ADDRESS Blackfoot.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 2194
File No. 36574
Registered No. 6

1. PLACE OF DEATH
County of Bingham
City of Blackfoot
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Rudolph Hadlaschk
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Caucasian
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: unknown (Month) (Day) 1 (Year)

7. AGE: about 37? Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Hostler O.S.L.& R.R.
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): unknown

10. NAME OF FATHER: unknown

11. BIRTHPLACE OF FATHER (State or Country): unknown

12. MAIDEN NAME OF MOTHER: unknown

13. BIRTHPLACE OF MOTHER (State or Country): unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Asylum Records by Martha E. Hyde-Clerk
(Address) Blackfoot, Idaho

15. Filed Dec-18 1921 Mrs Helen E. Yates Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: December (Month) 18 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 11 1920, to Dec. 18 1921, that I last saw him alive on Dec. 18 1921, and that death occurred on the date stated above, at 1 P. M.

The CAUSE OF DEATH* was as follows:

Paresis

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Syphilis

..... (Duration) 4 yrs. ..... mos. ..... ds.

(Signed) C. J. Hoover M. D.

12-18 1921 (Address) Blackfoot, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 1 yrs. 6 mos. 7 days. In the State 10 yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Missoula Mont. DATE OF BURIAL: On arrival 19

20. UNDERTAKER: E L Eyh ADDRESS: Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 1097
File No. 36575
Registered No. 9

1. PLACE OF DEATH
County of Bingham
City of Blackfoot
(No. East Court St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Thomas P Clark
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: March 28 1837 (Month) (Day) (Year)

7. AGE: 84 Yrs. 8 Mos. 22 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Virginia

10. NAME OF FATHER: John Clark

11. BIRTHPLACE OF FATHER (State or Country): Not known

12. MAIDEN NAME OF MOTHER: Not known

13. BIRTHPLACE OF MOTHER (State or Country): Not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Mary Clark
(Address) Blackfoot

15. Filed Dec 21 1921 Mrs Hulen E. Palmer Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: December 20 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12-12 1921, to 12-20 1921, that I last saw h[illegible] alive on 12-20 1921 and that death occurred on the date stated above, at 12 P M.

The CAUSE OF DEATH* was as follows:
Cirrhosis of Liver
(Duration) several years ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. O. Humphrey M. D.
12/21/1921 (Address) Blackfoot Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Grove City Cemetery
DATE OF BURIAL: Dec 22 1921
20. UNDERTAKER: E. L. Egli
ADDRESS: Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 21

Primary Registration District No. 2194

(No. ..... , ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36576

Registered No. 10

1. PLACE OF DEATH.

County of Bingham

City of Blackfoot

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Esther Lybbert Olsen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Feb (Month) 2 (Day) 1890 (Year)

7. AGE: 31 Yrs. 10 Mos. 25 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: C. F. B. Lybbert

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: Anthinette Marie Olsen

13. BIRTHPLACE OF MOTHER (State or Country): Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Daniel F. Olsen
(Address) Blackfoot, Idaho Route 1.

15. Filed Dec-28 1921 Mrs Hale E. Pa
Local Registrar

SYMS - YORK CO., PTRS. & BOBS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
December (Month) 27 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 23 1921, to Dec 27 1921, that I last saw her alive on Dec 26 1921, and that death occured on the date stated above, at 4:15 P.M.

The CAUSE OF DEATH* was as follows:

Thrombosis of Iliac artery

(Duration) Yrs. mos. 3 ds.

Contributory (Secondary) Child birth Dec 19, 1921

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) W. W. Beck M. D.

12/27 1921 (Address) Blackfoot, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Groveland Cemetery — DATE OF BURIAL: Dec 29 1921

20. UNDERTAKER: C. L. Egle — ADDRESS: Blackfoot

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 2194
File No. 36977
Registered No. 11

1. PLACE OF DEATH
County of Bingham
City of Shelley
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Rudger Wm. Johnson
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Mal
4. COLOR OR RACE:
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6. DATE OF BIRTH: Dec. 19 (Month) (Day) 1913 (Year)

7. AGE: 8 Yrs. ..... Mos. 9 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Shelley - Idaho.

10. NAME OF FATHER: Thos. Smith Johnson

11. BIRTHPLACE OF FATHER (State or Country): Utah.

12. MAIDEN NAME OF MOTHER: Alice Senn.

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Thos Smith Johnson
(Address) Shelley - Idaho

15. Filed Dec 31 1921 Mrs Walter E. Patrick
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 12 (Month) - 28 (Day) - 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19..... that I last saw him alive on ..... 19..... and that death occurred on the date stated above, at 7 a. M.
The CAUSE OF DEATH* was as follows:

Status Bloc.

half hour.
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Patent Foramen Ovale
(Duration) all his life yrs. ..... mos. ..... ds.

(Signed) Edwin Cook M. D.
12-29-1921 (Address) Shelley

*State the Disease Causing Death; or in deaths from Violent Causes, state (1), Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Shelley Cemetery,	12/30-1921
20. UNDERTAKER	ADDRESS
C. C. Dunwoody	Ida. Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 2 194
File No. 36578
Registered No. 12

1. PLACE OF DEATH
County of Bingham
City of Shelley
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Manuel Amaro

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Infant (Write the word.)

6. DATE OF BIRTH: Dec. (Month) 30 (Day) 1921 (Year)

7. AGE: 5 minutes (.....Yrs. .....Mos. .....ds.)
IF LESS than 1 day how many ..... hrs. or 5 min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Shelley Ida.

10. NAME OF FATHER: Florentino Amaro

11. BIRTHPLACE OF FATHER (State or Country): Mexico

12. MAIDEN NAME OF MOTHER: Secondina Yoora

13. BIRTHPLACE OF MOTHER (State or Country): Mexico

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. P. Egbert M. D.
(Address) Shelley Idaho.

15. Filed Jan. 4 1922 Wm Hales E. Palmer Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. (Month) 30 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 30 1921, to Dec. 30 1921, that I last saw h.. alive on Dec. 30 1921 and that death occurred on the date stated above, at 6.05 P. M.
The CAUSE OF DEATH* was as follows:
Premature
7 mo.
.....(Duration) .....Yrs. .....mos. .....ds.
Contributory (Secondary) .....
.....(Duration) .....Yrs. .....mos. .....ds.
(Signed) J. P. Egbert M. D.
Dec. 30 1921 (Address) Shelley Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs. .....mos. .....days. In the State .....yrs. .....mos. .....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Shelley Cem. | DATE OF BURIAL ..... 19.....

20. UNDERTAKER | ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 12

Primary Registration District No. 12

File No. 36579

County of Boise

City of Placerville (No. ....., ... St.)

Registered No. 19

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Augustie Lorisch

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH July 1 (Month) (Day) (Year)

7. AGE 78 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Mining

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Ireland.

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15. Filed Dec 30 1921 Geo E Robson
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec 24 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19....., to ..... 19.....,
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Heart trouble.

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

..... 19..... (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Portland	Dec 28 1921
20. UNDERTAKER	ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-18

RECEIVED JAN 19 1922 DIVISION OF VITAL STATISTICS

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 59

County of Butte Primary Registration District No.

City of Arco (No. , St.)

File No. 36580

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mark D Hurst

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Feb. (Month) 7 (Day) 1850 (Year)

7. AGE: 71 Yrs. 10 Mos. 12 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: Benj. F. Hurst

11. BIRTHPLACE OF FATHER (State or Country): Tenn

12. MAIDEN NAME OF MOTHER: Eliza Black

13. BIRTHPLACE OF MOTHER (State or Country): Ky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Dan Hurst

(Address) arco

15. Filed 12/19/1921 J M Cannon Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. (Month) 19 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11/28/21 191..., to 12/19/21 191..., that I last saw him alive on 12/17/21 191..., and that death occured on the date stated above, at 3 a.m. M.

The CAUSE OF DEATH* was as follows:

Cyonephreus

(Duration) ... Yrs. ... mos. 2 1 ds.

Contributory (Secondary) Injuries rec'd in runaway

(Duration ... yrs. ... mos. ... ds.

(Signed) J M Cannon M. D.

12/19 1921 (Address) arco

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs ... mos ... days In the State ... yrs ... mos ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Arco — DATE OF BURIAL: 12/20/1921

20. UNDERTAKER: Lohn — ADDRESS: Arco

B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BOKS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36581

Registered No. .....

RECEIVED
JAN 19 1922
BUREAU OF VITAL STATISTICS

Registration District No. 59

Primary Registration District No. .....

1. PLACE OF DEATH.

County of Butte

City of Arco (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James Thomas Lafferty

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): Single

6. DATE OF BIRTH. Aug (Month) 17 (Day) 1855 (Year)

7. AGE: 66 Yrs. 3 Mos. 28 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Indiana

10. NAME OF FATHER: Silas Lafferty

11. BIRTHPLACE OF FATHER (State or Country): N. Carolina

12. MAIDEN NAME OF MOTHER: Rebecca Jones

13. BIRTHPLACE OF MOTHER (State or Country): Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) John Don Lafferty
(Address) Arco

15. Filed 1/16/1922 Cannon Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24858

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. (Month) 15 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12/15/1921, to 12/15/1921, that I last saw him alive on 12/15/1921, and that death occured on the date stated above, at 7:45 P. M.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Hypertension

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D. H. Cannon M. D.

19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Arco

DATE OF BURIAL: 1/17/1922

20. UNDERTAKER: Hendrick

ADDRESS: Arco

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JAN 14 1920 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36582

Registered No.

1. PLACE OF DEATH

County of Butte Primary Registration District No. 39

City of Grouse Ward or Village No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Henry T. Clark

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Oct. 24 1840 (Month) (Day) (Year)

7. AGE: 80 Yrs. 11 Mos. 26 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Canada

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Josie Waddaups.

(Address) moore, Ida.

15. Filed 19 F. M. Cannon Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. 20 19 21 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 19 to 19, that I last saw h alive on 19, and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Infirmities incident to Old age

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) F. M. Cannon M. D.

19 (Address) Arco Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR ~~REMOVAL~~: Antelope — DATE OF BURIAL 19

20. UNDERTAKER: Josie Waddaups — ADDRESS moore, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED JAN 19 1922 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 3

Primary Registration District No. 2005

File No. 36583

Registered No. 130

County of Canyon

City of Notus (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John L. Powell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: June 25 (Month) (Day) 1841 (Year)

7. AGE: 80 Yrs. 6 Mos. 27 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: Wm Powell

11. BIRTHPLACE OF FATHER (State or Country): Tennessee

12. MAIDEN NAME OF MOTHER: Barbara Lindsay

13. BIRTHPLACE OF MOTHER (State or Country): Tennessee

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. M. Powell

(Address) Notus

15. Filed Dec. 23 1921 John L. Meyers Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 22 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 7, 1921 to Dec 22 1921 that I last saw him alive on Dec 22 1921 and that death occurred on the date stated above, at 12 P.M.

The CAUSE OF DEATH* was as follows: Gastric Carcinoma

(Duration) Yrs. one mos. ds.

Contributory (Secondary) Nephritis

(Duration) yrs. 2 mos. ds.

(Signed) M. Dalley M. D.

12-24 1921 (Address) Caldwell Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill

DATE OF BURIAL: 12-24 1921

20. UNDERTAKER: CASE FURNITURE CO.

ADDRESS: Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

RECEIVED DEC 8 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 136
Primary Registration District No. 2020
File No. 36592
Registered No. 20

1. PLACE OF DEATH

County of Elmore
City of Mountain Home (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Julia Ann Burgess

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Married

6. DATE OF BIRTH Nov. (Month) 22 (Day) 1876 (Year)

7. AGE 44 Yrs. 11 Mos. 20 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Kansas

10. NAME OF FATHER Beecher Chapin

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER Olivia Hoyt

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) L. B. Burgess
(Address) Mtn Home Ida

15. Filed 12-1-1921 — J. E. Evans, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. (Month) 10 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11-8-1921, to 11-10-1921 that I last saw h.r alive on 11-10-1921, and that death occurred on the date stated above, at 5:30 P.M.

The CAUSE OF DEATH* was as follows:

Status Medicus
+ Diphtheria

..... (Duration) ..... Yrs. ..... mos. 7 ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. E. Evans M. D.
12-1-1921 (Address) Mtn Home Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Boise Idaho — **DATE OF BURIAL** 11-12-1921

20. UNDERTAKER A W Conover — **ADDRESS** Mtn Home Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 34
Primary Registration District No. 2020
File No. 36593
Registered No. 21

1. PLACE OF DEATH
County of Elmore
City of Mtn Home (No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jose Bengoechea
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: 1921 [illegible] 10 (Month) (Day) 1861 (Year)

7. AGE: ..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Wool Grower
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Bedorona Spain

10. NAME OF FATHER: Pedro Antonia

11. BIRTHPLACE OF FATHER (State or Country): Spain

12. MAIDEN NAME OF MOTHER: Maria Antonia Andinza

13. BIRTHPLACE OF MOTHER (State or Country): Spain

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Mendiola
(Address) Mtn. Home Ida

15.
Filed 12-2-1921
J. E. Evans
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 12 (Day), 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 8 1921, to Nov 12 1921 that I last saw him alive on Nov 12 1921, and that death occurred on the date stated above, at 8:00 M.

The CAUSE OF DEATH* was as follows:
Chronic Nephritis.
(Duration) 2 Yrs. mos. ds.
Contributory (Secondary) Dropsy. Hemiplegia
(Duration) yrs. 8 mos. ds.

(Signed) O. P. Hamilton M. D.
11-14-1921 (Address) Mt. Home Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain Home
DATE OF BURIAL: 11-14-1921

20. UNDERTAKER: A W Conover
ADDRESS: Mtn Home Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JAN 11 1922 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 102

Primary Registration District No. 6

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36594
Registered No.

1. PLACE OF DEATH
County of Fremont.
City of Ashton.
(If outside limits of city or village, give township) (St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME James Agustus Brown.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married.

6. DATE OF BIRTH: December, 15. 18 7[illegible]. (Month) (Day) (Year)

7. AGE: 46 Yrs. 11 Mos. 30 ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Salesman.
(b) General nature of industry, business or establishment in which employed (or employer): Drygoods

9. BIRTHPLACE (State or Country): Camden. N.J.

10. NAME OF FATHER: William. Q. Brown.

11. BIRTHPLACE OF FATHER (State or Country): Penn.

12. MAIDEN NAME OF MOTHER: Lizzie Pancost.

13. BIRTHPLACE OF MOTHER (State or Country): New. Jersey.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Mrs. Eva, H. Brown.
(Address): Ashton. Idaho.

15. Filed 1-7- 19[illegible] [illegible] Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: December, 14th 19[illegible]1 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1 19[illegible]1 to Dec 6 19[illegible]1, that I last saw h[illegible] alive on Dec 6 19[illegible]1, and that death occurred on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

Cancer of Stomach

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary)

(Duration) 2 yrs. ... mos. ... ds.

(Signed) E. L. Capps M. D.

Dec 6 19[illegible]1 (Address) Ashton Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Ashton Idaho.xx/ DATE OF BURIAL: 12/9/21

20. UNDERTAKER: Lewis Kiser. Ashton ADDRESS: Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Fremont
City of Ashton (No. ....., ... St.)
Registration District No. 102
Primary Registration District No. 6
File No. 36596
Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME MARY AGNES CROUCH.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: FEMALE

4. COLOR OR RACE: WHITE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): MARRIED

6. DATE OF BIRTH. MARCH (Month) 31st. (Day) 1853 (Year)

7. AGE: 68 Yrs. 8 Mos. 24 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): VIRGINIA.

10. NAME OF FATHER: WILSON WHEELER

11. BIRTHPLACE OF FATHER (State or Country): VIRGINIA

12. MAIDEN NAME OF MOTHER: ——— AINSE

13. BIRTHPLACE OF MOTHER (State or Country): VIRGINIA.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) M. CROUCH.
(Address) ASHTON IDAHO.

15. Filed 12-27-191[illegible]
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
DECEMBER (Month) 24 th. (Day) 191[illegible] (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12-23 191[illegible], to ——— 191....,
that I last saw h[illegible] alive on 12-23 191[illegible],
and that death occured on the date stated above, at 7 A.M.
The CAUSE OF DEATH* was as follows:
Endocarditis
(Duration) ——— Yrs. ..... mos. ..... ds.
Contributory (Secondary) Erysipelas
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) [illegible] M. D.
12/27/191[illegible] (Address) Ashton, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: ASHTON IDAHO.
DATE OF BURIAL: 12/28/21[illegible]

20. UNDERTAKER: LEWIS KISER.
ADDRESS: ASHTON IDAHO

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

BYRNS - YORK CO., PTRS. & BDRS. 24853

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED JAN 19 1922 BUREAU OF VITAL STATISTICS STATE OF IDAHO

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36599

Registered No. 113

1. PLACE OF DEATH.

County of Idaho — Registration District No. 106

City of States — Primary Registration District No. 2184

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Robert Finlay Baldwin

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write word.): Married

6. DATE OF BIRTH. Oct (Month) 30 (Day) 1875 (Year)

7. AGE: 46 Yrs. 1 Mos. ——— ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Invalid

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kentuckey

10. NAME OF FATHER: Wm Baldwin

11. BIRTHPLACE OF FATHER (State or Country): Kentuckey

12. MAIDEN NAME OF MOTHER: Nancy Jane Robbins

13. BIRTHPLACE OF MOTHER (State or Country): Kentuckey

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Baldwin

(Address) States

15. Filed Dec 26 1921

J. M. Weber Rund
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 30 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 31 1915, to Nov 30 1921, that I last saw h[illegible] alive on Nov 30 1921, and that death occured on the date stated above, at 2:10 P M.

The CAUSE OF DEATH* was as follows:

Chronic rheumatism.
Gradual general decline
Most joints fixed

(Duration) 6 Yrs. 3 mos. 30 ds.

Contributory (Secondary) Mitral regurgitation
3 Tuberculous bones

(Duration 7 yrs. mos. ds.

(Signed) H W Wentworth M. D.

Nov 30 1921 (Address) States

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: States — DATE OF BURIAL: Dec 2 1921

20. UNDERTAKER — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 103
Primary Registration District No. 2181
File No. 36601
Registered No. 3

1. PLACE OF DEATH
County of Idaho
City of Grangeville (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John W. Johnston
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Sept (Month) 30 (Day) 1917 (Year)

7. AGE: 4 Yrs. 2 Mos. 21 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: W.E. Johnston

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Ethel McArmond

13. BIRTHPLACE OF MOTHER (State or Country): Colorado

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W.E. Johnston
(Address) Grangeville

15. Filed Jan 1 1922 G.S. Stockton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 27 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 24 1921 to Dec 26 1921, that I last saw him alive on Dec 26 1921, and that death occurred on the date stated above, at 9 A.M.
The CAUSE OF DEATH* was as follows:
Autoinfection
(Duration) ..... Yrs. ..... mos. 3 ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) B Shipman M. D.
1-1-1922 (Address) Grangeville Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Prairie View. DATE OF BURIAL: Dec 29 1921

20. UNDERTAKER: A.J. Maugg ADDRESS: City

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 4 8
Primary Registration District No. 2176
File No. 36606
Registered No. 3

RECEIVED FEB 6 1922 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Jefferson
City of Rigby (No. St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Gerald Cordon Gorton
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Dec 27 (Month) (Day) 1921 (Year)

7. AGE: ...Yrs. ...Mos. 4 ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Don Gorton

11. BIRTHPLACE OF FATHER (State or Country): Okla

12. MAIDEN NAME OF MOTHER: Emily Cordon

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Don Gorton
(Address) Rigby, Idaho

15. Filed Feb 10 1922 Ray H Fisher Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec 31st (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 27th 1921 to Dec 27 1921
that I last saw him alive on Dec 29th 1921
and that death occurred on the date stated above, at 4P M.
The CAUSE OF DEATH* was as follows:
Prematurity
Sclerederma
(Duration) ... Yrs. ... mos. ... ds.
Contributory (Secondary)
(Duration) ... yrs. ... mos. ... ds.
(Signed) Ray H Fisher M. D.
Dec 31 1921 (Address) Rigby, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rigby
DATE OF BURIAL: 1-1 1922

20. UNDERTAKER: Friends
ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JAN 10 1922 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 98
Primary Registration District No. 2176
File No. 36609
Registered No. 10

1. PLACE OF DEATH

County of Canyon
City of Ranch near Roberts (No. Usual Res. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Rudolph W Miller

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	White	Single

6. DATE OF BIRTH March 24 1912 (Month) (Day) (Year)

7. AGE 9 Yrs. Mos. 7 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: School boy
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Kansas

10. NAME OF FATHER Frank Miller

11. BIRTHPLACE OF FATHER (State or Country) Kan

12. MAIDEN NAME OF MOTHER Emma Stockebrand

13. BIRTHPLACE OF MOTHER (State or Country) Kan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Frank Miller
(Address) Roberts Ida

15. Filed Feb 10 1922 Ray Fisher Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Apr 1 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 1919, to 3/31 1921 that I last saw h— alive on 3/31 1921 and that death occurred on the date stated above, at 1.40 A.M.

The CAUSE OF DEATH* was as follows:

Endocarditis

(Duration) Yrs. 2 mos. ds.

Contributory (Secondary) Scarlet Fever

(Duration) yrs. mos. ds.

(Signed) Emil D Jones M. D.

4/2 1921 (Address) Roberts Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Roberts Ida — **DATE OF BURIAL** Apr 3 1921

20. UNDERTAKER Jeff C Hayes — **ADDRESS** Roberts Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 7 8

Primary Registration District No. 2-176

File No. 36610

Registered No. 9

County of Jefferson

City of Rigby No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Jennette Poore

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widow

6. DATE OF BIRTH: Feb 10 1836 (Month) (Day) (Year)

7. AGE: 95 Yrs. 3 Mos. 10 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: Wm Blaisdell

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Margaret Moss

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Susie Lawson

(Address) Lyman Ida

15.

Filed ..... 19 .....

Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 21 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 16 1921 to May 19 1921 that I last saw her alive on May 19 1921 and that death occurred on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Senile decay

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas S Moody M. D.

5/20 1921 (Address) Menan

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Annis

DATE OF BURIAL: 5-22 1921

20. UNDERTAKER: [signature]

ADDRESS: Rigby

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Jefferson, Registration District No. 9

City of Lewisville (No. ..... St.) Primary Registration District No. 2176

File No. 36614

Registered No. 14

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Infant

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	White	Infant.

6. DATE OF BIRTH Nov 23 1921
(Month) (Day) (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or 15 min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Wm Hansen

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Vera Allred

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm Hansen

(Address) Lewisville Ida

15. Filed 2-16 1922 Ray Fisher
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov 23 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 23 1921 to Nov 3 1921 that I last saw h.er alive on Nov 3 1921 and that death occurred on the date stated above, at 11 15 A M.

The CAUSE OF DEATH* was as follows:

Congenital Heart

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Premature

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A. M. Palmer M. D.

11-24 1921 (Address) Rigby

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Lewisville DATE OF BURIAL 11-24 1921

20. UNDERTAKER Friends ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 41
Primary Registration District No. 2116
File No. 36616
Registered No.

1. PLACE OF DEATH
County of Shoshone
City of Wallace
(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Royal W. McDonald

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Not known (Month) (Day) (Year)

7. AGE: about 63 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Quartz Miner
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Not known

10. NAME OF FATHER: " "

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wm C Doebler
(Address) Wallace Idaho

15. Filed Jan 10 1921 Chas C Bellamy Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: December 27th 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 18 1920, to Dec 27 1920, that I last saw h~~im~~ alive on Dec 27 1920, and that death occurred on the date stated above, at 12 M.
The CAUSE OF DEATH* was as follows:

Coba Pneumonia

(Duration) Yrs. mos. 5 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Chas F Hamm M. D.

12/28 1920 (Address) Wallace

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Wallace Cemetery
DATE OF BURIAL: 12-29-1920

20. UNDERTAKER: Wm C Doebler
ADDRESS: Wallace Ida

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 41
Primary Registration District No. 216
(No. ..... St.)

File No. 36617
Registered No. .....

1. PLACE OF DEATH.

County of Lemhi
City of Salmon.

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ralph P. Quarles

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. June (Month) 10 (Day) 1855 (Year)

7. AGE: 66 Yrs. 5 Mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Attorney at
(b) General nature of industry, business, or establishment in which employed (or employer)... Law

9. BIRTHPLACE (State or Country) Benton, Kentucky

10. NAME OF FATHER James M. Quarles

11. BIRTHPLACE OF FATHER (State or Country) Benton, Kentucky

12. MAIDEN NAME OF MOTHER Miss Petty

13. BIRTHPLACE OF MOTHER (State or Country) Murray, Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Ralph P. Quarles Jr.
(Address) Salmon, Idaho

15. Filed Jan 10 1922 Chas V. Williams Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 15th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 13 1921, to Nov 15 1921, that I last saw h[illegible] alive on Nov 15 1921 and that death occured on the date stated above, at 11-30 P M.

The CAUSE OF DEATH* was as follows:

[illegible]

(Duration) ..... Yrs. ..... mos. 5 ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Chas F. Hanner M. D.

Nov 19 21 (Address) Salmon

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Salmon Cemetery — DATE OF BURIAL: Nov 17 1921

20. UNDERTAKER [illegible] ADDRESS Salmon Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

U. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36618
Registered No.

RECEIVED
JAN 3 1922
BUREAU OF VITAL STATISTICS

PLACE OF DEATH.
County of Custer
Registration District No. 41
Primary Registration District No. 2116
City of Pattison Ida (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Nancy Kirkpatrick

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH: December 7 1839 (Month) (Day) (Year)

7. AGE: 81 yrs. 9 mos. 29 ds. IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kentuckey

10. NAME OF FATHER: Preston Horn

11. BIRTHPLACE OF FATHER (State or Country): not Known

12. MAIDEN NAME OF MOTHER: Nancy Horn

13. BIRTHPLACE OF MOTHER (State or Country): not Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Kirkpatric
(Address) May Idaho

15. Jan 10 1922 Clio C. Bellamy Dep. Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Oct (Month) 6 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 2 1921, to Oct 6 1921 that I last saw her alive on Oct 6 1921 and that death occurred on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

Valvular Insufficiency

(Duration) ..... yrs. ..... mos. 4 ds.

Contributory (Secondary) Bronchial Asthma

(Duration) 5 yrs. ..... mos. ..... ds.

(Signed) E. J. Gilmore M. D.

19 ..... (Address) May Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: May Cemetery
DATE OF BURIAL: 10-8 1921

20. UNDERTAKER: Dell Browne
ADDRESS: May Idaho

Nov

See instructions on back of certificate.
ment of OCCUPATION is very important.

IDAHO PRINTING CO., PRINTERS & BINDERS, BOISE 17143

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED JAN 19 1922 BUREAU OF STATISTICS

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36620

Registered No. 66

1. PLACE OF DEATH. Registration District No. 47

County of Lewis (Subdivision) Registration District No.

City of Nezperce (No. , St.)

If death occurs away from usual residence, give facts called for under special information. Route 2

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mildred Adell Weaver

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Aug 10 1915 (Month) (Day) (Year)

7. AGE: 6 Yrs. 4 Mos. 11 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Kamiah Nezperce Idaho

10. NAME OF FATHER: Albert Weaver

11. BIRTHPLACE OF FATHER (State or Country): Attala Co Miss.

12. MAIDEN NAME OF MOTHER: Cora Benson

13. BIRTHPLACE OF MOTHER (State or Country): West Va

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Albert Weaver
(Address) Nezperce Idaho

15. Filed 12-29 1921 Albert Hoff Local Registrar

SYMS - YORK CO., PTRS. & BNRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. 21 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 20, 1921, to Dec. 20, 1921, that I last saw her alive on Dec. 20, 1921, and that death occured on the date stated above, at 7 a. M.
The CAUSE OF DEATH* was as follows:

Fracture of Skull

(Duration) ..... Yrs. ..... mos. One ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. J. Darley M. D.

12/2/1921 (Address) Nezperce, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Kamiah Cemetery — DATE OF BURIAL: 12 22 1921

20. UNDERTAKER: C. J. Johnson — ADDRESS: Kamiah Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED JAN 10 1922 BUREAU OF VITAL STATISTICS STATE OF IDAHO

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 68

Primary Registration District No.

File No. 36623

Registered No.

1. PLACE OF DEATH.

County of Nez Perce

City of Juliaetta RFD 2 (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Otto Swanson Kimberling

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Oct (Month) 26 (Day) 1905 (Year)

7. AGE: 16 Yrs. 1 Mos. 25 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Virginia

10. NAME OF FATHER: Stewart M. Kimberling

11. BIRTHPLACE OF FATHER (State or Country): Virginia

12. MAIDEN NAME OF MOTHER: Rosa E Kimberling

13. BIRTHPLACE OF MOTHER (State or Country): Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) S. M. Kimberling

(Address) Juliaetta Idaho

15. Filed Dec 21 1921 R. St. Pepple Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 20 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 8 1921, to Dec 19 1921, that I last saw h.. alive on Dec 19 1921, and that death occured on the date stated above, at 3 40 a M.

The CAUSE OF DEATH* was as follows:

Typhoid Fever.

(Duration) Yrs. mos. 20 ds.

Contributory (Secondary)

(Duration yrs. mos. ds.

(Signed) J H Kelly M. D.

Dec 21 1921 (Address) Kendrick Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Juliaetta Cemetery	12-21 1921
20 UNDERTAKER: J. C. Croucher	ADDRESS: Juliaetta

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JAN 11 1922 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96

Primary Registration District No. 1009

File No. 36624

Registered No. 140

1. PLACE OF DEATH

County of Nez Perce

City of Lewiston (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Stella Hicks

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Sept (Month) 16 (Day) 1881 (Year)

7. AGE: 40 Yrs. 2 Mos. 23 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Geo. Simpson

11. BIRTHPLACE OF FATHER (State or Country): Wisconsin

12. MAIDEN NAME OF MOTHER: Jane Martin

13. BIRTHPLACE OF MOTHER (State or Country): Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Geo Hicks

(Address) 1402 Main St City. Phone 471 L

15. Filed Jan 11 1922 Susan E. Bruce Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 9 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1 1921 to Dec 7 1921 that I last saw her alive on Dec 9 1921 and that death occurred on the date stated above, at 3:30 P.M.

The CAUSE OF DEATH* was as follows:

Shock of surgical operation, Abdominal Section

(Duration) ..... Yrs. ..... mos. 1 ds.

Contributory (Secondary) Fistula of Uterus

(Duration) 7 yrs. ..... mos. ..... ds.

(Signed) John W. Alley M. D.

19 ..... (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston Idaho

DATE OF BURIAL: 12/1/1921

20. UNDERTAKER: Bassett Und. Co.

ADDRESS: Lewiston Ida

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 36625
Registered No. 741

1. PLACE OF DEATH.
County of Nez Perce
City of Lewiston (No. ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Madeline West

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): S

6. DATE OF BIRTH. Dec - 8 - 1921 (Month) (Day) (Year)

7. AGE: — Yrs. ... Mos. ... ds.
IF LESS than 1 day how many. 12 hrs. or ... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: J. B. Hunt

11. BIRTHPLACE OF FATHER (State or Country): North Carolina

12. MAIDEN NAME OF MOTHER: Madaline Johnson

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Esp Brown
(Address) Lewiston Ida.

15.
Filed Jan 11 1922 Irma E. Bruce Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec - 9 - 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 8 1921, to Dec 9 1921, that I last saw her alive on Dec 8 1921, and that death occured on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:
Premature birth
(Duration) ... Yrs. ... mos. ... ds.
Contributory (Secondary)
(Duration) ... yrs. ... mos. ... ds.

(Signed) John B. Alley M. D.
Dec 9, 1921 (Address) Lewiston, Idaho

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs ... mos ... days. In the State ... yrs ... mos ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston, Idaho — DATE OF BURIAL: 12/9 1921

20. UNDERTAKER: Vasaas Undertaking Co. — ADDRESS: Lewiston Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BOOK. 24653

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 36626
Registered No. 742

1. PLACE OF DEATH
County of Nez Perce
City of Lewiston (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Frank Gronert
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word.): Single

6. DATE OF BIRTH: Jan (Month) 26 (Day) 18 (Year)

7. AGE: 67 Yrs. 10 Mos. 17 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Austria

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): "

12. MAIDEN NAME OF MOTHER: "

13. BIRTHPLACE OF MOTHER (State or Country): "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. A. Patterson
(Address) 1835 G 21

15.
Filed Jan 11 1922 Sarah E. Bruce Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 13 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 13 1921, to Dec 13 1921, that I last saw h[illegible] alive on Dec 13 1921, and that death occurred on the date stated above, at 7:35 M.

The CAUSE OF DEATH* was as follows: Angina Pectoris

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) M. Lyle M. D.
12-15 1921 (Address) Lewiston Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston Ida
DATE OF BURIAL: 12/15 1921

20. UNDERTAKER: Vassar Mtd Co.
ADDRESS: Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 36627
Registered No. 743

1. PLACE OF DEATH
County of Nez Perce
City of Lewiston (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Susie Williamson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: Indian
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1880 (Year)

7. AGE: 41 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Wash.

10. NAME OF FATHER: Not Known

11. BIRTHPLACE OF FATHER (State or Country): Wash.

12. MAIDEN NAME OF MOTHER: Sally Wakkiecum

13. BIRTHPLACE OF MOTHER (State or Country): Wash.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Frank Stockish
(Address) White Swan, Wash.

15. Filed Jan 11 1922 Susan E. Bruce Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. (Month) 14th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 13 1921, to Dec 14 1921
that I last saw h.. alive on Dec 13 1921
and that death occurred on the date stated above, at 2 A. M.
The CAUSE OF DEATH* was as follows: Concussion of brain followed by hemorrhage

..... (Duration) ..... Yrs. ..... mos. 4 ds.
Contributory (Secondary) Injuries
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Louis V. Adler M. D.
19 ..... (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: White Swan Cem. | DATE OF BURIAL: 1/27 19.....

20. UNDERTAKER: Bassard Und Co | ADDRESS: Lewiston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 36628
Registered No. 744

1. PLACE OF DEATH
County of Nez Perce
City of Lewiston (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Helen May Caraness

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Oct 5 1899 (Month) (Day) (Year)

7. AGE: 22 Yrs. 2 Mos. 12 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Del

10. NAME OF FATHER: C. E. Brown

11. BIRTHPLACE OF FATHER (State or Country): Del

12. MAIDEN NAME OF MOTHER: Elizabeth A. Armstrong

13. BIRTHPLACE OF MOTHER (State or Country): Del.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. E. Brown
(Address) 1312 7th St City

15. Filed Jan 11 1921 Mrs. C. E. Brown Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec 17 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 8 1921, to Dec 17 1921 that I last saw her alive on Dec 16 1921 and that death occurred on the date stated above, at 1.30 AM.

The CAUSE OF DEATH* was as follows:

Peritonitis

(Duration) ..... Yrs. ..... mos. 10 ds.
Contributory (Secondary) Pelvic Abscess

(Duration) ..... yrs. ..... mos. 10 ds.

(Signed) John M. Alley M. D.
Dec 17 1921 (Address) Lewiston Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston Ida.
DATE OF BURIAL: 12/19/1921

20. UNDERTAKER: Bassett Mtd Co,
ADDRESS: Lewiston Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED FEB 4 1922 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH. 36629

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Nez Perce — Registration District No. 92
City of Lapwai — Primary Registration District No. 2170 — St.)
File No. 5
Registered No. 38

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ely Lea

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH. Feby (Month) 10 (Day) 1837 (Year)

7. AGE: 84 Yrs. 10 Mos. 22 ds.
IF LESS than 1 day how many .....hrs. or .....min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kentucky

10. NAME OF FATHER: Not Known

11. BIRTHPLACE OF FATHER (State or Country): Not Known

12. MAIDEN NAME OF MOTHER: Not Known

13. BIRTHPLACE OF MOTHER (State or Country): Not Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. A. E. Boots
(Address) Colfax Wash

15.
Filed 1-3 1924 — E E Watts — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Jan (Month) 2 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 26 1921, to Jan 2 1922, that I last saw him alive on Jan 1 1922, and that death occured on the date stated above, at 6 a M.

The CAUSE OF DEATH* was as follows:

Septicemia

(Duration) Yrs. 1 mos. 5 ds.

Contributory (Secondary)

(Duration ... yrs. ... mos. ... ds.

(Signed) E E Watts M. D.
1-2 1922 (Address) Gifford

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Gifford — DATE OF BURIAL: Jany 4 1921

20. UNDERTAKER: E E Stoddard — ADDRESS: Gifford

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STNRS. 24658

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36639
Registered No. 73
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Shoshone RECEIVED JAN 28 1922
Registration District No. 70
Primary Registration District No. 1011
City of Wallace (No.) Wallace Hospital St.
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Godfrey Kahls

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): Single
6. DATE OF BIRTH. ..... (Month) ..... 1 (Day) ..... (Year)
7. AGE: 62 Yrs. ..... Mos. ..... ds. IF LESS than 1 day how many .... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry, business, or establishment in which employed (or employer) .....
9. BIRTHPLACE (State or Country): Germany
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (State or Country)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (State or Country)
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Meyer
(Address) Wallace Ida
15. Filed Oct 12 1921 F. L. Jung Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 26 (Day) 1921 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Sept 5 1921 to Sept 26 1921 that I last saw h. alive on Sept 25 1921 and that death occurred on the date stated above, at 9.9 M.
The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis
(Duration) 3 Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... Yrs. ..... mos. ..... ds.
(Signed) Wm. T. Smith M. D.
19.... (Address) Wallace Ida
*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Wallace — DATE OF BURIAL: Oct 12 1921
20. UNDERTAKER: B E Mordell — ADDRESS: Wallace

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

Form V. S. No. 5. 12½M-7-24-11

RECEIVED JAN 23 1922

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH — Registration District No. 70
County of Shoshone — Primary Registration District No. 10 11
City of Burke. (No. Burke Idaho St.)
File No. 36640
Registered No. 74

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Samuel Mc Coy

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Oct (Month) 10 (Day) 1860 (Year)

7. AGE: 61 yrs. mos. ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ill

10. NAME OF FATHER: not given

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: not Given

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H. B. Green
(Address) Burke Ida

15.
Filed Oct 4 1921
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Oct (Month) 1 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1 1921, to Oct 1 1921
that I last saw h... alive on Sept 29 1921
and that death occurred on the date stated above, at 3:30 P.M.
The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis

(Duration) 4 yrs. — mos. — ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) Chas. A. Wellman M. D.
Oct 1 1921 (Address) Burke Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds.
In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence: Burke Idaho

19. PLACE OF BURIAL OR REMOVAL: Wallace Idaho
DATE OF BURIAL: Oct 4 1921

20. UNDERTAKER: Ward Und Co
ADDRESS: Wallace Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

FORM V. S. No. 5-12 M. 6-15-17.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

RECEIVED JAN 29 19[illegible] BUREAU OF VITAL STATISTICS

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36641
Registered No. 73

1. PLACE OF DEATH
County of Shoshone
City of Wallace
If death occurs away from usual residence, give facts called for under special information.
Registration District No. 70
Primary Registration District No. 10
St. No. Providence Hospital

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Chas. M. Kelsey

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): married
6. DATE OF BIRTH. June (Month) 6 (Day) 1879 (Year)
7. AGE: 42 Yrs. 3 Mos. 24 ds. IF LESS than 1 day how many .... hrs. or .... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: mail carrier
(b) General nature of industry, business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): New York
10. NAME OF FATHER: Kelsey
11. BIRTHPLACE OF FATHER (State or Country): not known
12. MAIDEN NAME OF MOTHER: Clarinda Putnam
13. BIRTHPLACE OF MOTHER (State or Country): not known
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Leroy Kelsey
(Address) Portland Ore.
15. Filed Oct 3 1921 F. L. Jun[illegible] Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 1 (Day) 1921 (Year)
17. I HEREBY CERTIFY, That I attended deceased from May 1921 to Oct 1 1921 that I last saw h[illegible] alive on Oct 1 1921 and that death occurred on the date stated above, at 1 P. M.
The CAUSE OF DEATH* was as follows:
Cancer of liver
1
(Duration) .... Yrs. .... mos. .... ds.
Contributory (Secondary)
(Duration) .... Yrs. .... mos. .... ds.
(Signed) D[illegible] Hoover M. D.
Oct 1921 (Address) Wallace Ida
*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Wallace Id
DATE OF BURIAL: Oct 3 1921
20. UNDERTAKER: [illegible] Gravelle
ADDRESS: Wallace

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36642

Registered No. 76

1. PLACE OF DEATH

County of Shoshone — Registration District No. 70

City of Wallace — Primary Registration District No. 1061

(No. Infirmary St.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED JAN 23 19[illegible] BUREAU OF VITAL STATISTICS

2. FULL NAME Joseph Lobe

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): single

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1 (Year)

7. AGE: 30 Yrs. — Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: miner

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: not given

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: not given

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E. E. Ward

(Address) Wallace Idaho

15. Filed Oct 8 1921 — F. L. Jenkins — Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 6 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 15 1921, to Oct 6 1921, that I last saw h[illegible]m alive on Oct 5 1921, and that death occurred on the date stated above, at 7:30 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) 2 or 3 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) James R Brannon M. D.

10/7 1921 (Address) Wallace Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence Wallace Ida

19. PLACE OF BURIAL OR REMOVAL: Wallace Ida — DATE OF BURIAL: Oct 8 1921

20. UNDERTAKER: Ward Und Co — ADDRESS: Wallace Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Dr. Bean

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 70

Primary Registration District No. 10 11

File No. 36643

Registered No. 7 7

1. PLACE OF DEATH

County of Shoshone

City of County Infirmary (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Nannie A. Nelson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F.	W.	Widowed

6. DATE OF BIRTH: Aug (Month) 4 (Day) 1861 (Year)

7. AGE: 60 Yrs. 2 Mos. 6 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: W. P. Nelson

11. BIRTHPLACE OF FATHER (State or Country): Virginia

12. MAIDEN NAME OF MOTHER: Mira McSpillman

13. BIRTHPLACE OF MOTHER (State or Country): Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) JAMES J NELSON
(Address) Keeney Jacks

15. Filed Oct 11 1921 F K Seamans Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. (Month) 8 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 14 1921, to Oct 8 1921, that I last saw her alive on Oct 8 1921 and that death occurred on the date stated above, at 1.30 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) James R Bean M. D.

10/11 1921 (Address) Wallace

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. 14 days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Kellogg, Idaho. DATE OF BURIAL: Oct. 11 21.

20. UNDERTAKER: M. C. Thornhill ADDRESS: Kellogg, Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JAN 23 1922 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 70
Primary Registration District No. 1011
File No. 36644
Registered No. 78

1. PLACE OF DEATH

County of Shoshone
City of Wallace (No. 2 Jefferson St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary Phyne

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F.	White	widowed

6. DATE OF BIRTH

(Month) (Day) (Year)

7. AGE 67 Yrs. — Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Redruth, England

10. NAME OF FATHER James Bath

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER not given

13. BIRTHPLACE OF MOTHER (State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Edward Phyne

(Address) Wallace

15. Filed Oct 3 1921

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 8 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 28 1921, to Oct 8 1921, that I last saw her alive on Oct 8 1921, and that death occurred on the date stated above, at 1:30 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) James R Bean M. D.

10/6 1921 (Address) Wallace

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence Wallace Idaho

19. PLACE OF BURIAL OR REMOVAL Wallace Ida

DATE OF BURIAL Oct 11 1921

20. UNDERTAKER Ward Und Co

ADDRESS Wallace Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35645
Registered No. 79

1. PLACE OF DEATH
County of Shoshone
City of Wallace
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 70
Primary Registration District No. 1041
(No.) Providence Hospital (St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Martin J. Mellott Jr.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Sept (Month) 30 (Day) 1902 (Year)

7. AGE: 19 Yrs. 0 Mos. 11 ds.
IF LESS than 1 day how many .... hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: mining
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Montana

10. NAME OF FATHER: Martin J Mellott

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Anna Carr

13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Martin J Mellott
(Address) Butte Mont

15. Filed Oct 13 1921 F L [illegible] Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 11 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 5 1921 to Oct 11 1921
that I last saw h[illegible] alive on Oct 11 1921
and that death occurred on the date stated above, at 4:30 P.M.
The CAUSE OF DEATH* was as follows:
Lobar Pneumonia
Both Lungs & all Lobes
(Duration) Yrs. mos. 6 ds.
Contributory (Secondary) Exposure
(Duration) Yrs. mos. ds.
(Signed) Dr. D. Mowry M. D.
10/12 1921 (Address) Wallace Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the ,State....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Butte Mont — DATE OF BURIAL: Oct 13 1921

20. UNDERTAKER: B[illegible] Worstell — ADDRESS: Wallace

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

Form V. S. No. 5 20M.1-16-12

RECEIVED DEC 23 1921

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36646

Registered No. 80

1. PLACE OF DEATH.

Registration District No. 70

Primary Registration District No. 7011

County of Shoshone

City of Wallace (No. Cameron Ave St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Isabella Blackburn

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F	white	widowed

6. DATE OF BIRTH

(Month) (Day) (Year)

7. AGE

65 yrs. mos. ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work ..... At Home

(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Ireland

10. NAME OF FATHER — Walkup.

11. BIRTHPLACE OF FATHER (State or Country) Ireland

12. MAIDEN NAME OF MOTHER not given

13. BIRTHPLACE OF MOTHER (State or Country) Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John T. Blackburn

(Address) Spokane Wash 124 Sherman St.

15. Filed Dec 2 1921 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Dec 1st 1921

(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1 1921, to Dec 1 1921, that I last saw h[illegible] alive on Dec 1 1921, and that death occurred on the date stated above, at 10 A.M. P

The CAUSE OF DEATH* was as follows:

lobar pneumonia

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) James R Bean M. D.

12/2 1921 (Address) Wallace

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence Wallace Idaho

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Spokane Wash.	Dec 5th 1921

20. UNDERTAKER	ADDRESS
Ward Undertaking Co	Wallace Ida

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 70
County of Shoshone Primary Registration District No. 1011
City of Wallace (No. Wallace Hospital St.)
If death occurs away from usual residence, give facts called for under special information.

File No. 36647
Registered No. 81
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Irene Kemp.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
F.	White	married

6. DATE OF BIRTH
(Month) (Day) (Year)

7. AGE
28 yrs. — mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work At Home
(b) General nature of industry business, or dstablishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Washington

10. NAME OF FATHER Charles Colvin

11. BIRTHPLACE OF FATHER (State or Country) [redacted] not given

12. MAIDEN NAME OF MOTHER not given

13. BIRTHPLACE OF MOTHER (State or Country) not given

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Thos. Kemp.
(Address) Kellogg Idg

15. Filed [redacted] 8 1921 H. C. McWhirk Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Dec 1 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 27 1921, to Dec 1 1921, that I last saw h[illegible] alive on Dec 6 1921, and that death occurred on the date stated above, at 4:40 A.M.
The CAUSE OF DEATH* was as follows:

Paralytic Ileus

(Duration) 4 yrs. mos. — ds.
Contributory Intestinal Obstruction
(Secondary)
(Duration) yrs. mos. 5 ds.

(Signed) James R Bean M. D.
12/9 1921 (Address) Wallace Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence Kellogg Idaho

19. PLACE OF BURIAL OR REMOVAL Wallace Idg. DATE OF BURIAL Dec. 9th 1921

20. UNDERTAKER Hart Hurd Co ADDRESS Wallace Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12 RECEIVED JAN 1924

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 70
County of Shoshone Primary Registration District No. 1011
City of Wallace (No. 210 Cedar St.)
File No. 36648
Registered No. 62
If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME James McKay
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH: (Month) (Day) (Year): about 1
7. AGE: 38 yrs. — mos. — ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry business, or dstablishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Ireland
10. NAME OF FATHER: not given
11. BIRTHPLACE OF FATHER (State or Country): Ireland
12. MAIDEN NAME OF MOTHER: not given
13. BIRTHPLACE OF MOTHER (State or Country): Ireland
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant)
(Address)
15. Filed Dec 17 1924 F L Jennings Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec (Month) 7th (Day) 1924 (Year)
17. I HEREBY CERTIFY, That I attended deceased from ... 191..., to ... 191..., that I last saw him alive on ... 191..., and that death occurred on the date stated above, at 7 P.M.
The CAUSE OF DEATH* was as follows: Gunshot wound Chest
(Duration) yrs. Instant ds.
Contributory (Secondary): None
(Duration) yrs. mos. ds.
(Signed) F. D. Mowry Coroner M.D.
12/12 1924 (Address) Wallace Ida.
*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.
18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence: Butte Montana
19. PLACE OF BURIAL OR REMOVAL: Wallace Idg DATE OF BURIAL: Dec 12 1924
20. UNDERTAKER: Ward Hud Co ADDRESS: Wallace

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

RECEIVED JAN 23 1922 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36649
Registered No. 83

1. PLACE OF DEATH.
Registration District No. 70
County of Shoshone
Primary Registration District No. 1011
City of Wallace (No. Wallace Hosp. St.)
If death occurred away from usual residence, give facts called for under special information.

2. FULL NAME Linnia May Vincent
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married
6. DATE OF BIRTH: January 24 (Month) (Day) 1861. (Year)
7. AGE: 60 yrs. 10 mos. 17 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: housewife
(b) General nature of industry business, or dstablishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Illinois
10. NAME OF FATHER: Thos. J. Sargent
11. BIRTHPLACE OF FATHER (State or Country): Indiana
12. MAIDEN NAME OF MOTHER: Julia Snyder
13. BIRTHPLACE OF MOTHER (State or Country): Virginia
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Charles Vincent
(Address) Wallace Ida
15.
Filed Dec 14 1921 F. L. Jennings Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: December (Month) 11 (Day) 1921 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Nov 9 1921 to Dec 11 1921, that I last saw her alive on Dec 11 1921 and that death occurred on the date stated above, at 10 p. M.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
(Duration) yrs. mos. ds.
Contributory (Secondary) Chronic Parenchymatous Nephritis - Arteriosclerosis
(Duration) 2 yrs mos. ds.
(Signed) Gordon C. Hamm M. D.
12-13 1921 (Address) Wallace, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Wallace Ida — DATE OF BURIAL: Dec 14 1921
20. UNDERTAKER: E. L. Norvell — ADDRESS: Wallace

SYMS - YORK CO., PTRS. & BDRS. 19760

Dr Done

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36650

Registered No. 84

1. PLACE OF DEATH. Registration District No. 90

County of Shoshone Primary Registration District No. 104

City of Wallace (No. 711 Reduce St. St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary Farris

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH: April 1st 1839 (Month) (Day) (Year)

7. AGE: 82 yrs. 8 mos. 12 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: Willoughby Williams

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER: Susan R Turner

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John C. Farris
(Address) Wallace Ida

15. Filed Dec 15 1921 F L Jones Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Mary Farris 191
Dec (Month) 13th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Oct intervals 1920, to Dec 1921,
that I last saw h[er] alive on May 20th 1921,
and that death occurred on the date stated above, at 8:30 A.M.
The CAUSE OF DEATH* was as follows:
Heart Failure — Senility

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) L. S. Stone M. D.

19 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Wallace Idaho | DATE OF BURIAL: Dec 15 1921

20. UNDERTAKER: Bruce L. Worstell | ADDRESS: Wallace

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 90
County of Shoshone Primary Registration District No. 1011 File No. 36651
City of Wallace (No. Providence Hospital) Registered No. 86
If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME Infant Madden
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single
6. DATE OF BIRTH: Still born (Month) 1 (Day) (Year)
7. AGE: yrs. 5/12 mos. ds. IF LESS than 1 day how many ....hrs. or ....mins.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry business, or dstablishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Wallace Idaho
10. NAME OF FATHER: William Madden
11. BIRTHPLACE OF FATHER (State or Country): England
12. MAIDEN NAME OF MOTHER: Barbara Bootrell
13. BIRTHPLACE OF MOTHER (State or Country): England
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) William Madden
(Address) Wallace Idaho
15. Filed Dec 15 1921 F L Jones Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec (Month) 13 (Day) 1921 (Year)
17. I HEREBY CERTIFY, That I attended deceased from ....191..., to ....191...,
that I last saw h alive on ....191...,
and that death occurred on the date stated above, at 12:30 P.M.
The CAUSE OF DEATH* was as follows:
Premature birth
Still born.
(Duration) ....yrs. five minutes ds.
Contributory (Secondary) None
(Duration) ....yrs. ....mos. ....ds.
(Signed) D. McDonald M. D.
12/14 1921 (Address) Wallace Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death....yrs....mos....days. In the State....yrs....mos....days.
Where was disease contracted if not at place of death?
Former or usual residence None

19. PLACE OF BURIAL OR REMOVAL: Wallace Ida — DATE OF BURIAL: Dec 15 1921
20. UNDERTAKER: Ward Undertaking Co — ADDRESS: Wallace Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

RECEIVED JAN 29 1922 BOARD OF HEALTH

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36652

Registered No. 86

1. PLACE OF DEATH

Registration District No. 70

County of Shoshone

Primary Registration District No. 194

City of Mace (No.), Mace Idaho (St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME L S Curtis

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male.	White	Widowed

6. DATE OF BIRTH

May 7th 1851
(Month) (Day) (Year)

7. AGE

70 yrs. 8 mos. 11 ds.

IF LESS than 1 day how many .....hrs. or .....mins.)

8. OCCUPATION

(a) Trade, profession or particular kind of work None.

(b) General nature of industry business, or dstablishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Missouri

10. NAME OF FATHER Calvin Curtis

11. BIRTHPLACE OF FATHER (State or Country) Not known

12. MAIDEN NAME OF MOTHER Not known

13. BIRTHPLACE OF MOTHER (State or Country) " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mace Idy

(Address) Mrs. L. L. Curtis

15.

Filed Dec 15 1921 F L Jones Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Dec 15 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 15 1921, to Dec 15 1921, that I last saw h[illegible] alive on Dec 15 1921, and that death occurred on the date stated above, at 2P M.

The CAUSE OF DEATH* was as follows:

Cardiac failure

(Duration) — yrs. — mos. — ds.

Contributory (Secondary) Alcoholism

(Duration) — yrs. — mos. — ds.

(Signed) Chas. A. Hartman M. D.

Dec 15 1921 (Address) Burke Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL, CREMATION OR REMOVAL: Wallace Idaho | DATE OF BURIAL: Dec 15 1921

20. UNDERTAKER: B B Worstell | ADDRESS: Wallace

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

BYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

RECEIVED JAN 26 1922 BUR. OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36653
Registered No. 57

1. PLACE OF DEATH. Registration District No. 70
County of Shoshone Primary Registration District No. 1011
City of Wallace (No. Morning Mine (St.)
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Todd Kotsfue (Todar Kelovogja)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M.	white	single

6. DATE OF BIRTH ..... 1 .....
(Month) (Day) (Year)

7. AGE about 38 yrs. — mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... miner
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Austria

10. NAME OF FATHER not given

11. BIRTHPLACE OF FATHER (State or Country) Austria

12. MAIDEN NAME OF MOTHER not given

13. BIRTHPLACE OF MOTHER (State or Country) Austria

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Geo Edmunston
(Address) Wallace Ida

15.
Filed Dec 20 1921 F. L. Snider
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Dec 16 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....191..., to ....191...,
that I last saw h[illegible] alive on ....191...,
and that death occurred on the date stated above, at 6:30 A.M.
The CAUSE OF DEATH* was as follows:
Fractured skull
Accident Mine
(Duration) ..... yrs. Instant ds.
Contributory
(Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
12/19 1921 (Signed) Dr. J. M. Wood M. D.
(Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death? .....
Former or usual residence Butte Mont

19. PLACE OF BURIAL OR REMOVAL: Wallace Ida — DATE OF BURIAL: Dec 20th 1921

20. UNDERTAKER: Ward Und Co — ADDRESS: Wallace Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36654
Registered No. 88

1. PLACE OF DEATH. RECEIVED JAN 23 1922
Registration District No. 10
County of Shoshone
Primary Registration District No. 10/11
City of Wallace (No.) Providence Hosp (St.)
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Harvey Cole

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)
Male	White	

6. DATE OF BIRTH — — 1 —
(Month) (Day) (Year)

7. AGE 65 yrs. — mos. — ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *mins.*

8. OCCUPATION
(a) Trade, profession or particular kind of work: miner
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Colorado

10. NAME OF FATHER: —

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Fahle
(Address) Wallace Ida

15. Filed Dec 24 1921 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Dec 21 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 17 1921, to Dec 21 1921, that I last saw him alive on Dec 21 1921, and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:
Acute Parenchymatous Nephritis
(Duration) 4 days
Contributory (Secondary) Exposure
(Duration) — yrs. — mos. — ds.
(Signed) Dr McMurry M. D.
12-22-1921 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Wallace Ida | DATE OF BURIAL: Dec 26 1921

20. UNDERTAKER: J. Bruce G. Worstell, Wallace | ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JAN BUREAU STATIS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 39
Primary Registration District No. 2087
File No. 36655
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of Burley
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John T. Craig
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: June (Month) 10 (Day) 1888 (Year)

7. AGE: 33 Yrs. 6 Mos. 1 ds.
IF LESS than 1 day: how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mason City, Neb.

10. NAME OF FATHER: Quinten Craig

11. BIRTHPLACE OF FATHER (State or Country): Dec.

12. MAIDEN NAME OF MOTHER: Katy Kelley

13. BIRTHPLACE OF MOTHER (State or Country): Dont Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Prudence Craig
(Address) Burley Idaho

15. Filed 12-17 1921 — J. N. Murphy, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. (Month) 11th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 6 1921, to Dec 11 1921, that I last saw him alive on Dec 10 1921, and that death occurred on the date stated above, at 11:45 P.M.

The CAUSE OF DEATH* was as follows:
Peritonitis, streptococcus, following rupture of appendix
(Duration) Yrs. mos. 1 ds.
Contributory (Secondary) Appendicitis, sub-acute (Duration) yrs. mos. 30 ds.
(Signed) A. J. Mc Clusky M. D.
12/19 1921 (Address) Burley Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF ~~BURIAL~~ OR REMOVAL: Long Beach, Cal — DATE OF BURIAL ..... 19.....

20. UNDERTAKER: Homer B Evans — ADDRESS: Burley Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Twin Falls — Registration District No. 39

City of Buhl — Primary Registration District No. 2087

(No. ... St.)

File No. 36656

Registered No. ...

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Harry Gault.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Male	White	Married (Write the word)

6. DATE OF BIRTH: Oct (Month) 3 (Day) 1883 (Year)

7. AGE: 38 Yrs. 2 Mos. 14 ds.

IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer.
(b) General nature of industry, business or establishment in which employed (or employer): ...

9. BIRTHPLACE (State or Country): Mo.

10. NAME OF FATHER: Wm Gault.

11. BIRTHPLACE OF FATHER (State or Country): Ken.

12. MAIDEN NAME OF MOTHER: Garrett Farmer.

13. BIRTHPLACE OF MOTHER (State or Country): Ind.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Myrtle Gault
(Address) Buhl Ida.

15. Filed 12-19 1921 — J. F. Murphy, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 17 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12-16 1921, to 12-17 1921 that I last saw him alive on 12-16 1921, and that death occurred on the date stated above, at 5 P M.

The CAUSE OF DEATH* was as follows:

Uremia.
Suppression of Urine.
(Duration) ... Yrs. ... mos. 1 ds.

Contributory (Secondary) Diabetes Mellitus
(Duration) 4 yrs. ... mos. ... ds.

(Signed) J. F. Murphy M. D.
12-19 1921 (Address) Buhl Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death? ...

Former or usual residence ...

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Buhl Cemetery	12/19 1921
20. UNDERTAKER	ADDRESS
Buhl Mort. Co.	Buhl Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 1-11 M. 6-15-17.

RECEIVED JA BUR

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 39
Primary Registration District No. 2087
File No. 36651
Registered No. .....

1. PLACE OF DEATH
County of Twin Falls
City of Burley (No. ....., ... St.) TOWN
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Edith Marion Lawson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Married

6. DATE OF BIRTH. April (Month) 22 (Day) 1897 (Year)

7. AGE 24 Yrs. 8 Mos. 4 ds. IF LESS than 1 day how many .... hrs. or .....min.?'

8. OCCUPATION
(a) Trade, profession or particular kind of work House wife
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Wis.

10. NAME OF FATHER William Hurell

11. BIRTHPLACE OF FATHER (State or Country) Wis.

12. MAIDEN NAME OF MOTHER Lillian Sarton

13. BIRTHPLACE OF MOTHER (State or Country) Wis.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Cornelius O'Dwyer TOWN
(Address) Burley Idaho R. F. D.

15. Filed Dec 26 1921 J. H. Murphy Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. (Month) 26 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 15 1921 to Dec. 26 1921 that I last saw her alive on Dec. 26 1921 and that death occurred on the date stated above, at 6:15 A. M.

The CAUSE OF DEATH* was as follows:
Brights disease
Complicated by Swelling on left side & possible miscarriage
(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) James Monroe M. D.
Dec. 26 1921 (Address) Burley, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the State....yrs.....mos....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Twin Falls Ida — DATE OF BURIAL Dec. 28 1921

20. UNDERTAKER J. F. Sorensen — ADDRESS Twin Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CERTIFICATE OF DEATH is given below, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED
JAN 19 1922
BUREAU OF VITAL STATISTICS
STATE OF IDAHO

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36658

Registered No.

1. PLACE OF DEATH

County of Twin Falls

Registration District No. 37

Primary Registration District No. 1085

City of

(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Gwendolyn Hughes

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: fe

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Jan 17 (Month) (Day) 1915 (Year)

7. AGE: 5 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: T. S. Hughes

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Minnie Bates

13. BIRTHPLACE OF MOTHER (State or Country): Ind

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant): T H Hughes

(Address): 533 4th Ave E

15. Filed Dec 26 1921 John S. Empkins Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec 25 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 22 1921, to Dec. 25 1921, that I last saw h. alive on Dec. 24 1921, and that death occurred on the date stated above, at 12:10 A.M.

The CAUSE OF DEATH* was as follows:

Diphtheria

(Duration) Yrs. mos. 3 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) C. D. Weaver M. D.

19 (Address) Twin Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls

DATE OF BURIAL: Dec 26 1921

20. UNDERTAKER: Edwards

ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Jan Falls

City of .....

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 37

Primary Registration District No. 1085

(No. ....., ... St.)

File No. 36660

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Andrew Shore

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH: May 10 (Month) (Day) 1 (Year)

7. AGE: 66 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: farmer

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Canada

10. NAME OF FATHER: Edward Shore

11. BIRTHPLACE OF FATHER (State or Country): Canada

12. MAIDEN NAME OF MOTHER: Not known

13. BIRTHPLACE OF MOTHER (State or Country): .....

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Clara Jolley.

(Address) .....

15. Filed Dec. 28 1921

John T. Coughlan
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 24 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1 1921 to Dec 24 1921 that I last saw him alive on Dec 22 1921 and that death occurred on the date stated above, at 2 P M.

The CAUSE OF DEATH* was as follows:

(Hemorrhage Pleural

.....

.....

(Duration) ..... Yrs. Sudden mos. ..... ds.

Contributory (Secondary) Pneumonia Phthisis

(Duration) time unknown Yrs. ..... mos. ..... ds.

(Signed) C. H. Timmis M. D.

19..... (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Twin Falls Idaho	12-28 1921
20. UNDERTAKER: J. E. Reed	ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Jun Falls — Registration District No. 37

City of ( ) (Name of Hospital) St.) — Primary Registration District No. 2085

File No. 36662

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Raymond Johnson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

RECEIVED JAN 19 1922 BUREAU OF VITAL STATISTICS

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	white	Single

6. DATE OF BIRTH: July 25 1910 (Month) (Day) (Year)

7. AGE: 11 Yrs. 4 Mos. 25 ds. — IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: School Boy
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Geo H Johnson

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Martha Stevenson

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) L. H. Johnson
(Address) 136 Poplar Ave.

15. Filed Dec. 22. 1921 John T. Coughlin Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. 21 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 19 1921, to Dec 21 1921 that I last saw h.. alive on Dec 20 1921 and that death occurred on the date stated above, at 4 P.M.
The CAUSE OF DEATH* was as follows:

Diphtheria, Laryngeal,

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) L. M. Davis M. D.
12/22/1921 (Address) Kimberly, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Jun Falls	Dec 22 1921
20. UNDERTAKER	ADDRESS
J. C. Ward	Jun Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 —20M.1-16-12

JAN 10 1922

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36666

Registered No.

1. PLACE OF DEATH. Registration District No.

County of Washington Primary Registration District No.

City of Cambridge (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Jacob Mertz

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Dec (Month) 25 (Day) 1854 (Year)

7. AGE: 70 yrs. mos. 2 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Switzerland

10. NAME OF FATHER: Tony Mertz

11. BIRTHPLACE OF FATHER (State or Country): Switzerland

12. MAIDEN NAME OF MOTHER: Kummer

13. BIRTHPLACE OF MOTHER (State or Country): Switzerland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Albert Mertz

(Address) Cambridge Idaho

15. Filed 1/13/22 191 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec (Month) 27 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 15 1921, to Dec 27 1921, that I last saw him alive on Dec 23 1921, and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Prostatic Hypertrophy Causing retention of urin.

Heart Blood Pressure

(Duration) yrs. mos. ds.

Contributory (Secondary): Senility

(Duration) 2 yrs. mos. ds.

(Signed) Faschnacht M. D.

12-27 1921 (Address) Midvale Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs....mos....days. In the State....yrs....mos....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Cambridge Ida | DATE OF BURIAL: 12/29/22 191

20. UNDERTAKER: J. A. Hudelson | ADDRESS: Cambridge Ida.

SYMS - YORK CO., PTRS. & BDRS. 19760

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registered No. 36666

1 PLACE OF DEATH
County Washington State Idaho
Township ____ or Village ____ or
City Cambridge No. ____, ____ St., ____ Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Jacob Mosig

(a) Residence. No. ____ St., ____ Ward. ____
(Usual place of abode)
Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
M.	W.	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 25-1851

7 AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	70	0	2	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) ____
(State or country) Switzerland

PARENTS

10 NAME OF FATHER Jacob Mosig

11 BIRTHPLACE OF FATHER (city or town) ____
(State or country) Switzerland

12 MAIDEN NAME OF MOTHER Kummer

13 BIRTHPLACE OF MOTHER (city or town) ____
(State or country) Switzerland

14 Informant Albert Mosig
(Address) Cambridge, Ida.

15 Filed 1-13, 1922 R. C. Whitesman
REGISTRAR

11—3184

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 27 1921

17 I HEREBY CERTIFY, That I attended deceased from Dec. 15, 1921, to ____, 19____,
that I last saw h____ alive on ____, 19____,
and that death occurred, on the date stated above, at ____m.
The CAUSE OF DEATH* was as follows:

____ (duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (SECONDARY) ____
____ (duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death? ____

Did an operation precede death? ____ Date of ____

Was there an autopsy? ____

What test confirmed diagnosis? ____

(Signed) ____, M. D.
____, 19 (Address)

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL 19
20 UNDERTAKER	ADDRESS

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

8—269 d
V. S. No. 98

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

RECEIVED JAN 19 1922 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. _____

Primary Registration District No. _____

File No. 36667

Registered No. _____

1. PLACE OF DEATH.

County of Adams

City of Indian Valley (No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Louis Vern Thompson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Oct (Month) 27 (Day) 1907 (Year)

7. AGE: 14 yrs. 11 mos. 30 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Washington Co Ida

10. NAME OF FATHER: Louis Thompson

11. BIRTHPLACE OF FATHER (State or Country): Montana

12. MAIDEN NAME OF MOTHER: Maud Smith

13. BIRTHPLACE OF MOTHER (State or Country): Dalles Ore

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) L. A. Thompson
(Address) Indian Valley

15. Filed 1/13/22 191 R. F. Whiteman Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Oct (Month) 22 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 10-22-21 191, to 10-22-21 191, that I last saw h[illegible] alive on _____ 191, and that death occurred on the date stated above, at 3P M.

The CAUSE OF DEATH* was as follows:
Broken neck — caused by fall from horse.
instantly killed.
(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary) _____
(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) R. F. Whiteman M. D.
19 (Address) Cambridge Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Indian Valley Ida — DATE OF BURIAL: 10-24-21 191

20. UNDERTAKER: J. A. Hudson — ADDRESS: Cambridge Ida

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED
JAN 19 1922
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1

1. PLACE OF DEATH

Registration District No.....

Primary Registration District No.....

File No. 36668

County of Adams

City of Council, (No.....) .....St.)

Registered No.....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mark Andrew Winkler.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Male	White	Married (Write word.)

6. DATE OF BIRTH

November 18th. 1921
(Month) (Day) (Year)

7. AGE

63 Yrs. 1 Mos. 18 ds.

IF LESS than 1 day how many..... hrs. or.....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country) Crawford Co. Ark.

10. NAME OF FATHER George A.Winkler,

11. BIRTHPLACE OF FATHER

(State or Country) Baltimore, Maryland.

12. MAIDEN NAME OF MOTHER

Artimicia E. Sheppard.

13. BIRTHPLACE OF MOTHER

(State or Country) Jackson Co. West Virginia.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) M. A. Winkler

(Address) Council, Idaho.

15. Filed 1/3/22 19..... W. W. Peterson Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov. 15 19 21
(Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11-15-21 19..., to 11-15-21 19.....

that I last saw h.. alive on 11 15 21 19.....

and that death occurred on the date stated above, at 5:4 M.

The CAUSE OF DEATH* was as follows: Cerebral Hemorrhage

(Duration) 1 Yrs. mos. 3 ds.

Contributory (Secondary) Arteriosclerosis

(Duration) ? yrs. ? mos. ? ds.

(Signed) W. W. Peterson M. D.

19..... (Address) Cambridge Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Council Ida	1/20/22 19
20. UNDERTAKER	ADDRESS
E W Fraser	Council

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

36669 4
Registered No.

1 PLACE OF DEATH
County Nezperce State Idaho
Township ____ or Village ____ or
City Lewiston, Idaho No. ____ St., ____ Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Robert W. Harsche

(a) Residence. No. R.F.D. Pendleton, Oregon St., ____ Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Male	Indian	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 4, 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	1	3	18	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work ---
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Kamiah,
(State or country) Idaho

PARENTS
10 NAME OF FATHER Ned W. Harsche
11 BIRTHPLACE OF FATHER (city or town) Kamiah
(State or country) Idaho
12 MAIDEN NAME OF MOTHER Nancy Eneas
13 BIRTHPLACE OF MOTHER (city or town) Lapwai,
(State or country) Idaho

14 Informant Ned W Harsche, Father,
(Address) Pendleton, Oregon

15 Filed 11/30, 1921 Mary M. Brady
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 22, 1921

17 I HEREBY CERTIFY, That I attended deceased from Sept 20, 1921, to Sept 22, 1921, that I last saw h____ alive on Sept 22, 1921, and that death occurred, on the date stated above, at ____ m.

The CAUSE OF DEATH* was as follows:

Infantile Paralysis

2 days (duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (SECONDARY) ____ (duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death? ____

Did an operation precede death? No Date of X

Was there an autopsy? No

What test confirmed diagnosis? ____

(Signed) E. L. Broadaack, M. D.

Nov 23 1921 (Address) Lewiston Idaho

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Lewiston, Idaho	9-22-21
20 UNDERTAKER Lasser Undertaker	ADDRESS Lewiston, Idaho

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

8—209 d
V. S. No. 93

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36702
Registered No.

1. PLACE OF DEATH
County of Adams
City of Meadows
(No. ..... St.)
Registration District No. .....
Primary Registration District No. .....
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Domonick Francis Royer

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: November 13 (Month) (Day) 1847 (Year)

7. AGE: 73 Yrs. 7 Mos. 14 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer & Stockraiser
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Pittsburgh City Pennsylvania

10. NAME OF FATHER: —

11. BIRTHPLACE OF FATHER (State or Country): France (Lyons)

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): France (Toulouse)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Florence Royer
(Address) Weiser, Idaho

15. Filed Dec 21 1921 — J. M. Boorman, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 27 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 27 1921, to June 27 1921, that I last saw h.im alive on June 27 (7 A.M.) 1921, and that death occurred on the date stated above, at 7 A.M.

The CAUSE OF DEATH* was as follows:
Heart disease, (mitral stenosis), resulting from "uraemia" following a surgical operation at St. Alphonsus Hospital.
(Duration) One Yrs. 5 mos. — ds.
Contributory (Secondary) Surgical operation, from which he never rallied (Duration) — yrs. 7 mos. — ds.

(Signed) J. M. Schuyler M. D.
June 27, 1921 (Address) The Meadows, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? St. Alphonsus Hospital
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Weiser Ida — DATE OF BURIAL: June 29 1921

20. UNDERTAKER: Northam & McCann — ADDRESS: Weiser Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36703

Registered No. .....

1. PLACE OF DEATH.

County of Adams

City of Council

Registration District No. .....

Primary Registration District No. .....

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Alvina McCall

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH. May (Month) 26 (Day) 1854 (Year)

7. AGE: 67 Yrs. 4 Mos. 10 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Home keeping

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ore

10. NAME OF FATHER: Jesse Applegate

11. BIRTHPLACE OF FATHER (State or Country): Mo

12. MAIDEN NAME OF MOTHER: ~~Alvina Applegate~~

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) G. L. McCall

(Address) Council

15. Filed Dec 31 1924 W. M. Brown Local Registrar

SVMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 5 (Day) 1924 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to Dec 5 1924, that I last saw h.r alive on Dec 1924, and that death occured on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

Apoplexy

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Hard Breath

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) W. M. Brown M. D.

Dec 6 1924 (Address) Council

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: I.O.O.F.

DATE OF BURIAL: Dec 6 1924

20. UNDERTAKER: Young

ADDRESS: .....

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

M. 1-16-1

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36704
Registered No. .....

1. PLACE OF DEATH.
Registration District No. .....
County of Gilmore
Primary Registration District No. .....
City of Council (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Alletta Duncan

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH.
May (Month) 21 (Day) 1911 (Year)

7. AGE
10 Yrs. 2 Mos. 1 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE
(State or Country) Ill

10. NAME OF FATHER
Sigfred Duncan

11. BIRTHPLACE OF FATHER
(State or Country)

12. MAIDEN NAME OF MOTHER
Minnie Forbes

13. BIRTHPLACE OF MOTHER
(State or Country) Ill

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. Neva Bryant
(Address) Council Idaho

15.
Filed Dec 31 1921
W. M. Bracy
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Nov (Month) 1st (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 1 1921, to Nov 5 1921, that I last saw h.r alive on Nov 5 1921, and that death occured on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:
cardiac dilatation of the heart

.....(Duration) .....Yrs.....mos.....ds.

Contributory (Secondary) .....
.....(Duration .....yrs.....mos.....ds.

(Signed) E Vadney M. D.
19..... (Address) Council Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL I.O.O.F. | DATE OF BURIAL 191

20. UNDERTAKER E W Tasker | ADDRESS Council

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYNS - YORK CO., PTRS. & BOKS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36705

Registered No. .....

1. PLACE OF DEATH.

County of Adams

City of Council

(No. ....., ... St.)

Registration District No. .....

Primary Registration District No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME August C Hoffman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH. Aug (Month) 31 (Day) 1869 (Year)

7. AGE: 62 Yrs. ..... Mos. 4 ds. 4

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Farmer.

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Ohio

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Bert Hoffman

(Address) Council

15.

Filed Dec 31 1921

W. M. Brown
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 4 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1921, to Sept. 15 1921, that I last saw him alive on Sept 15 1921, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

General Debility

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Paralysis Agitans (General)

70 (Duration 10 yrs. ..... mos. ..... ds.

(Signed) W. M. Brown M. D.

Dec 31 1921 (Address) Council

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: I.O.O.F.

DATE OF BURIAL: Nov 6 1921

20. UNDERTAKER: Young

ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24653

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
FEB 8 - 1922
BUREAU OF VITAL STATISTICS
STATE OF IDAHO

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 28
Primary Registration District No. 2161
File No. 26707
Registered No. 3233

1. PLACE OF DEATH
County of Bannock
City of Pocatello (No. 234 S. Arthur St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James Allan Andrews

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Dec (Month) 18 (Day) 1921 (Year)

7. AGE: \ Yrs. \ Mos. 13 ds.
IF LESS than 1 day how many..... hrs. or.....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: (
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho,

10. NAME OF FATHER: J. C. Andrews

11. BIRTHPLACE OF FATHER (State or Country): Indiana

12. MAIDEN NAME OF MOTHER: Leona Moore

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) L. A. Moore
(Address) 234 S. Arthur

15. Filed 1/3 1922
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 31 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 18th 1921, to Dec 31 1921
that I last saw h[illegible] alive on Dec 31 1921,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Pneumonia
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) [signature] M. D.
Dec 3rd 1921 (Address) Pocatello Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain View — DATE OF BURIAL: Dec 1 1921

20. UNDERTAKER: [illegible] & Schumacher — ADDRESS: City

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 28

County of Bannock

Primary Registration District No. 216

File No. 47

City of Pocatello (No. June 1005 Hospital St.)

Registered No. 3747

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Julia Tucker

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word.): Married

6. DATE OF BIRTH: June 20 1856 (Month) (Day) (Year)

7. AGE: 65 Yrs. 6 Mos. 24 ds. IF LESS than 1 day how many..... hrs. or..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Vernon Co Wis

10. NAME OF FATHER: David Smith

11. BIRTHPLACE OF FATHER (State or Country): ✓

12. MAIDEN NAME OF MOTHER: Margaret Sult

13. BIRTHPLACE OF MOTHER (State or Country): Penn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A. N. Jennings
(Address) Colfax Wash.

15. Filed 1/18 1922 J. H. Evans Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: January 13th 1922 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 4th 1922 to Jan 13th 1922 that I last saw her alive on Jan 13th 1922 and that death occurred on the date stated above, at 11-9 A.M.

The CAUSE OF DEATH*, was as follows:

Cerebral Hemorrhage

2 mos.
(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Fracture of the hip

(Duration) ..... yrs. ..... mos. 31 ds.

(Signed) A. W. Lynn M. D.

Jan 13th 1922 (Address) Pocatello Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mt View | DATE OF BURIAL: 1/20 1922

20. UNDERTAKER: H. H. Tucker | ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 52
Primary Registration District No. 2136
File No. 36738
Registered No.

1. PLACE OF DEATH
County of Bear Lake
City of Montpelier
If death occurs away from usual residence, give facts called for under special information.
(No. , St.)
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Robinson Richards

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widower (Write the word.)

6. DATE OF BIRTH: Sept 4 (Month) (Day) 1860 (Year)

7. AGE: 61 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Salt Lake City

10. NAME OF FATHER: Samuel M. Richards

11. BIRTHPLACE OF FATHER (State or Country): Mass.

12. MAIDEN NAME OF MOTHER: Helena Robinson

13. BIRTHPLACE OF MOTHER (State or Country): Isle of Man

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Mrs O H Goo
(Address): Montpelier Idaho

15. Filed 1-1-1922 — O H Kemp, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec 20th (Month) (Day) 1922 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 19 16, to Dec 19 20
that I last saw h alive on 19
and that death occurred on the date stated above, at 9 37 P.M.
The CAUSE OF DEATH* was as follows:
Diabetes Mellitus
8
(Duration) Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) O H Kemp M. D.
1-1 1922 (Address) Montpelier Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rumney Mrs Idaho — DATE OF BURIAL: Dec 22 1922

20. UNDERTAKER: J M Collins — ADDRESS: Montpelier

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 2194
File No. 36751
Registered No. 173

1. PLACE OF DEATH
County of Bingham
City of Mc Donaldville (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

RECEIVED
BUREAU OF VITAL STATISTICS

2. FULL NAME Margaret Geraldine Hiatt
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: July (Month) 25 (Day) 1921 (Year)

7. AGE: ~~Yrs.~~ 3 Mos. 18 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Payson Utah

10. NAME OF FATHER: Don H Hiatt

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Margaret Smith

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Don H. Hiatt
(Address) Blackfoot # 2

15. Filed Nov 14 1922 Mrs Walter E. Patrick Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 13 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I ~~attended~~ investigated ~~deceased from~~
Nov 13 1921, to ..... 19.....
~~that I last saw h..... alive on~~ ..... 19.....
and that death occurred on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:
Broncho-pneumonia
(Duration) ..... Yrs. ..... mos. 2 ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E L Egli Coroner Bingham Co ~~M. D.~~
Nov 14 1921 (Address) Blackfoot Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Grove City Cemetery — DATE OF BURIAL: Nov 15 1921

20. UNDERTAKER: E L Egli — ADDRESS: Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36752

Registered No. 14

Registration District No. 21

Primary Registration District No. 1194

1. **PLACE OF DEATH**

County of Bingham

City of Blackfoot (No. ... Rangeley ... St.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED FEB 21 1922 BUREAU OF VITAL STATISTICS

2. **FULL NAME** Maud Andersen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. **SEX** Female

4. **COLOR OR RACE** White

5. **SINGLE, MARRIED, WIDOWED OR DIVORCED** (Write the word.) Single

6. **DATE OF BIRTH** Aug. (Month) 19 (Day) 1906 (Year)

7. **AGE** 15 Yrs. 2 Mos. 28 ds.

IF LESS than 1 day how many ... hrs. or ... min.?

8. **OCCUPATION**

(a) Trade, profession or particular kind of work: School Girl

(b) General nature of industry, business or establishment in which employed (or employer):

9. **BIRTHPLACE** (State or Country) Utah

10. **NAME OF FATHER** C C Andersen

11. **BIRTHPLACE OF FATHER** (State or Country) Denmark

12. **MAIDEN NAME OF MOTHER** Sarah E. Muchem

13. **BIRTHPLACE OF MOTHER** (State or Country) Utah

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**

(Informant) C C Andersen

(Address) Pingree Idaho

15. Filed Nov. 18 1921 Mrs Hallie E. Fabrick Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH** Nov (Month) 17 (Day) 1921 (Year)

17. **I HEREBY CERTIFY, That I attended deceased from** Nov 10 1921, to Nov 17 1921, that I last saw h.er alive on Nov 17 1921, and that death occurred on the date stated above, at 12:30 P.M.

The CAUSE OF DEATH* was as follows:

Chorea Insaniens

(Duration) ... Yrs. ... mos. 10 ds.

Contributory (Secondary) ...

(Duration) ... yrs. ... mos. ... ds.

(Signed) W W Beck M. D.

11/18 1921 (Address) Blackfoot, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. **LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)**

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. **PLACE OF BURIAL OR REMOVAL** Thomas Riverside — **DATE OF BURIAL** 11-19 1921

20. **UNDERTAKER** E J Funk — **ADDRESS** Blackfoot Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 2110
File No. 36799
Registered No. 3

1. PLACE OF DEATH
County of Bannock
City of Ida Falls
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Melford Hansen
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Infant

6. DATE OF BIRTH: May (Month) 28 (Day) 1921 (Year)

7. AGE: 0 Yrs. 7 Mos. 0 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: \
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Taylor, Ida

10. NAME OF FATHER: Sidney Hansen

11. BIRTHPLACE OF FATHER (State or Country): Ida

12. MAIDEN NAME OF MOTHER: Maude Miller

13. BIRTHPLACE OF MOTHER (State or Country): Idoho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. E. Dinwoodey Phone
(Address) Ida Falls

15. Filed 1/6 1922 W. Fenwick Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 28 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 19 1921, to Dec 28 1921, that I last saw h. alive on Dec 27 1921, and that death occurred on the date stated above, at 4 P.M.
The CAUSE OF DEATH* was as follows:

Streptococcus Sepsis
(Duration) ..... Yrs. ..... mos. 6 ds.
Contributory (Secondary) Scarlet Fever
(Duration) ..... yrs. ..... mos. 11 ds.

(Signed) Dr. Cline M. D.
Jan 4 1922 (Address) Idaho Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Taylor, Ida — DATE OF BURIAL: 1/2/1921

20. UNDERTAKER: C. E. Dinwoodey — ADDRESS: Ida Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

Dr Cline.

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

36799

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

8—209 d
V. S. No. 68

1 PLACE OF DEATH
County Bonneville State Idaho Registered No.
Township or Village or
City Ida. Falls No. , St., Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Walfore Hansen

(a) Residence. No. St., Ward.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
M.	W.	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 5-28-1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	0	7	0	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Idaho

PARENTS

10 NAME OF FATHER Sidney Hansen

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ida.

12 MAIDEN NAME OF MOTHER Maude Miller

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Idaho

14 Informant C. E. Kinnaird
(Address) Ida. Falls

15 Filed 1-6, 1922 W. Kinnard
REGISTRAR

11—3184

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 28- 1921

17 I HEREBY CERTIFY, That I attended deceased from
, 19, to , 19,
that I last saw h alive on , 19,
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:

(duration) yrs. mos. ds.

CONTRIBUTORY
(SECONDARY)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) , M. D.
, 19 (Address)

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL 19
20 UNDERTAKER	ADDRESS

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 23

Primary Registration District No. 21 V-0

File No. 36800

Registered No. 2

1. PLACE OF DEATH

County of Bonneville

City of ..... (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Stella Firth

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	

6. DATE OF BIRTH: Mar. (Month) 21 (Day) 1921 (Year)

7. AGE: Stella Firth Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Charles Samuel Brown

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Ida L. Fry

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C. S. Brown

(Address) Rigby Ida. R 4 B 1

15. Filed Mar 24 1921 W. J. Furniss Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar. (Month) 21 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....

that I last saw h..... alive on ..... 19.....,

and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Stillborn.

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A. M. Palmer M. D.

19..... (Address) Rigby Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Idaho Falls Ida.	Mar. 24 1921

20. UNDERTAKER	ADDRESS
Lone	—

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 2150
File No. 36801
Registered No.

1. PLACE OF DEATH
County of Bannock
City of Ida Falls
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Alice L. Fields, Thackston
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Widowed

6. DATE OF BIRTH
Aug (Month) 23 (Day) 1878 (Year)

7. AGE
93 Yrs. 0 Mos. 0 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work at Home
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) England

10. NAME OF FATHER Thos. Lavender

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER Charlotte Apthorpe

13. BIRTHPLACE OF MOTHER (State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C E Dunwoody (Mortician)
(Address) Idaho Falls Ida

15. Filed 8/4/ 1931 W Thomas Local Registrar
Dr Rogers

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Aug (Month) 23 (Day) 1931 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....19...., to ....19....,
that I last saw h..... alive on ....19....,
and that death occurred on the date stated above, at 11 P M.
The CAUSE OF DEATH* was as follows:

Unknown

.....(Duration) ....Yrs....mos....ds.
Contributory (Secondary)
.....(Duration) ....yrs....mos....ds.

(Signed) D E Rogers M. D.
19..... (Address) Idaho Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Annuan Ida	8/3/1931

20. UNDERTAKER	ADDRESS
C E Dunwoody	Ida Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36814
Registered No.

1. PLACE OF DEATH
County of Canyon
City of Nampa
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No. 1
(No. Mercy Hospital St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Charles F. Yeamon

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	white	Single

6. DATE OF BIRTH
..... 1
(Month) (Day) (Year)

7. AGE
18 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Clerk
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Idaho

10. NAME OF FATHER Richard Yeamon

11. BIRTHPLACE OF FATHER
(State or Country) L

12. MAIDEN NAME OF MOTHER Rebecca Pitman

13. BIRTHPLACE OF MOTHER
(State or Country) L.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jno. Goleeke
(Address) Nampa Ida

15.
Filed Nov. 30 1921 [illegible]
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Nov 28 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 24 1921, to Nov 28 1921
that I last saw him alive on Nov 28 1921
and that death occurred on the date stated above, at 11:30 M
The CAUSE OF DEATH* was as follows:
Fracture 6 cervical vertebra
Paralysis & coma follows.
(Duration) ✓ Yrs. ✓ mos. 4 ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Horace P Belknap M D.
Nov 30 1921 (Address) Nampa Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Nampa Idaho	12/2 1921
20. UNDERTAKER	ADDRESS
Fred R Robinson	Nampa Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

B

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

36814
Registered No.

1 PLACE OF DEATH
County Canyon State Idaho
Township ____ or Village ____ or
City Nampa No. Mercy Hosp. St., ____ Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME ____

(a) Residence. No. ____ St., ____ Ward. ____
(Usual place of abode)
Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
M	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) ____

7 AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	18			

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work ____
(b) General nature of industry, business, or establishment in which employed (or employer) Clerk
(c) Name of employer

9 BIRTHPLACE (city or town) ____
(State or country) Idaho

PARENTS

10 NAME OF FATHER Richard Yeomans

11 BIRTHPLACE OF FATHER (city or town) ____
(State or country) ____

12 MAIDEN NAME OF MOTHER Rebecca Pitmon

13 BIRTHPLACE OF MOTHER (city or town) ____
(State or country) ____

14 Informant J. W. Galbreath
(Address) Nampa, Ida.

15 Filed Dec 10, 1918 Lonie M. Allen
11—3184 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) / 19

17 I HEREBY CERTIFY, That I attended deceased from ____, 19____, to ____, 19____,
that I last saw h____ alive on ____, 19____,
and that death occurred, on the date stated above, at ____m.
The CAUSE OF DEATH* was as follows:

____
____
____
____ (duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (SECONDARY) ____
____ (duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death? ____
Did an operation precede death? ____ Date of ____
Was there an autopsy? ____
What test confirmed diagnosis? ____

(Signed) ____, M. D.
____, 19 (Address)

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL 19
20 UNDERTAKER	ADDRESS

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

6—203 d
V. S. No. 93

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36815
Registered No.

1. PLACE OF DEATH

County of Canyon

City of Nampa Idaho

(No. ..... St.)

Registration District No. .....

Primary Registration District No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Aaron Henry Roberts.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
male	white	married

6. DATE OF BIRTH: March 4th (Month) (Day) 1852 (Year)

7. AGE: 69 Yrs. 9 Mos. 17 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer & Contractor

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: Charles Roberts.

11. BIRTHPLACE OF FATHER (State or Country): Illinoe

12. MAIDEN NAME OF MOTHER: Eliza Ann Wilson

13. BIRTHPLACE OF MOTHER (State or Country): Illinoe.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Malinda D. Roberts

(Address) 301-16th Ave So. Nampa, Ida

15. Filed Dec. 16 1922 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 23 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 12 1921, to Dec 23 1921, that I last saw h.. alive on Dec 23 1921, and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

General Peritonitis

(Duration) ..... Yrs. ..... mos. 10 ds.

Contributory (Secondary): Ruptured gall bladder

(Duration) ..... yrs. ..... mos. 11 ds.

(Signed) J. H. Murray M. D.

12/24/1921 (Address) Nampa Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Spokane Wash	19.....
20. UNDERTAKER: Fred K Robinson	ADDRESS: Nampa Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

368715

1 PLACE OF DEATH
County Canyon State Idaho Registered No.
Township / or Village or
City Nampa No. St., Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Mason Henry Roberts

(a) Residence. No. St., Ward.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
M	W	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 3-4-1852

7 AGE	Years	Months	Days	If LESS than 1 day, ---- hrs. or ---- min.
	69	9	17	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) Contractor
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Mo.

PARENTS

10 NAME OF FATHER Chas. Roberts

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ill.

12 MAIDEN NAME OF MOTHER Elizabeth Mason

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ill.

14 Informant Malinda V. Roberts
(Address) Nampa, Ida

15 Filed 2-10, 19 22 Pearle Dodds
REGISTRAR

11—3184

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) DEC. 23- 1922

17 I HEREBY CERTIFY, That I attended deceased from
----------, 19----, to ----------, 19----,
that I last saw h---- alive on ----------, 19----,
and that death occurred, on the date stated above, at ----------m.
The CAUSE OF DEATH* was as follows:

---------- (duration) ---- yrs. ---- mos. ---- ds.

CONTRIBUTORY (SECONDARY) ----------
---------- (duration) ---- yrs. ---- mos. ---- ds.

18 Where was disease contracted if not at place of death? ----------

Did an operation precede death? ---------- Date of ----------

Was there an autopsy? ----------

What test confirmed diagnosis? ----------

(Signed) ----------, M. D.
, 19 (Address)

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL 19
20 UNDERTAKER	ADDRESS

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

8—209 d
V. S. No. 98

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No.....
Primary Registration District No.....
File No. 36817
Registered No.....

1. PLACE OF DEATH

County of Canyon
City of Nampa (No. Dewey Palace Hotel St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charles Albert Cawley

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH

Aug (Month) 30 (Day) 1884 (Year)

7. AGE

37 Yrs. 3 Mos. 18 ds.

IF LESS than 1 day how many..... hrs. or.....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Indiana

10. NAME OF FATHER John Cawley

11. BIRTHPLACE OF FATHER (State or Country) Ireland

12. MAIDEN NAME OF MOTHER Mary Pane

13. BIRTHPLACE OF MOTHER (State or Country) Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs C A Cawley
(Address) Nampa Idaho

15.

Filed Dec 21 1921

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec. (Month) 18 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 3rd 1921, to Dec 17th 1921 that I last saw him alive on Dec 17th 1921 and that death occurred on the date stated above, at 3a.M.

The CAUSE OF DEATH* was as follows:

Septicemia

.....(Duration) — Yrs. 3 mos. 14 ds.

Contributory (Secondary) Acute Retail chronic

.....(Duration) — yrs. 4 mos. — ds.

(Signed) Leo W. Chilton M. D.

.....19..... (Address).....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Nampa Idaho	12-20 1921
20. UNDERTAKER	**ADDRESS**
Fred K Robertson	Nampa Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36818
Registered No. 24 1

1. PLACE OF DEATH. Registration District No. 9
County of Clearwater Primary Registration District No. 2007
City of Notus Precinct (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Dooms

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
male	W	single

6. DATE OF BIRTH Dec. ~~X~~ 16 1921
(Month) (Day) (Year)

7. AGE ..... yrs. ..... mos. ..... ds. IF LESS than 1 day how many ..... hrs. or 15 min.?

8. OCCUPATION —
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Geo. A. Dooms

11. BIRTHPLACE OF FATHER (State or Country) Mo.

12. MAIDEN NAME OF MOTHER Ida. Smallwood

13. BIRTHPLACE OF MOTHER (State or Country) Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Geo. A. Dooms
(Address) Notus, Ida.

15.
Filed Jan 9 1922 Emily Waldo
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. 16 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 16 1921, to Dec 16 1921
that I last saw him alive on not at all 191...,
and that death occurred on the date stated above, at 7:15 P. M.

The CAUSE OF DEATH* was as follows:
Premature birth — 7½ mos.

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas. B. Allen M. D.
19... (Address) Parma, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Hyde Cem East of Notus	Dec 17 1921
20. UNDERTAKER	ADDRESS
none	-

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36838

Registered No. .....

1. PLACE OF DEATH.

Registration District No. .....

Primary Registration District No. .....

County of Cassia

City of Malta No. ....., St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Charles Scott Gamble

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH. Mar (Month) 7 (Day) 1846 (Year)

7. AGE: 75 Yrs. 8 Mos. 18 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Kent Co. Maryland

10. NAME OF FATHER: Robert Gamble

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Ann Caroline Miller

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Helena Horne

(Address) Malta Idaho

15. Filed Jan 1 1922 C. I. Salter Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 25 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 18 1921, to Dec 25 1921, that I last saw h.... alive on Dec 25 1921, and that death occured on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) — Yrs. — mos. 7 ds.

Contributory (Secondary) .....

(Duration — yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

19..... (Address) C. I. Salter

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. 5-2 yrs. ..... mos. ..... days. In the State 5-2 yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? at place of death

Former or usual residence Malta Idaho

19. PLACE OF BURIAL OR REMOVAL: Albion Idaho — DATE OF BURIAL: Dec 28 1921

20. UNDERTAKER: None — ADDRESS: —

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYNS - YORK CO., PTRS. & BOKS. 24658

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

36547

PLACE OF DEATH
County Clearwater State Idaho Registered No. 1
Township Grey Perce Reservation or Village or
City Orofino No. St., Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

RECEIVED MAR 6 1922 BUREAU OF STATISTICS

2 FULL NAME Daniels Reynolds

(a) Residence. No. St., Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word)
M.	Indian	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1901. April 15.

7 AGE	Years	Months	Days	If LESS than 1 day, ---- hrs. or ---- min.
19 —	19	10	8	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Grey Perce Reservation

PARENTS
10 NAME OF FATHER Mr. Reynolds
11 BIRTHPLACE OF FATHER (city or town)
(State or country) Grey Perce Reservation
12 MAIDEN NAME OF MOTHER —
13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Grey Perce Reservation

14 Informant J. J. Lawyer
(Address) Lapwai Idaho

15 Filed 3/10, 19 21 Corbett Lawyer REGISTRAR
Filed 3/22

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 12. 1921

17 I HEREBY CERTIFY, That I attended deceased from
, 19, to , 19,
that I last saw h alive on , 19,
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:

1
J. B.

(duration) yrs. mos. ds.
CONTRIBUTORY
(SECONDARY)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) Corbett Lawyer Clerk, M. D.
, 19 (Address) Lapwai Idaho

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Orofino —	Feb. 18 1921
20 UNDERTAKER	ADDRESS
C. F. Johnson.	Lenore Ida

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

8—209 d
V. S. No. 98

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

36847 Registered No.

1 PLACE OF DEATH
County Clearwater State Idaho
Township ____ or Village ____ or
City Orofino No. Nez Perce Reservation St., ____ Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Daniels Reynolds

(a) Residence. No. ____ St., ____ Ward. ____
(Usual place of abode)
Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.
(If nonresident give city or town and State)

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

8—209 d
V. S. No. 23

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
M	Indian	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	19	10	3	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Nez Perce Reservation

PARENTS

10 NAME OF FATHER Reynolds

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Nez Perce Reservation

12 MAIDEN NAME OF MOTHER — —

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) " " "

14 Informant J. J. Sawyer
(Address)

15 Filed 3/10, 1922 Corbett Sawyer
REGISTRAR

11—3184

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 12 - 1921

17 I HEREBY CERTIFY, That I attended deceased from
____, 19____, to ____, 19____,
that I last saw h____ alive on ____, 19____,
and that death occurred, on the date stated above, at ____m.
The CAUSE OF DEATH* was as follows:

____ (duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY
(SECONDARY) ____
____ (duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death? ____

Did an operation precede death? ____ Date of ____

Was there an autopsy? ____

What test confirmed diagnosis? ____

(Signed) ____, M. D.
____, 19 (Address)

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL 19
20 UNDERTAKER	ADDRESS

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 34
Primary Registration District No. 2021
File No. 36849
Registered No.

1. PLACE OF DEATH
County of Elmore
City of Mtn Home (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ella Esther Lahtinen
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: June (Month) 7 (Day) 1891 (Year)

7. AGE: 30 Yrs. 4 Mos. 18 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Nurse
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Finland

10. NAME OF FATHER: Adolph Lahtinen

11. BIRTHPLACE OF FATHER (State or Country): Finland

12. MAIDEN NAME OF MOTHER: Anna Nybantas

13. BIRTHPLACE OF MOTHER (State or Country): Finland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Adolph Lahtinen
(Address) Mtn. Home

15. Filed 12-2-1922 J E Evans Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. (Month) 24 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 10-20 1921, to 10-23 1921 that I last saw h.. alive on 10-23 1921 and that death occurred on the date stated above, at about 5:00 A. M.

The CAUSE OF DEATH* was as follows: Abscess Mastoid cells left side - Same broke into left Lateral sinus -

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Otitis Media suppurative chronic left

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) O B Hamilton M. D.

10-25 1921 (Address) Mt. Home Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mtn Home — DATE OF BURIAL: 10-25 1921

20. UNDERTAKER: A W Conover — ADDRESS: Mtn Home Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 99

County of Fremont

Primary Registration District No. 2177

File No. 36865

City of St Anthony (St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Venice Jackson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F	White	

6. DATE OF BIRTH: May (Month) 14 (Day) 1916 (Year)

7. AGE: 5 Yrs. 7 Mos. 11 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business or establishment in which employed (or employer) —

9. BIRTHPLACE (State or Country) Parker, Ida

10. NAME OF FATHER Henry S. Jackson

11. BIRTHPLACE OF FATHER (State or Country) Paradise, Utah

12. MAIDEN NAME OF MOTHER Mary F. Flint

13. BIRTHPLACE OF MOTHER (State or Country) Morgan Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H. S. Jackson
(Address) St Anthony - Ida

15. Filed Jan 10 1922 W B Wrst
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 25 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 22 1921, to Dec. 25 1921, that I last saw her alive on Dec. 25 1921 and that death occurred on the date stated above, at 11 P M.
The CAUSE OF DEATH* was as follows:
Entero-Colitis
(Duration) ..... Yrs. ..... mos. 10 ds.
Contributory (Secondary) Acidosis
(Duration) ..... yrs. ..... mos. 4 ds.
(Signed) J. C. Metton M. D.
12-26 1921 (Address) St Anthony - Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Parker, Ida	Dec. 27 1921

20. UNDERTAKER Wm Hansen ADDRESS St Anthony Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruct

CAUSE OF DEATH back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

36865
Registered No.

1 PLACE OF DEATH
County Fremont State Idaho
Township ____ or Village ____ or
City St. Anthony No. ____ St., ____ Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Venice Jackson

(a) Residence. No. ____ St., ____ Ward. ____
(Usual place of abode)
Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
F	W.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 11-14-1916

7 AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	5	1	11	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Parker
(State or country) Ida.

PARENTS

10 NAME OF FATHER Henry S. Jackson
11 BIRTHPLACE OF FATHER (city or town) Paradise
(State or country) Utah
12 MAIDEN NAME OF MOTHER Mary J. Hunt
13 BIRTHPLACE OF MOTHER (city or town) Morgan
(State or country) Utah

14 Informant H. S. Jackson
(Address) St. Anthony, Ida.

15 Filed 1-10-, 19 22 W. B. West
REGISTRAR

11—3184

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 25- 19 21

17 I HEREBY CERTIFY, That I attended deceased from
____, 19____, to ____, 19____,
that I last saw h____ alive on ____, 19____,
and that death occurred, on the date stated above, at ____m.
The CAUSE OF DEATH* was as follows:

*
____ (duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY
(SECONDARY)
____ (duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? ____ Date of ____
Was there an autopsy? ____
What test confirmed diagnosis? ____

(Signed) ____, M. D.
____, 19 (Address)

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL 19
20 UNDERTAKER	ADDRESS

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

8—209 d
V. S. No. 98

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 24

Primary Registration District No.

File No. 36878

County of Gooding

City of Gooding (No. 922 St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ervin Quinten Thompson.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	white	single

6. DATE OF BIRTH.

Feb. (Month) 14 (Day) 1919 (Year)

7. AGE

2 Yrs. 7 Mos. 29 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION

(a) Trade, profession or particular kind of work... baby

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Gooding, Idaho

10. NAME OF FATHER Joseph Thompson

11. BIRTHPLACE OF FATHER (State or Country) South Dakota

12. MAIDEN NAME OF MOTHER Sigrid Olson

13. BIRTHPLACE OF MOTHER (State or Country) Colorado

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph Thompson

(Address) Gooding, Idaho.

15. Filed 1-16- 191 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct (Month) 3 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 2 1921, to Oct 3 1921, that I last saw him alive on Oct 3 1921, and that death occured on the date stated above, at 11- M.

The CAUSE OF DEATH* was as follows:

Gangrenous Appendicitis.

General Peritonitis

Intusseption.

(Duration) Yrs. mos. 3 1/2 ds.

Contributory (Secondary)

(Duration Yrs. mos. ds.

(Signed) H. E. Lewis M. D.

10/5 1921 (Address) Gooding Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL 191

20. UNDERTAKER | ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36879

Registered No. .....

1. PLACE OF DEATH.

County of Gooding

City of Gooding

Registration District No. 24

Primary Registration District No. .....

(No. .... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George Durwood Bonney

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Oct. (Month) 3 (Day) 1861 (Year)

7. AGE: 60 Yrs. 2 Mos. 2 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Maine

10. NAME OF FATHER: George Bonny

11. BIRTHPLACE OF FATHER (State or Country): Rhode Island

12. MAIDEN NAME OF MOTHER: - Carlos -

13. BIRTHPLACE OF MOTHER (State or Country): Maine -

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. G. D. Bonney

(Address) Gooding, Idaho -

15. Filed 1-16-1911 F. E. Caywood Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: December (Month) 5 (Day) 1911 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,

that I last saw h... alive on ..... 191...,

and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Fractured Neck and died instantly

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) F. E. Caywood M. D.

1911 (Address) Gooding Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL ..... 191...

20. UNDERTAKER | ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

8Y108 - YORK CO., PTRS. & BOKS. 24653

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

36879

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Gooding State Idaho Registered No.
Township ____ or Village ____ or
City Gooding No. ____ St., ____ Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME George Durwood Bonney

(a) Residence. No. ____ St., ____ Ward. ____
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
M	W.	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 10-3-1861

7 AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	60	2	2	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) ____
(State or country) Maine

PARENTS

10 NAME OF FATHER Geo. Bonney
11 BIRTHPLACE OF FATHER (city or town) ____
(State or country) Rhode Island
12 MAIDEN NAME OF MOTHER Cosloo
13 BIRTHPLACE OF MOTHER (city or town) ____
(State or country) Maine

14 Informant Mrs. G. D. Bonney
(Address) Gooding, Ida.

15 Filed 1-11-, 1922 F. T. Cox
REGISTRAR

11—3184

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 5 - 1921

17 I HEREBY CERTIFY, That I attended deceased from
____, 19____, to ____, 19____,
that I last saw h____ alive on ____, 19____,
and that death occurred, on the date stated above, at ____m.
The CAUSE OF DEATH* was as follows:

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (SECONDARY)
(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? ____ Date of ____
Was there an autopsy? ____
What test confirmed diagnosis? ____

(Signed) ____, M. D.
____, 19 (Address)

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL 19
20 UNDERTAKER	ADDRESS

$\frac{\text{M—200 d}}{\text{V. S. No. 98}}$

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

Registration District No. 24

Primary Registration District No.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36880

Registered No.

1. PLACE OF DEATH

County of Gooding

City of Gooding

(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jennie Mead Bryant

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Female	white	Married

6. DATE OF BIRTH: August 2nd 1871 (Month) (Day) (Year)

7. AGE: 50 Yrs. 4 Mos. 14 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER: E. R. Mead

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Dora Ruso

13. BIRTHPLACE OF MOTHER (State or Country): New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Henry J. Bryant
(Address): Gooding Ida

15. Filed 1-16- 19 22 F. J. Claymore Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 16 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 8th 1921, to Dec 16 1921, that I last saw her alive on Dec 8 1921, and that death occurred on the date stated above, at 3:45 A.M.

The CAUSE OF DEATH* was as follows:

Stomach Cyst

(Duration) 6 Yrs. mos. ds.

Contributory (Secondary) Cancerous degeneration of Cyst (Duration) yrs. 2 mos. ds.

(Signed) J. H. Cromwell M. D.

12/16 1921 (Address) Gooding Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Gooding Cemetery	12/17 1921
20. UNDERTAKER	ADDRESS
A E Thompson	Gooding

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36881
Registered No.

1. PLACE OF DEATH
County of Gooding
City of Wendell
(No. St.)
Registration District No.
Primary Registration District No.
If death occurs away from usual residence, give facts called for under special information.

RECEIVED MAR 6 1922 BUREAU OF VITAL STATISTICS

2. FULL NAME Cornelius Patterson
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH October 14 1866
(Month) (Day) (Year)

7. AGE 55 Yrs. 2 Mos. 11 ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Utah

10. NAME OF FATHER Oscar Patterson

11. BIRTHPLACE OF FATHER (State or Country) Sweden

12. MAIDEN NAME OF MOTHER Sophia Sunburg

13. BIRTHPLACE OF MOTHER (State or Country) Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant)
(Address) Mrs Evelyn Patterson

15. Filed Dec 27 1921 E C Simonton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec 25 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1 1919 to after death 19...
that I last saw h... alive on ... 19...,
and that death occurred on the date stated above, at 1:30 A.M.
The CAUSE OF DEATH* was as follows:
Angina Pectoris
Duration 12 hours
(Duration) ... Yrs. ... mos. ... ds.
Contributory (Secondary) ...
(Duration) ... yrs. ... mos. ... ds.
(Signed) E. C. Simonton M. D.
12-27 1921 (Address) Wendell Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Buhl	Dec 30 1921

20. UNDERTAKER	ADDRESS
Johnson	Buhl Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36882

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

RECEIVED MAR 6 192[illegible] BUREAU OF VITAL STATISTICS

Registration District No. 22

Primary Registration District No. 2018

1. PLACE OF DEATH.

County of Gooding

City of Wendell (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Rowland De Graw.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Oct (Month) 9 (Day) 1[illegible] (Year)

7. AGE: 23 Yrs. 6 Mos. 20 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Farming
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Utah

10. NAME OF FATHER Jacob De Graw

11. BIRTHPLACE OF FATHER (State or Country) Iowa

12. MAIDEN NAME OF MOTHER Arillia Brimhall

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Arilla B. De Graw
(Address) Wendell Ida

15. Filed May 9 1921 E L Simonton Local Registrar

SYMS - YORK CO., PTRS. & STRS. 24854

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr (Month) 29 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 1, 1921, to Apr 29 1921, that I last saw h[illegible] alive on Apr 29 1921, and that death occured on the date stated above, at 4 P M.

The CAUSE OF DEATH was as follows*: Chronic Nephritis

(Duration) 2 Yrs. 6 mos. — ds.

Contributory (Secondary) Meningitis

(Duration) 7 yrs. mos. 12 ds.

(Signed) E L Simonton M. D.

19..... (Address) Wendell Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Wendell Ida — DATE OF BURIAL: May 1 1921

20. UNDERTAKER: Thompson — ADDRESS: Gooding Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36894

Registered No.

Registration District No. 98

Primary Registration District No. 2176

1. PLACE OF DEATH

County of Jefferson

City of Rigby (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Earl Lyon

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: May 3 1906 (Month) (Day) (Year)

7. AGE: 15 Yrs. 5 Mos. 23 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Clerk in
(b) General nature of industry, business or establishment in which employed (or employer): Drug Store

9. BIRTHPLACE (State or Country): Oklahoma

10. NAME OF FATHER: R. E. Lyon

11. BIRTHPLACE OF FATHER (State or Country): Tenn.

12. MAIDEN NAME OF MOTHER: Minnie V. Marton

13. BIRTHPLACE OF MOTHER (State or Country): Ky.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Aubrey Lyon
(Address) Rigby

15. Filed 12/10 1921 Ray H. Fisher Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct 27 21 (Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 27 19 21 to Oct 27 19 21 that I last saw h. alive on Oct 27 19 21 and that death occurred on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Diphtheria

(Duration) Yrs. mos. 5 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) O. T. Call M. D.

10/28 1921 (Address) Rigby

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rigby — DATE OF BURIAL: 10/29 21

20. UNDERTAKER: D. A. Harris — ADDRESS: Rigby

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36895
Registered No.

1. PLACE OF DEATH
County of Jefferson
City of Ruby (No. St.)
Registration District No. 98
Primary Registration District No. 2176
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Benjamen Franklin Hall
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): widowed

6. DATE OF BIRTH: Apr 15 1846 (Month) (Day) (Year)

7. AGE: 75 Yrs. 5 Mos. 21 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Maine

10. NAME OF FATHER: Wm Henry Hall

11. BIRTHPLACE OF FATHER (State or Country): Maine

12. MAIDEN NAME OF MOTHER: Mehitable Sawyer

13. BIRTHPLACE OF MOTHER (State or Country): Maine

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ina A Hall
(Address) Lorenzo #1 Ida

15. Filed 12/10/1921 Ray H Fisher Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct 6 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 14 1921 to Oct 6 1921
that I last saw h~~im~~ alive on Oct 5 1921
and that death occurred on the date stated above, at 4 a M.
The CAUSE OF DEATH* was as follows:
Heart Failure following 10 day previous prostatectomy
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) H. D. Spencer M. D.
10/8 1921 (Address) Ida Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Annis — DATE OF BURIAL: 10/8 1921

20. UNDERTAKER: D. A. Harris — ADDRESS: Rigby

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36896
Registered No.

1. PLACE OF DEATH
County of Jefferson
City of Rigby (No. , St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 98
Primary Registration District No. 2176

2. FULL NAME Antonio Silvo

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: Mexican
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: married (Write the word.)

6. DATE OF BIRTH: unknown 1899 (Month) (Day) (Year)

7. AGE: 22 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mexico

10. NAME OF FATHER: Leandro Silvo

11. BIRTHPLACE OF FATHER (State or Country): Mexico

12. MAIDEN NAME OF MOTHER: Carmen Martina

13. BIRTHPLACE OF MOTHER (State or Country): Mexico

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Luis Silvo
(Address) Rigby

15. Filed Nov 10 1921 Ray H Fisher Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov 4 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Shot & instantly killed by another mexican

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Ray H Fisher M. D.
11/5 1921 (Address) Rigby

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rigby — DATE OF BURIAL: 11-6 1921

20. UNDERTAKER: D. A. Harris — ADDRESS: Rigby

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 98
Primary Registration District No. 2176
File No. 36897
Registered No.

1. PLACE OF DEATH
County of Jefferson
City of Ryby (No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Edna Eliza Munson
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Nov 4 1910 (Month) (Day) (Year)

7. AGE: 11 Yrs. Mos. 23 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At school
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Nels Munson

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Wealthy Hayes

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Nels Munson
(Address) Ryby Idaho

15. Filed 12/10 1921 Ray H Fisher Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov 27 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 26 1921 to Nov 27 1921 that I last saw h. alive on Nov 27 1921 and that death occurred on the date stated above, at 4 P. M.
The CAUSE OF DEATH* was as follows:
Diphtheria
(Duration) Yrs. mos. 7 ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) O. J. Call M. D.
11/28 1921 (Address) Ryby

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Ryby — DATE OF BURIAL: 11-28 1921

20. UNDERTAKER: D A Harris — ADDRESS: Ryby

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 98
Primary Registration District No. 2176
File No. 36898
Registered No.

1. PLACE OF DEATH

County of Jefferson
City of Rigby (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Valentine Percival Hanson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	White	married

6. DATE OF BIRTH Nov (Month) 5 (Day) 1881 (Year)

7. AGE 40 Yrs. ..... Mos. 18 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Utah

10. NAME OF FATHER Frank B. Hanson

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER Annie E. Simpson

13. BIRTHPLACE OF MOTHER (State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. V. Hansen
(Address) Rigby

15. Filed 12/10 1921 Ray Fisher Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 23 (Day) 19 21 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 22 19 21 to Nov 23 19 21 that I last saw h[illegible] alive on Nov 23 19 21 and that death occurred on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) O. F. Gail M. D.

19..... (Address) Rigby

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Salt Lake City, Ut. | **DATE OF BURIAL** 19.....

20. UNDERTAKER | **ADDRESS**

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 48
Primary Registration District No. 2176
File No.
Registered No. 36899

1. PLACE OF DEATH
County of Jefferson
City of Rigby (No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Howard Wayne Hanson
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	White	Single

6. DATE OF BIRTH: May (Month) 5 (Day) 1918 (Year)

7. AGE: 3 Yrs. 6 Mos. 21 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: School Boy
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Oscar J Hanson

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: Anna A Balka

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Oscar Hanson
(Address) Rigby Ida

15. Filed 12/10 1921 Ray H Fisher Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 26 (Day) 21 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 24 1921 to Nov 26 1921
that I last saw h. alive on Nov 25 1921
and that death occurred on the date stated above, at 10 P. M.
The CAUSE OF DEATH* was as follows:

Diphtheria

(Duration) Yrs. mos. 10 ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) A. F. Call M. D.
12/7 1921 (Address) Rigby

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rigby
DATE OF BURIAL: 12/7 1921

20. UNDERTAKER: D. A. Hatrick
ADDRESS: Rigby

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 98
Primary Registration District No. 2176
File No. 36900
Registered No.

1. PLACE OF DEATH
County of Jefferson
City of Roberts
(No. ....., St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lucenia D. Stephenson
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widowed

6. DATE OF BIRTH: Sept 7 (Month) (Day) 1921 (Year)

7. AGE: 77 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Jim Pollock

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Don't know

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) T. L. Healy
(Address) Roberts Ida

15. Filed 12-10 1921
Ray H. Fisher
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept 7 (Month) (Day) 21 (Year) 1921

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Old age

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Jno. Balmer coroner M. D.
19..... (Address) Roberts

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Roberts
DATE OF BURIAL: Sept 8 19 21

20. UNDERTAKER: Cliff Hayes
ADDRESS: Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF [redacted]ATH

[redacted] of Ida[redacted]
[redacted]F HEALTH
Vital Statistics

1. PLACE OF DEATH

Registration District No. 98

County of Jefferson Primary Registration District No. 216 File No. 36901

City of Rigby (No. ..... St.) Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lucinda Emma Kingy Kinge

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F	White	married

6. DATE OF BIRTH Aug 9 1897 (Month) (Day) (Year)

7. AGE 24 Yrs. 3 Mos. 20 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Wyoming

10. NAME OF FATHER Joseph Crow

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Sara Welchman

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Joseph Crow
(Address) Donna Ida

15. Filed 12/10 1921 Ray L. Fisher Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov 29 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 19 1921 to Nov 29 1921 that I last saw h[illegible] alive on Nov 29 1921 and that death occurred on the date stated above, at 2 9 M.

The CAUSE OF DEATH* was as follows:

Puerpal Septic Infection

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Septic Pneumonia

(Duration) ..... yrs. ..... mos. 6 ds.

(Signed) C. F. Call M. D.

11/30 1921 (Address) Rigby

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL 12-1-1921

20. UNDERTAKER W. L. Young | ADDRESS Rigby

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 48
Primary Registration District No. 2176
File No. 36902
Registered No.

1. PLACE OF DEATH
County of Jefferson
City of Rigby (No. St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Le Roy Hardcastle
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Oct 22 1899 (Month) (Day) (Year)

7. AGE: 21 Yrs. 11 Mos. 21 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Jno W. Hardcastle

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Lucy Boulter

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jno W. Hardcastle
(Address) Labelle Ida

15. Filed 12/10 1921 Ray Fisher Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct 13 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 7 1921 to Oct 13 1921
that I last saw h. alive on Oct 13 1921
and that death occurred on the date stated above, at 3 A.M.
The CAUSE OF DEATH* was as follows:

Appendicitis

(Duration) Yrs. mos. ds.
Contributory (Secondary) Post operative hemorrhage
(Duration) yrs. mos. 3 ds.

(Signed) O. P. Call M. D.
10/14 1921 (Address) Rigby

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Labelle — DATE OF BURIAL: 10/15 1921

20. UNDERTAKER — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 98
Primary Registration District No. 2176
File No. 36903
Registered No.

1. PLACE OF DEATH
County of Jefferson
City of Rigby
(No. St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Heaber Hill
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: (Month) 1 (Day) 876 (Year)

7. AGE: 45 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer on
(b) General nature of industry, business or establishment in which employed (or employer): State Highway

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Franklin Hill

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Sarah Edwards

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ben Hill
(Address) Pocatello Ida

15. Filed Dec 10 1921
Ray H Fisher
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 21 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 15 1921, to Nov 21 1921
that I last saw h~~im~~ alive on Nov 20 1921
and that death occurred on the date stated above, at 1 P.M.
The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. 6 ds.

(Signed) Dr. F. Call M. D.
11-22-1921 (Address) Rigby

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Albion Ida — DATE OF BURIAL: 11-23-1921

20. UNDERTAKER: D A Harris — ADDRESS: Rigby

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 97
Primary Registration District No. 2176
File No. 36904
Registered No.

1. PLACE OF DEATH
County of Jefferson
City of Menan
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Carissa Howells
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widow

6. DATE OF BIRTH: Dec (Month) 13 (Day) 1836 (Year)

7. AGE: 85 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: James James

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Don't Know

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wm Howells
(Address) Menan

15. Filed 12/12 1921 Ray H Fisher Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 12 (Month) - 12 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 11 1921 to Dec 11 1921 that I last saw h[er] alive on Dec 11 1921 and that death occurred on the date stated above, at 8 A M.

The CAUSE OF DEATH* was as follows:

Senile Decay

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Chas. D. Moody M. D.

12/12 1921 (Address) Menan

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Keokuk Iowa
DATE OF BURIAL 19

20. UNDERTAKER: Cliff C. Hayes
ADDRESS Ida Falls

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 98
Primary Registration District No. 2176
File No. 36906
Registered No.

1. PLACE OF DEATH
County of Jefferson
City of Rigby
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George Lamont Hanson
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	White	Single

6. DATE OF BIRTH: Oct 14 1913 (Month) (Day) (Year)

7. AGE: 8 Yrs. 2 Mos. 2 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: at school
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: Oscar G. Hanson

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: Anna A. Balka

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Geo. L. Hansen
(Address) Rigby, Ida

15. Filed 12/16 1921 Ray H. Fisher Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec 16 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 10 1921 to Dec 16 1921
that I last saw him alive on Dec 16 1921
and that death occurred on the date stated above, at 4 P. M.
The CAUSE OF DEATH* was as follows:
Mitral insufficiency.
Myocarditis.
(Duration) 3 Yrs. mos. ds.
Contributory (Secondary) Diphtheria. Few.
(Duration) yrs. mos. ds.
(Signed) Ray H. Fisher M. D.
Dec 17 1921 (Address) Rigby, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rigby — DATE OF BURIAL: 12/18/1921

20. UNDERTAKER: Das Harris — ADDRESS: Rigby

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36911
Registered No. 89

1. PLACE OF DEATH.
County of Kootenai
City of Harrison
(No. ..... St.)
Registration District No. 124
Primary Registration District No. 2204
If death occurs away from usual residence, give facts called for under special information.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME W Harvy Yager

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH. (Month) Mar (Day) 26 (Year) 1875

7. AGE: 46 Yrs. 8 Mos. 14 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Minister
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mo.

10. NAME OF FATHER: A W. Yager

11. BIRTHPLACE OF FATHER (State or Country): Va.

12. MAIDEN NAME OF MOTHER: Cornelia Calaway

13. BIRTHPLACE OF MOTHER (State or Country): Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs W H Yager
(Address) Harrison Ida

15. Filed 12-1 1922 J M Tenney Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (Month) Dec (Day) 10 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 8 1921, to Dec 10 1921, that I last saw b... alive on Dec 10 1921, and that death occured on the date stated above, at 8:30 A.M.

The CAUSE OF DEATH* was as follows:
Apoplexy
(Duration) Yrs. 5 mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) J M Tenney M. D.
12-10 1921 (Address) Harrison Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Ellensburg. DATE OF BURIAL ..... 191...

20. UNDERTAKER: H E Hunt ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SORS. 24653

36944

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

1 PLACE OF DEATH
County Lewis State Idaho Registered No. 2
Township Nez Perce Reservation or Village or
City No. St., Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Rebecca Moody

(a) Residence. No. St., Ward.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word)
Female	Indian	Single

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of widowed

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	--	--	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Invalid
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Indian Res
(State or country) Idaho

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) Idaho
(State or country)

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Idaho

14 Informant David McFarland
(Address) Lapwai, Idaho.

15 Filed 6/13/21, 19 Corbett Sawyer REGISTRAR
Filed 3/6/22. O.W. Almond Asst.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-12-21 19

17 I HEREBY CERTIFY, That I attended deceased from
, 19, to , 19,
that I last saw h alive on , 19,
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:

Pneumonia and old age

(No regular physician)

(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Corbett Sawyer Clerk, M. D.
, 19 (Address) Lapwai, Idaho.

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Indian cemetary	6/13/21 19
20 UNDERTAKER J.N. Wann Lapwai, Idaho.	ADDRESS

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

8—209 d
V. S. No. 98

36945

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

RECEIVED MAR 1 1922 STATE BUREAU OF VITAL STATISTICS

1 PLACE OF DEATH
County Idaho. State Idaho Registered No. 5
Township Nez Perce Reservation. or Village ____ or
City Kamiah No. ____, ____ St., ____ Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Moo Too

(a) Residence. No. ____ St., ____ Ward. ____
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word)
F	Indian	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	85			

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Invalid
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) ____
(State or country)

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) ____
(State or country)

12 MAIDEN NAME OF MOTHER unknown.

13 BIRTHPLACE OF MOTHER (city or town) ____
(State or country)

14 Informant James Stuart
(Address) Kooskia, Idaho

15 Filed 3/21, 1922 Corbett Lawyer REGISTRAR
Filed 3/6/22 H.C. Almond State

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 21 1922

17 I HEREBY CERTIFY, That I attended deceased from ____, 19____, to ____, 19____,
that I last saw h____ alive on ____, 19____,
and that death occurred, on the date stated above, at ____m.
The CAUSE OF DEATH* was as follows:

Old age.

____ (duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (SECONDARY) ____
(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death? ____
Did an operation precede death? ____ Date of ____
Was there an autopsy? ____
What test confirmed diagnosis? ____

(Signed) Corbett Lawyer Clerk, M. D.
, 19 (Address) Lapwai, Idaho.

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Indian Cemetary	3/22 1921
20 UNDERTAKER	ADDRESS
Kooskia Furniture & Co	Kooskia Idaho

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

8—209 d
V. S. No. 98

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
36945
Registered No.

1 PLACE OF DEATH
County Idaho State Idaho
Township ____ or Village ____ or
City Nez Perce Reservation No. ____ St., ____ Ward
Kamiah
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Moo Foo

(a) Residence. No. ____ St., ____ Ward. ____
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
M	Indian	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	75			

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Invalid
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) ____
(State or country) — —

PARENTS

10 NAME OF FATHER — —

11 BIRTHPLACE OF FATHER (city or town) ____
(State or country) — —

12 MAIDEN NAME OF MOTHER — —

13 BIRTHPLACE OF MOTHER (city or town) ____
(State or country) — —

14 Informant James Stuart
(Address) Kooskia, Idaho

15 Filed 3-26, 1928 Corbett Lawyer
REGISTRAR

11—3184

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

17 I HEREBY CERTIFY, That I attended deceased from ____, 19____, to ____, 19____, that I last saw h____ alive on ____, 19____, and that death occurred, on the date stated above, at ____m.

The CAUSE OF DEATH* was as follows:

____ (duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY ____
(SECONDARY)
____ (duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death? ____

Did an operation precede death? ____ Date of ____

Was there an autopsy? ____

What test confirmed diagnosis? ____

(Signed) ____, M. D.
, 19 (Address)

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL 19
20 UNDERTAKER	ADDRESS

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

8—209 d
V. S. No. 98

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36952

Registered No.

1. PLACE OF DEATH

County of Lewis

City of Winchester (No. ..... St.)

Registration District No. 78

Primary Registration District No. 7177

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Georgina Alice Hosley

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: February 22 (Month) (Day) 1900 (Year)

7. AGE: 21 Yrs. 1 Mos. 18 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Thomas Stevens

11. BIRTHPLACE OF FATHER (State or Country): California

12. MAIDEN NAME OF MOTHER: Helen Mary Vallem

13. BIRTHPLACE OF MOTHER (State or Country): Nevada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Thomas Stevens

(Address) Winchester Ida

15. Filed April 11 19 21 H. H. Naughlin Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr (Month) 1 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 1 1921, to April 1 1921, that I last saw h..... alive on ..... 19....., and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows: Suicide, Strychnine

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John T. Gest M. D.

19..... (Address) Culdesac Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston Ida — DATE OF BURIAL ..... 19.....

20. UNDERTAKER: C. E. Clovis — ADDRESS Craigmont Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 48
Primary Registration District No. 2127
File No. 36953
Registered No.

1. PLACE OF DEATH
County of Lewis
City of Winchester
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Helen Mary Stevens

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: March (Month) 14 (Day) 1865 (Year)

7. AGE: 56 Yrs. — Mos. 26 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Nevada

10. NAME OF FATHER: Peter Vallem

11. BIRTHPLACE OF FATHER (State or Country): Norway

12. MAIDEN NAME OF MOTHER: Harriet Skinner

13. BIRTHPLACE OF MOTHER (State or Country): Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Thomas Stevens
(Address) Winchester Ida

15. Filed April 11th 19 21 H. E. Naughlin Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 9 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 4 1921, to April 9 1921
that I last saw h... alive on ... 19...
and that death occurred on the date stated above, at 2 36 M.
The CAUSE OF DEATH* was as follows:
Suicide — Strychnine
(Duration) ... Yrs. ... mos. ... ds.
Contributory (Secondary)
(Duration) ... yrs. ... mos. ... ds.
(Signed) Wm. F. Gist M. D.
19... (Address) Nezperce Ida

*State the Disease Causing Death; or, if deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston Ida — DATE OF BURIAL 19...

20. UNDERTAKER: C. E. Clover — ADDRESS Craigmont Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36954
Registered No.

1. PLACE OF DEATH. Registration District No. 7
County of Lewis Primary Registration District No. 2127
City of Winchester (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Perry John Hoffman
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: April (Month) 18 (Day) 1895 (Year)

7. AGE: 6 yrs. 4 mos. 13 ds. IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Clerk
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Lewis Co.

10. NAME OF FATHER: John Hoffman

11. BIRTHPLACE OF FATHER (State or Country): Wisconsin

12. MAIDEN NAME OF MOTHER: Mumford Watts

13. BIRTHPLACE OF MOTHER (State or Country): Wisconsin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John P. Hoffman
(Address) Winchester Idaho

15. Filed Aug 30 1911 Jell Laughlin Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 30 (Day) 1911 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 26 1911, to Aug 30 1911, that I last saw h in alive on Aug 30 1911, and that death occurred on the date stated above, at 1 PM.

The CAUSE OF DEATH* was as follows:
Septic meningitis

(Duration) ..... yrs. ..... mos. 5 ds.
Contributory (Secondary) Pleurisy general abscess not determined
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John L. Kelly M. D.
Aug 30 1911 (Address) Winchester Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and 2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL 191

20. UNDERTAKER | ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & RINDERS, BOISE 18672

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36955

Registered No.

1. PLACE OF DEATH

County of Lewis

City of Winchester (No. St.)

Registration District No.

Primary Registration District No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Herboldt

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: April 16 (Month) (Day) 1872 (Year)

7. AGE: 49 Yrs. 8 Mos. — ds.

IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farming

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Roumania

10. NAME OF FATHER: Conrad Herboldt

11. BIRTHPLACE OF FATHER (State or Country): Roumania

12. MAIDEN NAME OF MOTHER: Christine Lemke

13. BIRTHPLACE OF MOTHER (State or Country): Suppose Roumania

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mathew Herboldt

(Address)

15. Filed Feb 1 1922

Tom Laughlin
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. (Month) 16 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from about Dec 1 1921 to Dec 15t 1921 that I last saw him alive on Dec 15t 1921 and that death occurred on the date stated above, at 3 A.M.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(Duration) Yrs. 1 mos. ds.

Contributory (Secondary) Diabetis Melitis

(Duration) 7 yrs. — mos. — ds.

(Signed) Tom Laughlin M. D.

Dec 17 1921 (Address) Winchester Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL ... 19...

20. UNDERTAKER | ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 48
Primary Registration District No. 2127
File No. 36956
Registered No.

1. PLACE OF DEATH
County of Lewis
City of Winchester
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME L. Carson Moffitt
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Oct. (Month) 12 (Day) 1882 (Year)

7. AGE: 39 Yrs. 4 Mos. 25 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Cattle man
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): N. Carolina

10. NAME OF FATHER: John Moffitt

11. BIRTHPLACE OF FATHER (State or Country): N. Carolina

12. MAIDEN NAME OF MOTHER: ——— Grant

13. BIRTHPLACE OF MOTHER (State or Country): N. Carolina

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) .....
(Address) .....

15. Filed ..... 19 21 J. W. Langdon Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 6 (Day) 19 21 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Found dead in barn
that I last saw h..... alive on ..... 19 .....,
and that death occurred on the date stated above, at 9:30 A.M.
The CAUSE OF DEATH* was as follows:
Gunshot Wound in head (Suicidal)
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Instantaneous death
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) J. W. Langdon M. D.
19 21 (Address) Winchester, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston | DATE OF BURIAL ..... 19 .....

20. UNDERTAKER | ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 7-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36957

Registered No.

1. PLACE OF DEATH

County of Lewis

City of Lenore (No. ..... St.)

Registration District No. 1

Primary Registration District No. 2 49

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Fred Raymond Cope

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH: Dec 13 1898
(Month) (Day) (Year)

7. AGE: 22 Yrs. 2 Mos. 18 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Soldier
(b) General nature of industry, business or establishment in which employed (or employer): Marine

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: Wm Hugh Cope

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Nellie Thompson

13. BIRTHPLACE OF MOTHER (State or Country): Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ted Cope
(Address) Winchester.

15. Filed Feb 1st 1922 Tom Laughlin Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar 2 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 26, 1920 to Mar 1 1921 that I last saw h[illegible] alive on Mar 1 1921 and that death occurred on the date stated above, at 4:30 P.M.

The CAUSE OF DEATH* was as follows:

Tuberculosis
Pulmonary
(Duration) 1 Yrs. 6 mos. 6 ds.
Contributory (Secondary) Pneumonia
(Duration) 2 Yrs. 2 mos. 18 ds.
(Signed) Tom Laughlin M. D.
Mar 2 1921 (Address) Lewiston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL ..... 19.....
20. UNDERTAKER	ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 48
Primary Registration District No. 2127
File No. 36958
Registered No.

1. PLACE OF DEATH
County of Lewis
City of Forest
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME: Kenneth Elijah Bedwell
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Oct. (Month) 12 (Day) 1902 (Year)

7. AGE: 19 Yrs. 5 Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Living Home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): North Dakota

10. NAME OF FATHER: Robt Henry Bedwell

11. BIRTHPLACE OF FATHER (State or Country): Wisconsin

12. MAIDEN NAME OF MOTHER: Sarah Hutton

13. BIRTHPLACE OF MOTHER (State or Country): South Dakota

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. M. Langhlin
(Address) Winchester Ida

15. Filed Feb 1st 1921 J. M. Langhlin Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 12 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 11th 1921 to Mar 12 1921
that I last saw him alive on Mar 12 1921
and that death occurred on the date stated above, at 9 45 P.M.
The CAUSE OF DEATH* was as follows:

Pneumonia
(Duration) Yrs. mos. 2 ds.
Contributory (Secondary) Acute Heart
(Duration) yrs. mos. 2 ds.
(Signed) J. M. Langhlin M. D.
Mar 13 1921 (Address) Winchester Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL 19

20. UNDERTAKER | ADDRESS

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Lewis Registration District No. 2127

City of Reubens (No. ..... St.) Primary Registration District No. 48

File No. 36959

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Opal Frances Hewett

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Mar. (Month) 17 (Day) 1921 (Year)

7. AGE: Yrs. 9 Mos. 5 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Reubens Ida

10. NAME OF FATHER: Geo. I. Hewett

11. BIRTHPLACE OF FATHER (State or Country): Mo.

12. MAIDEN NAME OF MOTHER: Lena Marguam

13. BIRTHPLACE OF MOTHER (State or Country): Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Geo. Hewett
(Address) Reubens Ida

15. Filed Dec 1st 1921 H. E. McLaughlin Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. (Month) 21 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 10 1921 to Dec 20 1921 that I last saw her alive on Dec 20 1921 and that death occurred on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:

Labar Pneumonia Right

(Duration) ..... Yrs. ..... mos. 4 ds.

Contributory (Secondary) Empyema Left Operated 5 days before

(Duration) ..... yrs. ..... mos. 28 ds.

(Signed) H. E. McLaughlin M. D.

12/21/1921 (Address) Winchester Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Jimo Bomelie — DATE OF BURIAL: Dec 22 1921

20. UNDERTAKER: ..... ADDRESS: Reubens

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 47

Primary Registration District No.

File No. 36960

Registered No. 78

County of Lewis

City of Nezperce

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information. Route 3

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Andrea Emeline White

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Infant

6. DATE OF BIRTH. Jan. (Month) 20 (Day) 1922 (Year)

7. AGE: ..... Yrs. ..... Mos. 6 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Nezperce Idaho

10. NAME OF FATHER: Archie L. White

11. BIRTHPLACE OF FATHER (State or Country): Uniontown Wash.

12. MAIDEN NAME OF MOTHER: Melvina Evelina Bunker

13. BIRTHPLACE OF MOTHER (State or Country): Illinois ~~Lewiston Idaho~~

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Archie L. White

(Address) Nezperce Idaho

15.

Filed 2-1 1922

Albert Huff
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 1-26 (Month) (Day) 1922 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1-20 1922 to 1-26 1922, that I last saw h[illegible] alive on 1-20 1922 and that death occured on the date stated above, at 8 M.

The CAUSE OF DEATH* was as follows:

Mitral insufficiency

(Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) A. Taylor M. D.

19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Nezperce Catholic Cemetery — DATE OF BURIAL: 1-28 1922

20. UNDERTAKER: Albert Huff — ADDRESS: Nezperce Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24658

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (b) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers,* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer* (*retired, 6 yrs.*) For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, *septicemia,*" "PUERPERAL *peritonitis,*" etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36961
Registered No. 74

1. PLACE OF DEATH. Registration District No. 47
County of Nez Perce Idaho Primary Registration District No.
City of Village (No. , , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John R Mockler

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): ~~Write the word.~~

6. DATE OF BIRTH: 23 Dec (Month) (Day) 1858 (Year)

7. AGE: 63 yrs. mos. ds. IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farming
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Novascosia

10. NAME OF FATHER: Richard Mockler

11. BIRTHPLACE OF FATHER (State or Country): Tipperary Ireland

12. MAIDEN NAME OF MOTHER: Katherine Brophy

13. BIRTHPLACE OF MOTHER (State or Country): St Johns New Brunswick

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) William H Mockler
(Address) Nezperce Idaho

15.
Filed 1-22-1922 Albert Huff Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 11-4 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2-12 1921, to 11-4 1921
that I last saw him alive on 11-3 1921
and that death occurred on the date stated above, at 1 0'c M.
The CAUSE OF DEATH* was as follows:

Nephritis

(Duration) 2 yrs. 8 mos. 4 ds.

Contributory (Secondary)
(Duration) 1 yrs. mos. ds.

(Signed) W Taylor M. D.
11-4 1921 (Address) Nezperce

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Nezperce Catholic Cemetery — DATE OF BURIAL: 11-6 1921

20. UNDERTAKER: Albert Huff — ADDRESS: Nezperce Idaho

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

36968

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of [redacted]
BOARD OF HEALTH
Bureau of Vital Statistics
File No. ....
Registered No. ....3....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Madison
Registration District No. ....100....
Primary Registration District No. ....2178....
City of .... (No. .... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lola Bell Lutz

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH. 2 (Month) 17 (Day) 1905 (Year)
7. AGE: 16 Yrs. 10 Mos. 7 ds. IF LESS than 1 day how many .... hrs. or .... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: General House work
(b) General nature of industry, business, or establishment in which employed (or employer) ....
9. BIRTHPLACE (State or Country): Hebford Idaho
10. NAME OF FATHER: Wm H. Lutz
11. BIRTHPLACE OF FATHER (State or Country): Utah
12. MAIDEN NAME OF MOTHER: Minnie Florence Mateer
13. BIRTHPLACE OF MOTHER (State or Country): Wisconsin
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wm H. Lutz
(Address) Rupert Idaho
15. Filed 12/28 1921. G. G. Hope Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 27 (Day) 1921 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Dec 24 1921 to Dec 27 1921
that I last saw her alive on Dec 27 1921
and that death occurred on the date stated above, at .... M.
The CAUSE OF DEATH* was as follows:
Broncho Pneumonia
(Duration) .... Yrs. .... mos. 4 ds.
Contributory (Secondary) ....
(Duration) .... Yrs. .... mos. .... ds.
(Signed) Parley Nelson M. D.
12-27 1921. (Address) Rupert Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .... yrs. .... mos. .... days. In the State .... yrs. .... mos. .... days
Where was disease contracted if not at place of death? ....
Former or usual residence ....

19. PLACE OF BURIAL OR REMOVAL: Rupert — DATE OF BURIAL: 12/29 1921
20. UNDERTAKER: [illegible] — ADDRESS: Rupert

FORM V. S. No. 5-25 M. 1-16-19

Idaho

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 3697 4

County of Nez Perce — Primary Registration District No. — File No.

City or Indian Res. (No. ..., ... St.) — Registered No. 2

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Amelia Bronche

RECEIVED MAR 6 1922 STATE REGISTRAR

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: Indian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. 1905 (Month) 1 (Day) (Year)

7. AGE: 16 Yrs. Mos. ds. — IF LESS than 1 day how many ...hrs. or ...min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Indian Reservation

10. NAME OF FATHER: Paul Bronche

11. BIRTHPLACE OF FATHER (State or Country): Indian Reservation Idaho

12. MAIDEN NAME OF MOTHER: Emma Wolf

13. BIRTHPLACE OF MOTHER (State or Country): Indian Res. Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Corbett Lawyer
(Address) Lapwai, Idaho

15. Filed 4/18/ 21 191 Corbett Lawyer Deputy Registrar
MAR 6 - 1922 E. W. Almond State

SYMS - YORK CO., PTRS. & BOOKS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April 18th 1921 (Month) (Day) 191 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ... 191 ..., to ... 191 ..., that I last saw h... alive on ... 191 ..., and that death occured on the date stated above, at ... M.

The CAUSE OF DEATH* was as follows:

T. B.
(No regular attendant)

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary) ...
(Duration) ... yrs. ... mos. ... ds.

(Signed) Corbett Lawyer Clerk M. D.
19... (Address) Lapwai, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs ... mos ... days. In the State ... yrs ... mos ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Indian Cemetary — DATE OF BURIAL: 4/19/21 191

20. UNDERTAKER: J.N.W ann, Lapwai, Idaho — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

Idaho

CERTIFICATE OF DEATH.

36975

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
MAR 6 1922
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH.
County of Nez Perce
City or Town Indian Res.
(If death occurs away from usual residence, give facts called for under special information.)

Registration District No. 2
Primary Registration District No.
(No. ..... St.)

File No.
Registered No. 1

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mrs. Yellow Bull

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: Indian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. 1845 (Month) 1 (Day) (Year)

7. AGE: 76 Yrs. Mos. ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Indian Res.

10. NAME OF FATHER: unknown

11. BIRTHPLACE OF FATHER (State or Country): unknown

12. MAIDEN NAME OF MOTHER: unknown

13. BIRTHPLACE OF MOTHER (State or Country): unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Jeanette Stephens.
(Address) Spalding, Idaho.

15. Filed 4/4/1921 191 MAR 6 - 1922
Corbett Lawyer Local Registrar
F. W. Ahrend State

SYMS - YORK CO., PTRS. & BORS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
April 4, 1921
(Month) (Day) 191 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Pneumonia
(No attendant)
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Corbett Lawyer Clerk M. D.
19... (Address) Lapwai, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Indian Cemetary
DATE OF BURIAL: 4/4/21 191

20. UNDERTAKER: J.N.Wann, Lapwai, Idaho
ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, if known. Physicians should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH. 36976

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED MAR 10 1922 REGISTRAR

1. PLACE OF DEATH. Idaho

Registration District No.....

Primary Registration District No.....

File No. .....

County of Nez Perce

City of Indian Res.

(No. ....., ... St.)

Registered No. 3

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jeanette James.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: Indian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. 1920 (Month) 1 (Day) (Year)

7. AGE: 1 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Infant

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Indian Res, Idaho.

10. NAME OF FATHER: Lewis James

11. BIRTHPLACE OF FATHER (State or Country): Lapwai, Idaho

12. MAIDEN NAME OF MOTHER: Theresa James

13. BIRTHPLACE OF MOTHER (State or Country): Indian Res. Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Corbett Lawyer

(Address) Lapwai, Idaho.

15.

Filed 4/21/21 191.... Corbett Lawyer Registrar

MAR 6 - 1922 FW. Almond State

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April 21, 1921 (Month) (Day) 191 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191..., that I last saw h... alive on ..... 191..., and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(No regular attendant)

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) Corbett Lawyer Clerk M. D.

19.... (Address) Lapwai, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Indian Cemetary	4/22/21 191....
20. UNDERTAKER	ADDRESS
J.N.Wann,	Lapwai, Idaho.

SYMS - YORK CO. PRINT. & BIND. 24053

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED MAR 6 1922 STATE VITAL STATISTICS

CERTIFICATE OF DEATH. 36977

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Idaho

County of Nez Perce
City of Indian Res.

Registration District No.....
Primary Registration District No.....
(No. ..... St.)

File No. .....
Registered No. 5

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Clarisa Williams

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
F	Indian	Single

6. DATE OF BIRTH.
1919 (Month) 1 (Day) (Year)

7. AGE
2 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Infant
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Lapwai, Idaho

10. NAME OF FATHER Philip Williams

11. BIRTHPLACE OF FATHER (State or Country) Meadow Creek, Idaho

12. MAIDEN NAME OF MOTHER Amelia Williams

13. BIRTHPLACE OF MOTHER (State or Country) Lapwai, Idaho/

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) David McFarland
(Address) Lapwai, Idaho.

15. Filed 4/26/21 191 Corbett Lawyer Local Registrar
MAR 6 - 1922
F.W. Almond State

SYMS - YORK CO., PTRS. & BORS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
April 26, 1921
(Month) (Day) 191 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Pneumonia
(No regular attendant)
.....(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
.....(Duration ..... yrs. ..... mos. ..... ds.
(Signed) Corbett Lawyer Clerk M. D.
..... 19..... (Address) Lapwai, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Indian Cemetery	4/27/21 191

20. UNDERTAKER	ADDRESS
J.N.Wann, Lapwai, Idaho.	

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD!

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

Idaho

CERTIFICATE OF DEATH.

36978

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Nez Perce

City of Indian Res.

Registration District No.

Primary Registration District No.

(No. ..... St.)

File No.

Registered No. 7

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Te-tah-pil-ma

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

RECEIVED
MAR 6 1922
STATE BOARD OF HEALTH

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: Indian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH.: 1844 (Month) (Day) 1 (Year)

7. AGE: 77 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Indian Res. Idaho

10. NAME OF FATHER: unknown

11. BIRTHPLACE OF FATHER (State or Country): unknown

12. MAIDEN NAME OF MOTHER: unknown

13. BIRTHPLACE OF MOTHER (State or Country): unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) St. Joseph's Hospital

(Address) Lewiston, Idaho.

15.

Filed 4/27/21 191

MAR 6 - 1922

Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April 26, 1921. (Month) (Day) 191 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191....., to ..... 191....., that I last saw h..... alive on ..... 191....., and that death occured on the date stated above, at .....M.

The CAUSE OF DEATH* was as follows:

Pneumonia

.....(Duration) .....Yrs.....mos.....ds.

Contributory (Secondary) .....

.....(Duration .....yrs.....mos.....ds.

(Signed) Dr. J. N. Alley M.D. M. D.

.....19..... (Address) Lewiston, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Indian Cemetery	4/25/21 191
20. UNDERTAKER	ADDRESS
Vassar Undt. Co.,	Lewiston Idaho.

T. W. Almond

STANDARD CERTIFICATE OF DEATH

36979

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MAR 6 1922
REGISTRAR OF VITAL STATISTICS

1 PLACE OF DEATH
County Nez Perce Reservation State Idaho Registered No. 5
Township ~~Kamiah~~ or Tribe: Umatilla
City ..... No. ....., St., ... Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Annabelle Penny
(a) Residence. No. ..... St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word)
Female	Indian	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----

6 DATE OF BIRTH (month, day, and year) Feby. 5, 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ---- hrs. or ---- min.
	0	2	7	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work ----
(b) General nature of industry, business, or establishment in which employed (or employer) ----
(c) Name of employer

9 BIRTHPLACE (city or town) Nez Perce Reservation
(State or country) Lapwai, Idaho

PARENTS
10 NAME OF FATHER George Penny
11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Nez Perce Reservation
12 MAIDEN NAME OF MOTHER Alice Barnhart
13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Umatilla Reservation

14 Informant Corbett Lawyer
(Address) Lapwai, Idaho,

15 Filed 6-30-, 1921 Mary M. Brady Chief Clerk REGISTRAR
MAR 6 - 1922 F.W. Aldrond

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 13, 1921.

17 I HEREBY CERTIFY, That I attended deceased from April 8th, 1921, to April 8th, 1921,
that I last saw h[illegible] alive on April 8th, 1921,
and that death occurred, on the date stated above, at .....m.
The CAUSE OF DEATH* was as follows:
Pneumonia bronchi
.....
.....
..... (duration) ..... yrs. ..... mos. 6 ds.
CONTRIBUTORY .....
(SECONDARY)
..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? Clinical
(Signed) L.D. Riggs, M. D.
, 19 (Address) Lapwai, Idaho

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
North Lapwai	4-14- 1921
20 UNDERTAKER	ADDRESS
Mr Known	

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

8—209 d
V. S. No. 93

STANDARD CERTIFICATE OF DEATH

36980

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

1 PLACE OF DEATH
County Nez Perce State Idaho Registered No. 6
Township Indian Reservation or Village or
City No. St., Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Susie Hines

(a) Residence. No. St., Ward.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word)
Female	Indian	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Widowed

6 DATE OF BIRTH (month, day, and year) 1846

7 AGE	Years	Months	Days	If LESS than 1 day, ---- hrs. or ---- min.
	75			

8 OCCUPATION OF DECEASED
(a) *Trade, profession, or particular kind of work* Inval id and old
(b) General nature of industry, *business*, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Indian Res.
(State or country) Idaho

PARENTS
10 NAME OF FATHER unknown
11 BIRTHPLACE OF FATHER (city or town) Indian Res
(State or country) Idaho
12 MAIDEN NAME OF MOTHER unknown
13 BIRTHPLACE OF MOTHER (city or town) Indian Res
(State or country)

14 Informant David Scott Jr.
(Address) Lenore, Idaho.

15 Filed 5/1/21 19 Corbett Sawyer
MAR 6 - 1922 F W Almond REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 31, 1921

17 I HEREBY CERTIFY, That I attended deceased from
, 19, to , 19,
that I last saw h alive on , 19,
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:

Heart failure
(No attending physician)

(duration) yrs. mos. ds.
CONTRIBUTORY
(SECONDARY)
(duration) yrs. mos. ds.
18 Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Corbett Sawyer Clerk, M. D.
, 19 (Address) Lapwai, Idaho.

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Indian cemetary	5/2/1921 19
20 UNDERTAKER unknown	ADDRESS

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

8—209 d
V. S. No. 98

36981

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

1 PLACE OF DEATH
County Nez P erce State Idaho Registered No. 2
Township Nez Perce Indian Reservation or Village or
City No. St., Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Elmer Whitfield, Jr.,

(a) Residence. No. St., Ward.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word)
Male	Indian	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of -- - - - - - - - - - - --

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, ---- hrs. or ---- min.
	13	--	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Lapwai,
(State or country) Idaho

PARENTS
10 NAME OF FATHER Elmer Whitfield
11 BIRTHPLACE OF FATHER (city or town) Reservation
(State or country) Idaho
12 MAIDEN NAME OF MOTHER Mary Ann Bronche
13 BIRTHPLACE OF MOTHER (city or town) Ind. Res.
(State or country) Idaho

14 Informant David Mc Farland
(Address) Lapwai, Idaho.

15 Filed 4/10/21 Corbett Sawyer
MAR 6 - 1922 F.W. Almond REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 9, 1921

17 I HEREBY CERTIFY, That I attended deceased from
, 19, to , 19,
that I last saw h alive on , 19,
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:

Pneumonia
(No attending physician)

(duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) Corbett Sawyer Clerk, M. D.
, 19 (Address) Lapwai, Idaho.

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Indian cemetrary	4/10/21 19
20 UNDERTAKER J.N. Wann, Lapwai, Idaho.	ADDRESS

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

8—209 d
V. S. No. 08

FORM V. S. No. 5-25 M. 1-16-13 Idaho

CERTIFICATE OF DEATH.

Registration District No. 36982

Primary Registration District No.

(No. ..... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. .....

Registered No. 4

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1922

PLACE OF DEATH.

County of Nez P erce

City of Indian R es.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lucy Raymond

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
F	Indian	Single

6. DATE OF BIRTH.

1863 (Month) 1 (Day) (Year)

7. AGE

57 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country) Indian Res. Idaho

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER

(State or Country) unknwon

12. MAIDEN NAME OF MOTHER Petyoustonmy

13. BIRTHPLACE OF MOTHER

(State or Country) Indian Res. Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) David McFarland

(Address) Lapwai, Idaho.

15.

Filed 4/24/21 191 F.W. Almond Local Registrar

MAR 6 - 1922

SYMS - YORK CO., PTRS. & BOKS. 24654

F. W. Almond Clerk

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 26, 1921 191
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Pneumonia
(No regular attendant)

.....(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

.....(Duration ..... yrs. ..... mos. ..... ds.

(Signed) ..... Clerk ..... M. D.

.....19..... (Address) Lapwai, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Indian Cemetery	4/24/21 191

20. UNDERTAKER	ADDRESS
J.N.Wann, Lapwai, Idaho	

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH. 36983

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Nez Perce
City or Indian. Res. (Idaho)
(No. ..... St.)
Registration District No. .....
Primary Registration District No. .....
File No. .....
Registered No. 8

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elizabeth White

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS MUST BE CAREFUL TO STATE EXACTLY. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, Exact statement should state CAUSE OF DEATH in plain terms, so that it may be properly classified, Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: Indian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. 1920 (Month) 1 (Day) (Year)

7. AGE: ....Yrs. 15 Mos. ....ds.
IF LESS than 1 day how many ....hrs. or ....min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country) Lapwai, Idaho

10. NAME OF FATHER: Chas. White Jr.,

11. BIRTHPLACE OF FATHER (State or Country): Lapwai, Idaho

12. MAIDEN NAME OF MOTHER: Delia McAtty

13. BIRTHPLACE OF MOTHER (State or Country): Lapwai, Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) David McFarland
(Address) Lapwai, Idaho.

15. Filed 4/29/21 191 Corbett Lawyer Local Registrar
Filed 3/6/22

SYMS - YORK CO., PTRS. & STRS. 24854

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
April 29, 1921
(Month) (Day) 191 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....191...., to ....191....,
that I last saw h....alive on ....191....,
and that death occured on the date stated above, at ....M.
The CAUSE OF DEATH* was as follows:
pneumonia
(No regular attendant)
....(Duration) ....Yrs. ....mos. ....ds.
Contributory (Secondary) .....
....(Duration ....yrs. ....mos. ....ds.
(Signed) Corbett Lawyer Clerk, M. D.
....19.... (Address) Lapwai, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Indian Cemetary	4/30/21 191

20. UNDERTAKER J.N.Wann, Lapwai, Idaho. ADDRESS

36984

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

1 PLACE OF DEATH
County Nez Perce State Idaho Registered No. 1
Township Indian Reservation or Village or
City No. , St., Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Elsie Lawrence Conner

(a) Residence. No. St., Ward.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Female	Indian	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of widowed

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	27	---	--	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Kooskia,
(State or country) Idaho

PARENTS
10 NAME OF FATHER Osias Lawrence
11 BIRTHPLACE OF FATHER (city or town) Ind. Res.
(State or country) Idaho
12 MAIDEN NAME OF MOTHER Pheobe Nelson
13 BIRTHPLACE OF MOTHER (city or town) Stites
(State or country) Idaho

14 Informant James Stuart,
(Address) Kooskia, Idaho.

15 Filed 6/9, 19 21 Corbett Sawyer
Filed 3/6/22 [illegible] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 8, 1921 19

17 I HEREBY CERTIFY, That I attended deceased from
, 19, to , 19,
that I last saw h alive on , 19,
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:

T. B.

(No regular attending physician)

(duration) yrs. mos. ds.
CONTRIBUTORY
(SECONDARY)
(duration) yrs. mos. ds.
18 Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Corbett Sawyer Clerk, M. D.
, 19 (Address) Lapwai, Idaho.

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Indian cemetery	6-9-21 19
20 UNDERTAKER Kooskia Undertaking Co.,	ADDRESS Kooskia

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

8—209 d
V. S. No. 98

STANDARD CERTIFICATE OF DEATH

6985

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

1 PLACE OF DEATH
County Nez Perce. State Idaho Registered No. 2
Township Webb, Idaho Tribe: NezPerce & Umatilla or
City ____ No. ____, ____ St., ____ Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Joseph Webb.

(a) Residence. No. Webb, Idaho St., ____ Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Male	Indian	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of -----

6 DATE OF BIRTH (month, day, and year) April 17, 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ---- hrs. or ---- min.
	0	11	19	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work -----
(b) General nature of industry, business, or establishment in which employed (or employer) -----
(c) Name of employer

9 BIRTHPLACE (city or town) Cayuse, Oregon
(State or country)

PARENTS
10 NAME OF FATHER Charles Webb
11 BIRTHPLACE OF FATHER (city or town) ____
(State or country) Nez Perce Reservation
12 MAIDEN NAME OF MOTHER Amy Joshua
13 BIRTHPLACE OF MOTHER (city or town) ____
(State or country) Umatilla Reservation

14 Informant Amy Joshua Webb, Mother
(Address) Webb, Idaho.

15 Filed 5/31, 1921 Mary M. Brady REGISTRAR
Filed 3/6/22 FW

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7, 1921

17 I HEREBY CERTIFY, That I attended deceased from April 21, 1921, to May 6, 1921
that I last saw him alive on May 6, 1921
and that death occurred, on the date stated above, at 6:00 a.m.
The CAUSE OF DEATH* was as follows:

Measles

(duration) ____ yrs. ____ mos. 14 ds.
CONTRIBUTORY (SECONDARY) Bronchopneumonia
(duration) ____ yrs. ____ mos. 7 ds.

18 Where was disease contracted if not at place of death? ____
Did an operation precede death? No Date of ____
Was there an autopsy? No
What test confirmed diagnosis? ____

(Signed) George Gaisnard, M. D.
, 19 (Address) Culdesac Idaho

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Slickpoo Mission	May 8, 1921
20 UNDERTAKER	ADDRESS

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

8—209 d
V. S. No. 98

36386

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

1 PLACE OF DEATH
County Nez Perce State Idaho Registered No. 5
Township Nez Perce Indian Reservation or Village or
City No. , St., Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Tom Hill Jr.,

(a) Residence. No. Craigmont, Idaho. St., Ward.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Male	Indian	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Weyahtulwenunmy

6 DATE OF BIRTH (month, day, and year) 1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	37	--	--	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Indian Reservation
(State or country) Idaho

PARENTS
10 NAME OF FATHER John Hill, decd.,
11 BIRTHPLACE OF FATHER (city or town) Indian Res.
(State or country) Idaho
12 MAIDEN NAME OF MOTHER unknown
13 BIRTHPLACE OF MOTHER (city or town) Indian Res
(State or country) Idaho.

14 Informant Weyahtulwenunmy.
(Address) Craigmont, Idaho

15 Filed 4/24/21 Garlett Sawyer REGISTRAR
Filed 3/6/27

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/24/21 19

17 I HEREBY CERTIFY, That I attended deceased from
, 19, to , 19,
that I last saw h alive on , 19,
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:

Pneumonia
(No regular attending physician)

(duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Garlett Sawyer Clerk, M. D.
, 19 (Address) Lapwai, Idaho

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Indian Cemetary	2/26/21 19
20 UNDERTAKER J. N. Mann, Lapwai, Idaho.	ADDRESS

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

8—209 d
V. S. No. 98

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS, should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

8—209 d
V. S. No. 98

36987

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STANDARD CERTIFICATE OF DEATH

1 PLACE OF DEATH
County Nez Perce State Idaho Registered No. 3
Township Indian Reservation or Village or
City No. St., Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME James Matt

(a) Residence. No. St., Ward.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word)
Male	Indian	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ---- hrs. or ---- min.
	84	--	--	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Invalid
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Indian Reservation
(State or country) Idaho

PARENTS
10 NAME OF FATHER unknown
11 BIRTHPLACE OF FATHER (city or town) Indian Res.
(State or country) Idaho
12 MAIDEN NAME OF MOTHER unknown
13 BIRTHPLACE OF MOTHER (city or town) Indian Res.
(State or country) Idaho

14 Informant Sophia Peterson
(Address) Lapwai, Idaho

15 Filed 4/20/21, 19 Corbett Sawyer REGISTRAR
Filed 3/6/22 Fw Q.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 19, 1921

17 I HEREBY CERTIFY, That I attended deceased from
----------, 19----, to ----------, 19----,
that I last saw h---- alive on ----------, 19----,
and that death occurred, on the date stated above, at ----------m.
The CAUSE OF DEATH* was as follows:

Pneumonia

(No attending physician)

---------- (duration) ---- yrs. ---- mos. ---- ds.
CONTRIBUTORY (SECONDARY)
---------- (duration) ---- yrs. ---- mos. ---- ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? ---- Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) Corbett Sawyer Clerk, M. D.
, 19 (Address) Lapwai, Idaho.

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Indian cemetary	4/20/21 19

20 UNDERTAKER J.N.Wann, Lapwai, Idaho. ADDRESS

36988

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

1 PLACE OF DEATH
County Nez Perce State Idaho. Registered No. 1
Township Nez Perce Reserv tion or Village or
City Lapwai, No. , St., Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Pe yel i path (Celia Whit an)

(a) Residence. No. St., Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word)
F	Indian	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Jim White

6 DATE OF BIRTH (month, day, and year) 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57			

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Invalid
(b) General nature of industry, business, or establishment in which employed (or employer) Invalid
(c) Name of employer

9 BIRTHPLACE (city or town) unknown
(State or country)

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant David McFarland
(Address) Lapwai, Idaho

15 Filed 3/6, 1921 Corbett Lawyer REGISTRAR
Filed 3/6/21 FW

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 6 1921

17 I HEREBY CERTIFY, That I attended deceased from
, 19, to , 19,
that I last saw h alive on , 19,
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:

T. B.

(duration) yrs. mos. ds.

CONTRIBUTORY
(SECONDARY)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Corbett Lawyer clerk., M. D.
, 19 (Address) Lapwai, Idaho.

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Lapwai, Idaho	3/7 1921
20 UNDERTAKER	ADDRESS
Wann,	Lapwai, Idaho

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

8—209 d
V. S. No. 98

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

Registration District No. 96 — 36989

Primary Registration District No. 1009

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

Registered No. 745

1. PLACE OF DEATH

County of Nezperce

City of Lewiston (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George Asman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widowed

6. DATE OF BIRTH: January (Month) 20 (Day) 1866 (Year)

7. AGE: 55 Yrs. 11 Mos. 8 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Francis Asman

11. BIRTHPLACE OF FATHER (State or Country): England.

12. MAIDEN NAME OF MOTHER: Merinda Carpenter

13. BIRTHPLACE OF MOTHER (State or Country): New York.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Alta K Florence

(Address) Uniontown Wash

15. Filed 2-10-1922 Susan E Bruce, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 28 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1921, to Dec 28 1921 that I last saw h. alive on Dec 28 1921 and that death occurred on the date stated above, at 4-30 P.M.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

Probably several years.
(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Paul W Johnson M. D.

12/31/1921 (Address) Clarkston Wash

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Asotin Wash — DATE OF BURIAL: 1/1/1922

20. UNDERTAKER: H R Merchant — ADDRESS: Clarkston Wash

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 4 — 37004

County of Payette — Primary Registration District No. 1008 — File No.

City of Payette — (No. ..... St.) — Registered No. 42

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Franklin Judd Cumberland

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Infant

6. DATE OF BIRTH: June (Month) 3 (Day) 1921 (Year)

7. AGE: 0 Yrs. 5 Mos. 0 ds. — IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Louis B Cumberland

11. BIRTHPLACE OF FATHER (State or Country): Fulton Mo.

12. MAIDEN NAME OF MOTHER: Mary Clanton

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Louis B. Cumberland
(Address) Payette Idaho

15. Filed Nov 4 1921 — J C Woodward, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 3 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 19 1921 to Nov 3 1921
that I last saw h~~im~~ alive on Nov 3 1921
and that death occurred on the date stated above, at 11:50 P.M.
The CAUSE OF DEATH* was as follows:
Broncho-Pneumonia

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J C Woodward M. D.
11/4/1921 (Address) Payette Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicida.

18. LENGTH OF RESIDENCE (For Hospitals, Institu... Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... m.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Payette Idaho	Nov 4 1921
20. UNDERTAKER	ADDRESS
Glenn C London	Payette Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
DEC 10 1921
BUREAU OF VITAL STATISTICS

37005

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Fayette. Registration District No. 4

City of Fayette (No. ..... St.) Registration District No. 1008

File No. 411

Registered No. 57

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Henry M Young

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word.): Single

6. DATE OF BIRTH: April (Month) 15 (Day) 1907 (Year)

7. AGE: 14 Yrs. 7 Mos. 12 ds.

IF LESS than 1 day how many..... hrs. or.....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Student

(b) General nature of industry, business or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): North D.

10. NAME OF FATHER: H R Young

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Minnie Margus

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. H R Young

(Address) Fayette Ida

15. Filed Nov 30 1921 J C Woodward Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 27 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 26 1921 to Nov 27 1921, that I last saw him alive on Nov 27 1921, and that death occurred on the date stated above, at 2:00 P.M.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) unknown mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. L. Richmond M.

11-29 1921 (Address) Fayette Ida

*State the Disease Causing Death; or in deaths from Violent Causes (1) Means of Injury; and (2) whether Accidental, Suicidal or Homic

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... m

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Fayette Ida | DATE OF BURIAL: Nov 29 192

20. UNDERTAKER: J N Adair Fayette Ida | ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

25 37006

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 25

County of Power Primary Registration District No. 2072 File No. 3

City of American Falls (If outside limits, give township.) St.) Registered No. 146

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Herman Hamermeister

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)
Male	White	Single

6. DATE OF BIRTH: Sept 15 1918
(Month) (Day) (Year)

7. AGE: 3 yrs. 2 mos. 27 ds. IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): American Falls, Idaho

10. NAME OF FATHER: Rudorf Hamermeister

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Fena Lehmann

13. BIRTHPLACE OF MOTHER (State or Country): Tex

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Rudolf Hamermeister
(Address) American Falls, Idho

15. Filed 1 – 7 1922 Richard F. Noth Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec 16 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 15 1921, to Dec 16 1921, that I last saw him alive on Dec 16 1921, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Intussusception of intestines

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) V.V. Logan M. D.

19 ..... (Address) American Falls Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: American Falls, Idaho | DATE OF BURIAL: Dec 17 19

20. UNDERTAKER: A.W. Davis | ADDRESS: American Falls Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

Registration District No. 25 - 37009

Primary Registration District No. 2072

(No. ....., ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3
Registered No. 139
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Power
City of Crystal
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elva Wallace Thacker Jr

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. 12 (Month) 1 (Day) 1921 (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many 2½ hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Power Co Idaho

10. NAME OF FATHER Elva Wallace Thacker

11. BIRTHPLACE OF FATHER (State or Country) Virginia

12. MAIDEN NAME OF MOTHER Emma Sylvia Brown

13. BIRTHPLACE OF MOTHER (State or Country) Idaho,

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Alice G. Martin
(Address) Crystal Idaho

15.
Filed 1-7 1922 Richard J. Nott
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 12 (Month) 1 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1-30 A.M. 1921 to 4 Oclock A.M. 1921 that I last saw him alive on 12/1 1921 and that death occurred on the date stated above, at 4 A.M.

The CAUSE OF DEATH* was as follows:
Premature Birth
Born a 7 mo.,
.....
..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
..... (Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
..... 19.... (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Robin Idaho — DATE OF BURIAL: 12/1 1921

20. UNDERTAKER — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH 37018

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Twin Falls — Registration District No. 37

City of " " (No. ..... St.) — Primary Registration District No. 1185

File No. .....

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Calvin Allison

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	White	Widowed

6. DATE OF BIRTH: Dec. (Month) 18 (Day) 1837 (Year)

7. AGE: 84 Yrs. — Mos. 12 ds. — IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Kent

10. NAME OF FATHER: James Allison

11. BIRTHPLACE OF FATHER (State or Country): Ky.

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. F. Allison
(Address) Twin Falls

15. Filed Feb. 7 1922 — John Tillery Parker, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. (Month) 30 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 25-21 1921, to Dec 30 1921 that I last saw h.is alive on Dec 29 1921, and that death occurred on the date stated above, at .....M.
The CAUSE OF DEATH* was as follows:

Senility

(Duration) ..... Yrs. 7 mos. ..... ds.

Contributory (Secondary): Arteriosclerosis

(Duration) 2 yrs. ..... mos. ..... ds.

(Signed) Duncan C. Alexander M. D.

1/1 1922 (Address) Twin Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Twin Falls	12-31 1921
20. UNDERTAKER	ADDRESS
[illegible]	Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH — Registration District No. 37 — 37028

County of Twin Falls — Primary Registration District No. 2085 — File No.

City of (No. St.) — Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Benjamin B Squires

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH — Not known (Month) (Day) (Year)

7. AGE — about 47 Yrs. Mos. ds. — IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Laborer (Farm)
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) New Jersey

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant)
(Address)

15. Filed Feb. 7 1922 — John L. Boyd — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec 23 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dept 20 1921 to Dec 25 1921 that I last saw h[illegible] alive on Dec 24 1921 and that death occurred on the date stated above, at 7 A.M.

The CAUSE OF DEATH* was as follows:

Acute Dilitation Heart

(Duration) Yrs. mos. 1 ds.

Contributory (Secondary) Mitral regurgitation

(Duration) 3 yrs. mos. ds.

(Signed) Duncan L. Alexander M. D.

Dec 27 1921 (Address) Twin Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Twin Falls	Dec 28 1921
20. UNDERTAKER	ADDRESS
J. J. Grossman	Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 36 37030
County of T F Primary Registration District No.
City of 15 (No. , St.)
File No.
Registered No. 15-
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William Martin Jones

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): M

6. DATE OF BIRTH: Jan 31 1862 (Month) (Day) (Year)

7. AGE: 59 yrs. 10 mos. 21 ds.
IF LESS than 1 day how many .....hrs. or .....mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Ret. farmer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mo.

10. NAME OF FATHER: Hiram Henry Jones

11. BIRTHPLACE OF FATHER (State or Country): Tenn

12. MAIDEN NAME OF MOTHER: M. Hall

13. BIRTHPLACE OF MOTHER (State or Country): Tenn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): C. Elmo Jones
(Address): R

15. Filed Dec 22 1921 J.M.D. Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec 21 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 5 1921, to Dec 21 1921, that I last saw h— alive on Dec 21 1921, and that death occurred on the date stated above, at 7.30 P.M.

The CAUSE OF DEATH* was as follows:

Influenza Pneumonia

(Duration) yrs. mos. ds.

Contributory (Secondary): Asthma

(Duration) 25 yrs. mos. ds.

(Signed) J. M. Davis M. D.

12/22 1921 (Address) Twin Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls. Ida — DATE OF BURIAL: Dec-23 1921

20. UNDERTAKER: P. J. Grossman — ADDRESS: Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BORS. 19760

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 86 — 37041
Primary Registration District No. 2112
File No.
Registered No. 2

1. PLACE OF DEATH
County of Washington
City of Weiser
(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Orson Wallace Howell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Jan (Month) 1 (Day) 1911 (Year)

7. AGE: 9 Yrs. 10 Mos. 18 ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Shoal Bay
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: E. F. Howell

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Anna L Henderson

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E F Howell
(Address) Weiser Ida

15. Filed Dec 20th 1921 — W R Hamilton — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 18th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 12th 1921, to Dec 15th 1921, that I last saw h[im] alive on Dec 6th 1921, and that death occurred on the date stated above, at 5 P M.

The CAUSE OF DEATH* was as follows:

Emphysema

(Duration) ... Yrs. ... mos. 30 ds.

Contributory (Secondary): Pneumonia

(Duration) ... yrs. ... mos. 10 ds.

(Signed) W. R. Hamilton M. D.

12/20 1921 (Address) Weiser Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Clifton Idaho — DATE OF BURIAL ... 19...

20. UNDERTAKER: Northcutt & McCann — ADDRESS Weiser Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

37042

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 86

County of Washington — Primary Registration District No. 1010

City of Weiser (No. ..... St.)

File No. .....

Registered No. 1

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ann Elizabeth Benson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	widowed

6. DATE OF BIRTH May 2 1 (Month) (Day) (Year)

7. AGE 81 Yrs. 7 Mos. 4 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Penn.

10. NAME OF FATHER Anthony Lamb

11. BIRTHPLACE OF FATHER (State or Country) —

12. MAIDEN NAME OF MOTHER Elizabeth Thomas

13. BIRTHPLACE OF MOTHER (State or Country) Penn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Geo Benson
(Address) Eatons Ida.

15. Filed 2/8 1922 W. P. Hamilton Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec 5 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 14 1921, to Dec 5 1921, that I last saw her alive on Dec 5 1921, and that death occurred on the date stated above, at 2 P M.

The CAUSE OF DEATH* was as follows:
Chronic valvular disease, Mitral insufficiency

(Duration) about 1 year Yrs. ..... mos. ..... ds.

Contributory (Secondary) senility

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G. M. Waterhouse M. D.

12/6 1921 (Address) Weiser Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Hillcrest Cemetery	12/8 1921
20. UNDERTAKER Northam & McCann	ADDRESS Weiser Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

37043

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 86

Primary Registration District No. 1010

File No.

County of Washington

City of Weiser (No. , St.)

Registered No. 10

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ersella Huber

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: Wh

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Nov (Month) 14 (Day) 1900 (Year)

7. AGE: 21 Yrs. 1 Mos. 17 ds.

IF LESS than 1 day how many..... hrs. or.....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Utah

10. NAME OF FATHER Joseph A Huber

11. BIRTHPLACE OF FATHER (State or Country) France

12. MAIDEN NAME OF MOTHER Ina Dalley

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Albert Huber

(Address) Weiser Idaho

15. Filed 2/13 1922 H. P. Hamilton M.D. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: December 26 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1921, to Dec 26 1921 that I last saw h-r alive on Dec 26 1921, and that death occurred on the date stated above, at 3.30 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis.

.....(Duration) 3 Yrs. — mos. — ds.

Contributory (Secondary).....

.....(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C C Jouant M. D.

12-27 1921 (Address) Weiser Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Hillcrest Cemetery | DATE OF BURIAL: 12/28 1921

20. UNDERTAKER: Northam & McCann | ADDRESS: Weiser Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

37050

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

Primary Registration District No.

File No.

County of Washington

City of Cambridge (No. , St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Dave Colson Dead

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Nov 8 1883
(Month) (Day) (Year)

7. AGE: 38 yrs. 1 mos. 9 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Washington Co Ida

10. NAME OF FATHER: A M Colson

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Eliza Daniels

13. BIRTHPLACE OF MOTHER (State or Country): Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) x C. M. Colson
(Address) Cambridge Ida

15. Filed 2-K 27 191 W. W. Coleman Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: December 17 191 3
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 17 1921, to Dec. 17 1921, that I last saw h[illegible] alive on Dec. 17 1921 and that death occurred on the date stated above, at 4-7 M.

The CAUSE OF DEATH* was as follows:
Acute Tuberculous Laryngitis
Acute Miliary Tuberculosis - Meningitis
(Duration) yrs. [illegible] mos. [illegible] ds.
Contributory (Secondary) Septicemia -
(Duration) yrs. 25 mos. 25 ds.

(Signed) W. W. Coleman M. D.
Dec 18 1921 (Address) Cambridge Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Caldwell — DATE OF BURIAL: Dec 19 1921

20. UNDERTAKER: J A Anderson — ADDRESS: Cambridge

Dec

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

37103

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 124
Primary Registration District No. 7702
File No. 1
Registered No. 39

1. PLACE OF DEATH
County of Ada
City of Kuna (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Alice J Linebaugh
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem
4. COLOR OR RACE: Wht
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widowed

6. DATE OF BIRTH: Nov. (Month) 27 (Day) 1847 (Year)

7. AGE: 74 Yrs. ..... Mos. 1 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): N.C.

10. NAME OF FATHER: Louis C. Right

11. BIRTHPLACE OF FATHER (State or Country): N.C.

12. MAIDEN NAME OF MOTHER: Elizabeth Hughes

13. BIRTHPLACE OF MOTHER (State or Country): N.C.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. F. Hamby
(Address) Kuna Idaho

15. Filed 2-27 1922
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 28 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 7 1921, to Nov 28 1921, that I last saw her alive on Nov 23 1921, and that death occurred on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:
Cystic tumor on ovary
(Duration) ..... Yrs. 2 mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Halbert F. Neal M. D.
11-29 1921 (Address) Meridian Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Dilcan Springs Park — DATE OF BURIAL ..... 19.....
20. UNDERTAKER: Fred K Robinson — ADDRESS Nampa Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
APR 5 1922
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No.....

County of Gem

Primary Registration District No.....

File No. 37245

City of Emmett (St.)

Registered No.....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Talley Martin

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fe

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): married

6. DATE OF BIRTH: June (Month) 1 (Day) 1850 (Year)

7. AGE: 71 Yrs. 11 Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Rochelle Illinois

10. NAME OF FATHER: Harrison Talley

11. BIRTHPLACE OF FATHER (State or Country): Illinois

12. MAIDEN NAME OF MOTHER: Hannah Talley

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15. Filed 4/3 1921

Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 18 (Day) 19 21 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 10 19 21, to May 18 19 21 that I last saw h-er alive on May 17 19 21 and that death occurred on the date stated above, at 11:50 P. M.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia

(Duration) Yrs. mos. 2 ds.

Contributory (Secondary) Senility

(Duration) yrs. mos. ds.

(Signed) Austin H. Byrd M. D.

5/20 19 21 (Address) Emmett, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ...yrs...mos...days. In the State ...yrs...mos...days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL 19

20. UNDERTAKER | ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED DEC 10 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 16

Primary Registration District No. 1016

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 37289

Registered No. 18

1. PLACE OF DEATH

County of Lincoln

City of Shoshone

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Amola Arrieta

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1 (Year)

7. AGE: 28 Yrs. — Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Shoe Worker

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): France

10. NAME OF FATHER: unknown

11. BIRTHPLACE OF FATHER (State or Country): France

12. MAIDEN NAME OF MOTHER: unknown

13. BIRTHPLACE OF MOTHER (State or Country): France

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) Pete Erurreta

15. Filed Dec 5th 1921

J. H. Sullivan
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec 2 (Month) at (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 10 1919, to Dec 2 — 1921, that I last saw h[illegible] alive on Dec 2 1921, and that death occurred on the date stated above, at Night M!

The CAUSE OF DEATH* was as follows:

Suicide, Inhaled Gas

(Duration) 2 Yrs. ..... mos. ..... ds.

Contributory (Secondary) Insan.

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) O. W. Dee M. D.

12/5 1921 (Address) Shoshone Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Shoshone — DATE OF BURIAL: Dec 5 1921

20. UNDERTAKER: O. J. Brennan — ADDRESS: Shoshone

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1

Registration District No. 15

Primary Registration District No.

File No. 37350

Registered No.

1. PLACE OF DEATH

County of Valley

City of Norwood

(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Margaret Balsh

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): single

6. DATE OF BIRTH: Sept (Month) 4 (Day) 1919 (Year)

7. AGE: 2 Yrs. 3 Mos. 20 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Valley Idaho

10. NAME OF FATHER Earl B. Balsh

11. BIRTHPLACE OF FATHER (State or Country) Nebr.

12. MAIDEN NAME OF MOTHER not known

13. BIRTHPLACE OF MOTHER (State or Country) Nebr.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Rev. E. E. McClintick

(Address) Roseberry Idaho

15.

Filed 19

Stella Cain
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 24 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 19 , to 19 , that I last saw h alive on 19 , and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Bronchitis

(Duration) Yrs. mos. 2 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

19 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: McCall.

DATE OF BURIAL: Dec 27 1921.

20. UNDERTAKER: D. M. Fleming

ADDRESS: Cascade, Ida

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Valley

City of McCall

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No. , St.)

File No. 37351

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John McConkey

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Totally Single

6. DATE OF BIRTH: Not Known (Month) (Day) (Year)

7. AGE: 70+ Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Timber Jack

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Not Known

10. NAME OF FATHER: Not Known

11. BIRTHPLACE OF FATHER (State or Country): Not Known

12. MAIDEN NAME OF MOTHER: Not Known

13. BIRTHPLACE OF MOTHER (State or Country): Not Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) G E Hoggle

(Address) Cascade

15. Filed 19 Stella Cain Deputy Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 28 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9-26 1921, to 9-28 1921, that I last saw h alive on 19, and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Totally Pneumonia

Exposure

(Duration) Yrs. mos. 4 ds.

Contributory (Secondary): old age

(Duration) yrs. mos. ds.

(Signed) G E Hoggle M. D.

9-29 1921 (Address) Cascade

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death? Logging Camp

Former or usual residence Not Known

19. PLACE OF BURIAL OR REMOVAL: McCall — DATE OF BURIAL: 11/30 1921

20. UNDERTAKER: Johnson — ADDRESS: McCall

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 37352
Registered No.

1. PLACE OF DEATH
County of Valley
City of Cascade (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 15
Primary Registration District No.

2. FULL NAME Clyde C Gowan

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Not Known ..... 1 (Month) (Day) (Year)

7. AGE: 20 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Truck driver
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Not Known

11. BIRTHPLACE OF FATHER (State or Country): Not Known

12. MAIDEN NAME OF MOTHER: Not Known

13. BIRTHPLACE OF MOTHER (State or Country): Not Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C E Hoggle
(Address) Cascade Ida

15.
Filed ..... 19.....
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 8 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 6-7 1921, to 6-8 1921 that I last saw h[illegible] alive on 6-8 1921 and that death occurred on the date stated above, at 4 A.M.

The CAUSE OF DEATH* was as follows:
Accidental Injury
(Duration) 12 hrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) C E Hoggle M. D.
19..... (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Salt Lake Utah — DATE OF BURIAL: June 1921
20. UNDERTAKER: Summers & Turk — ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 37461

Registered No.

RECEIVED APR 21 1922 BUREAU OF VITAL STATISTICS

Registration District No.

Primary Registration District No. 33

1. PLACE OF DEATH

County of Bear Lake

City of St Charles (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Maxwell Gardner Pugmire

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH: May (Month) 13 (Day) 1916 (Year)

7. AGE: Yrs. 4 Mos. 8 ds. 26

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: X
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) St Charles, Ida.

10. NAME OF FATHER H. Matthew Pugmire

11. BIRTHPLACE OF FATHER (State or Country) Paris, Ida.

12. MAIDEN NAME OF MOTHER Grace E. Gardner

13. BIRTHPLACE OF MOTHER (State or Country) Fish Haven Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H. Matthew Pugmire
(Address) St Charles Ida

15. Filed April 1922 John Mattson Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 8 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Pneumonia.

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) L. Dutton M. D.

19..... (Address) Paris Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: St Charles — DATE OF BURIAL: Feb 11 1921

20. UNDERTAKER — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

OCT 4 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No.....

County of.....

Primary Registration District No.....

File No. 37474

City of.....

(No....., ...St.)

Registered No.....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Joe Strzelecki

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Don't know (Month) (Day) (Year)

7. AGE: about 36 years ....Yrs. ....Mos. ....ds.

IF LESS than 1 day how many....hrs. or....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Logger

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Poland

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. E. Hunt

(Address) St. Maries

15. Filed Oct 4 1921 — F. W. Almond, Local Registrar — Clerk

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 21 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....19...., to ....19....,

that I last saw h.... alive on ....19....,

and that death occurred on the date stated above, at ....M.

THE CAUSE OF DEATH* was as follows:—

Struck by log which fell on him struck & broke neck

....(Duration) ....Yrs. ....mos. ....ds.

Contributory (Secondary)

....(Duration) ....Yrs. ....mos. ....ds.

(Signed) Chas R. Mowry Coroner

....19.... (Address) Wallace Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death....yrs....mos....days. In the State....yrs....mos....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL ....19....
20. UNDERTAKER W. E. Hunt	ADDRESS St Maries

FORM V. S. No. 5-A--25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3758

1. PLACE OF DEATH
County of Canyon
City of Nampa
If death occurs away from usual residence, give facts called for under special information.

Registration District No. .....
Registrar's Registration District No. 2229
(No. ....., ... St.)
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Peter Adams

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Feb. (Month) 24 (Day) 1837 (Year)

7. AGE: 84 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): N. Y.

10. NAME OF FATHER: Adams

11. BIRTHPLACE OF FATHER (State or Country): .....

12. MAIDEN NAME OF MOTHER: .....

13. BIRTHPLACE OF MOTHER (State or Country): .....

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E E Allen
(Address) Nampa

15.
Filed April 15 1922 Pearle Smith
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 10 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 20 1921, to June 10 1921, that I last saw h[illegible] alive on June 9 1921, and that death occurred on the date stated above, at 6 A.M.

CAUSE OF DEATH* was as follows:
[illegible] Cancer of Prostate.
(Duration) One Yrs. ~ mos. ~ ds.
Contributory (Secondary) .....
(Duration) ~ yrs. ..... mos. ..... ds.

(Signed) Horace P Belknap M. D.
19..... (Address) Nampa Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rockerlawn Cem — DATE OF BURIAL: June 12 19[illegible]
20. UNDERTAKER: Fred K Robinson — ADDRESS: Nampa Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

B

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED APR 21 1922 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 37589
Registered No.

1. PLACE OF DEATH
County of Canyon
City of Nampa
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 7
Primary Registration District No. 1056
(No. ..... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Don R. Stoddard

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: June (Month) 25 (Day) 1874 (Year)

7. AGE: 47 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Pioneer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Minn.

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country): Geo. D. Stoddard

12. MAIDEN NAME OF MOTHER: Susie Willey

13. BIRTHPLACE OF MOTHER (State or Country): Mass.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Christina Stoddard
(Address) Cor. 11th & 1st So.

15. Filed April 10 1922 Pearle Dodds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 25 (Day) 1922 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1920, to June 23 1922 that I last saw him alive on June 24 1922 and that death occurred on the date stated above, at 7 A.M.

The CAUSE OF DEATH* was as follows:
Pulmonary tuberculosis

(Duration) 3 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo. R. Proctor M. D.
April 2, 1922 (Address) Nampa Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Fairlawn Cem	4/27 1922
20. UNDERTAKER	ADDRESS
H. Robinson	Nampa Ida

(Proctor)

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51067

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 37590

Registered No.

RECEIVED APR 27 1922

1. PLACE OF DEATH

Registration District No.

Primary Registration District No.

County of Canyon

City of Nampa

(No.) 116 6th ave south (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Eliza N. Bramlett

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Married

6. DATE OF BIRTH: Feb. 4th 1844
(Month) (Day) (Year)

7. AGE: 77 Yrs. 6 Mos. 18 ds.

IF LESS than 1 day how many..... hrs. or.....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Geo.

10. NAME OF FATHER: Thomas Summers

11. BIRTHPLACE OF FATHER (State or Country): N.C.

12. MAIDEN NAME OF MOTHER: Polly Ensly

13. BIRTHPLACE OF MOTHER (State or Country): N.C.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs John Sites
(Address) Nampa, Ida.

15. Filed April 13 1922 Earl Chilton
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug. 22, 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1921, to Aug 19 1921
that I last saw her alive on Aug 19 1921
and that death occurred on the date stated above, at a M.
The CAUSE OF DEATH* was as follows:
Carcinoma uterus, bladder etc.

(Duration) 1 Yrs. 3 mos. — ds.

Contributory (Secondary) —

(Duration) yrs. mos. ds.

(Signed) Horace P Belknap M. D.

8/23/21 (Address) Nampa, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Kohlerlawn Cemetery Nampa, Ida.

DATE OF BURIAL: Aug 24 1921

20. UNDERTAKER: F. H. Tedrow

ADDRESS: Nampa Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Chilton

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
APR 21 1922
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Duplicate

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 76

County of Custer

Primary Registration District No. 2153

File No. 37623

City of Mackay (No. ....., ... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charles alden white

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	white	single

6. DATE OF BIRTH: Feb. (Month) 24 (Day) 1917 (Year)

7. AGE: 2 Yrs. 7 Mos. 29 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Salt Lake city Utah

10. NAME OF FATHER: Dudley a white

11. BIRTHPLACE OF FATHER (State or Country): Mich.

12. MAIDEN NAME OF MOTHER: Rose Marie Powers

13. BIRTHPLACE OF MOTHER (State or Country): Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Dudley A White
(Address) Salt Lake Utah

15. Filed 4/17 1922 Rose Nourse
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: October (Month) 23 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 10 1921, to Oct 23 1921, that I last saw him alive on Oct 23 1921, and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Acute Nephritis.
Toxemia

..... (Duration) ..... Yrs. ..... mos. 3 ds.

Contributory (Secondary) Acute Tonsillitis

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Carroll A. B. Jensen M. D.

10/24 1921. (Address) Mackay Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mackay Ida. DATE OF BURIAL ..... 19.....

20. UNDERTAKER ..... ADDRESS .....

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 37625
Registered No.

RECEIVED
APR 21 1932
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 76
County of Custer
Primary Registration District No. 2153
City of Mackay (No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Maggie M. Weiler

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
F.	W.	Married

6. DATE OF BIRTH: May (Month) 1 (Day) 1868 (Year)

7. AGE 53 — 54 Yrs. 6 Mos. 8 ds. — IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Sacramento - Cal

10. NAME OF FATHER: Robert M. Household

11. BIRTHPLACE OF FATHER (State or Country): Penn.

12. MAIDEN NAME OF MOTHER: Margaret Stewart

13. BIRTHPLACE OF MOTHER (State or Country): Penn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jesse Bricker
(Address) Mackay Idaho

15. Filed 4/17 1932 — Rose Maxwell, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 9 (Day) 1932 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 4 1932, to Jan 9 1932, that I last saw h.. alive on Jan 9 1932, and that death occurred on the date stated above, at 2:30 A.M.
The CAUSE OF DEATH* was as follows:

Apoplexy
(Duration) ..... Yrs. ..... mos. 5 ds.
Contributory (Secondary) Endocarditis, Myocarditis
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Carl Jensen M. D.
19..... (Address) Mackay Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL 19.....
20. UNDERTAKER	ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED APR [illegible] Not Amended
JAN 10 [illegible]
BUREAU OF [illegible]

CERTIFICATE OF DEATH

Registration District No. 28
Primary Registration District No. 2176

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 37652
Registered No. 2692

1. PLACE OF DEATH
County of Jefferson
City of ..... (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Ann Butler
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Feby. 20 1843 (Month) (Day) (Year)

7. AGE: 79 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: at Home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: Joseph Thompson

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Eliz. Kennell

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. H. Butler
(Address) Idaho Falls

15. Filed 4-10 1922 Ray H. Finch Local Registrar
L. Hatch

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec 9 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 9 1921, to Nov 15 1921 that I last saw h[illegible] alive on Nov 15 1921 and that death occurred on the date stated above, at 10 a M.

The CAUSE OF DEATH* was as follows:
Chronic valvular endocarditis.
(Duration) X Yrs. ..... mos. ..... ds.
Contributory (Secondary) Anuria, colloid goitre
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
19..... (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Idaho Falls, Ida. DATE OF BURIAL: Dec 11 1921

20. UNDERTAKER: C. E. Underwood ADDRESS: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 23

County of Jerome Primary Registration District No. 1017-2017

City of Jerome (No. ....., ... St.)

File No. 37666

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)
M.	W	

6. DATE OF BIRTH: April (Month) 23 (Day) 1920 (Year)

7. AGE: ..... yrs. ..... mos. 1 ds. IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Jerome, Ida

10. NAME OF FATHER Clyde O. Bragg

11. BIRTHPLACE OF FATHER (State or Country) Michigan

12. MAIDEN NAME OF MOTHER Amelia M. Heuer

13. BIRTHPLACE OF MOTHER (State or Country) Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. F. Teller
(Address) Jerome Ida

15. Filed Apr 27 1922 E. D. Pyle M.D. Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: April (Month) 23 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 23 1921, to Apr. 23 1921, that I last saw h..... alive on ..... 191..., and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Breech Presentation
Prolapsus funi
Still Born

(Duration) ..... yrs. ..... mos. 1 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. F. Teller M. D.

4/23 1921 (Address) Jerome Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs .....mos .....days. In the State .....yrs .....mos .....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Jerome Cemetery — DATE OF BURIAL: Apr 23 1921

20. UNDERTAKER: D. A. L. Heuer — ADDRESS: Jerome Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 37667
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Jerome — Registration District No. 23
City of Jerome — Primary Registration District No. 1017-2017
If death occurs away from usual residence, give facts called for under special information. (No. ..... St.)

2. FULL NAME Lela W Lee

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Infant

6. DATE OF BIRTH. apr 12 21
(Month) (Day) (Year)

7. AGE ..... Yrs. ..... Mos. 13- ds.
IF LESS than 1 day how many .... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Jerome Idaho

10. NAME OF FATHER: Harvey Lee

11. BIRTHPLACE OF FATHER (State or Country): Wyo.

12. MAIDEN NAME OF MOTHER: Hazel White

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) .....
(Address) Emerson White

15. Filed apr 28 1921 — E. D. Pyle M.D. Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH apr 22 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from apr 12 1921 to apr 22 1921
that I last saw her alive on apr 22 1921
and that death occurred on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:

Premature Birth

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) E. D. Pyle M.D. M. D.
4/28 1921 (Address) Jerome Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Jerome Cemetery — DATE OF BURIAL: apr 28 1921

20. UNDERTAKER: Henry White (grandfather) — ADDRESS: Jerome Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED APR 6 1922 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 65

Primary Registration District No. 2145

File No. 37691

County of Latah.

City of Potlatch (If outside limits of city or village, give township.) St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Franklin H Berry.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1841 (Year)

7. AGE: 80 Yrs. 7 Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer.

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Not Known

11. BIRTHPLACE OF FATHER (State or Country): .....

12. MAIDEN NAME OF MOTHER: .....

13. BIRTHPLACE OF MOTHER (State or Country): .....

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Moses L. Berry

(Address) Potlatch. Ida

15. Filed March 20th 1922 J. Jr. Thompson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov 24 (Month) (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased ~~from~~ on Nov 1 1921, to ..... 19..., that I last saw ~~him~~ alive on Nov 1 1921, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency.

(Duration) Many Yrs. — mos. — ds.

Contributory (Secondary) .....

(Duration) — yrs. — mos. — ds.

(Signed) E. K. Wolf (M. D.)

Nov 24 1922 (Address) Palouse, Wn.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Palouse Cem. | DATE OF BURIAL: Nov 26 1922

20. UNDERTAKER: E. M. Irwin | ADDRESS: Palouse Wash

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

RECEIVED APR 1 1922 BUREAU OF STATISTICS

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 19
Primary Registration District No. 2015
File No. 37717
Registered No. 1

1. PLACE OF DEATH.
County of Minidoka
City of Acequia
(If death occurs away from usual residence, give facts called for under special information.)
No. ..... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Reva Brewerton

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Jan. (Month) 13 (Day) 1912 (Year)

7. AGE: 9 Yrs. 11 Mos. 12 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Jackson Ida

10. NAME OF FATHER: Albert Chas. Brewerton

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Pearl Montgomery

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Chas A. Brewerton
(Address) Acequia

15.
Filed 12-29 1921
E. T. Edmonson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Dec. (Month) 29 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 19 1921, to Dec. 29 1921, that I last saw her alive on Dec. 28 1921, and that death occured on the date stated above, at 3 a. M.

The CAUSE OF DEATH* was as follows:
Acute Peritonitis (General)

(Duration) Yrs. mos. 4 ds.
Contributory (Secondary) Acute Appendicitis
(Duration) yrs. mos. 6 ds.

(Signed) E. T. Edmonson M. D.
1921 (Address) Rupert, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL 191...

20. UNDERTAKER: Alvin Keller | ADDRESS: Rupert

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24853

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 123
Primary Registration District No.
File No. 37795
Registered No. 41

1. PLACE OF DEATH
County of Shoshone
City of Kellogg
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lila Juntti

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F.	White	Single

6. DATE OF BIRTH: Feb (Month) 14 (Day) 1922 (Year)

7. AGE: ..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: at Home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kingston

10. NAME OF FATHER: Chas. Juntti

11. BIRTHPLACE OF FATHER (State or Country): Finland

12. MAIDEN NAME OF MOTHER: Hilma Saylor

13. BIRTHPLACE OF MOTHER (State or Country): Finland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chas Juntti
(Address) Kingston Idaho

15. Filed Jan 28 – 1922 E E Hardy Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 31 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19....., to ..... 19.....,
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows: Meningitis Tuberculosis

(Duration) ..... Yrs. 10 mos. ..... ds.
Contributory (Secondary) Colitis enteritis
(Duration) ..... yrs. ..... mos. 14 ds.

(Signed) W. C. Lindsay M. D.
1/3 1922 (Address) Kellogg Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Kingston Idaho.	Jan 3 1922
20. UNDERTAKER: M. C. Shanahan	ADDRESS Kellogg Idaho.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19. Copied

CERTIFICATE OF DEATH

RECEIVED NOV 3 1927 BUREAU OF VITAL STATISTICS

RECEIVED DEC 1 1927 BUREAU OF VITAL STATISTICS

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 12

County of Boise Primary Registration District No. 12

File No.

City of Idaho (Not within city limits, write "Rural" and give name of township, St.)

Registered No. 37958

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ah Sue.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	Colored	

6. DATE OF BIRTH ..... 1 .....
(Month) (Day) (Year)

7. AGE about 75 Yrs. ..... Mos. ..... ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Miner.
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) China

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15. Filed Nov 28 1927 Mrs Ed Robison
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH about Nov 10 19 .....
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
found dead
a
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
..... 19..... (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Idaho	..... 19.....
20. UNDERTAKER	ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19. Grade 5

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 37959
Registered No. 18

RECEIVED
DEC 10 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
Registration District No. 16
Primary Registration District No. 16
County of Boise
City of Horse Shoe Bend (If outside limits, give township) St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James Casner.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: May - 20 - 1840 (Month) (Day) (Year)

7. AGE: 81 Yrs. 6 Mos. 6 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE: Cincinnati Hamilton Co. Ohio. (State or Country)

10. NAME OF FATHER: Josiah Casner.

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER: Anna Penton

13. BIRTHPLACE OF MOTHER: New Jersey (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) B. E. Casner
(Address) Horse Shoe Bend Ida

15. Filed Dec 9th 1921 Mrs E S Robison. Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH 175°C

16. DATE OF DEATH: Nov 26 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows: accident
Run over by auto, stepped behind car then the driver backed up and run over him. died instantly.
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) ..... M. D.
..... 19..... (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
~~Former or~~ usual residence Horse Shoe Bend Idaho.

19. PLACE OF BURIAL OR REMOVAL: Horse Shoe Bend — DATE OF BURIAL: Nov 28 1921

20. UNDERTAKER — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 37998
Registered No.

RECEIVED
MAY 23 1922
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
Registration District No. 7
County of Canyon
Primary Registration District No. 1334
City of Nampa (Ward) St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Frederick C. Michener

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH
Oct (Month) 4 (Day) 1843 (Year)

7. AGE
78 Yrs. 1 Mos. 11 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Tent + Awning Maker
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Maine

10. NAME OF FATHER unknown

11. BIRTHPLACE OF FATHER (State or Country) Me

12. MAIDEN NAME OF MOTHER unknown

13. BIRTHPLACE OF MOTHER (State or Country) Me

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) X F. C. Michener
(Address) Nampa, Ida

15.
Filed May 23 1922
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Dec (Month) 15 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 19 1921, to Dec 15 1921
that I last saw him alive on Dec 15 1921
and that death occurred on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:
Acute Dilitation of Heart

(Duration) Yrs. mos. 7 ds.
Contributory (Secondary) Hypertrophy, Mitral + Tricuspid Murmur
(Duration) 15 yrs. — mos. — ds.

(Signed) Leo W Chilton M. D.
5/10 1922 (Address) Leo W Chilton Nampa Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ...yrs...mos...days. In the State ...yrs...mos...days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Kohlenberg Cem	Dec 18 1921
20. UNDERTAKER	ADDRESS
Fred T Robinson	Nampa

(Chilton)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. XVIII
Registered No. 2

RECEIVED JUN 8 1921 STATE BOARD OF HEALTH

Registration District No. 17
Primary Registration District No. 2197
38029

1. PLACE OF DEATH
County of Cassia
City of Oakley
If death occurs away from usual residence, give facts called for under special information.

(No. 307 E. 2nd S. Oakley Ida. St.)

2. FULL NAME William Geo. Schiefer

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE:

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.):

6. DATE OF BIRTH. Oct. (Month) 28 (Day) 1885 (Year)

7. AGE 36 Yrs. 1 Mos. 22 ds.
IF LESS than 1 day how many .... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): Druggist

9. BIRTHPLACE (State or Country): West Point Nebraska

10. NAME OF FATHER: Adam Schiefer

11. BIRTHPLACE OF FATHER (State or Country): Iowa.

12. MAIDEN NAME OF MOTHER: Dorthy Fischer.

13. BIRTHPLACE OF MOTHER (State or Country): Germany. Nebraska

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Mable Schiefer
(Address): Oakley Ida. R.F.D. #

15. Filed June 1 1921 — M. D. Nelson, Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 12 (Month) 20 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 18 1921 to Dec 20 1921 that I last saw h[illegible] alive on Dec 20 1921 and that death occurred on the date stated above, at 7:30 P.M.

The CAUSE OF DEATH* was as follows:

Ulcer of Stomach

(Duration) Long Time Unknown ds.

Contributory (Secondary): .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) M. D. Nelson M. D.

12-23-1921 (Address) Oakley Idaho

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: St Charles Nebr. — DATE OF BURIAL: 12/27/1921

20. UNDERTAKER: L B Talboys — ADDRESS: Burley Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

38030

State of Idaho
BOARD OF ~~HEALTH~~
Bureau of Vital Statistics

CERTIFICATE OF DEATH

RECEIVED JUN 8 1922 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Cassia

City of Oakley

(No. ..... St.)

Registration District No. .....

Primary Registration District No. 2-199

File No. X 4611

Registered No. 17

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Joseph Alma Read

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): single

6. DATE OF BIRTH: Feb (Month) 19 (Day) 1906 (Year)

7. AGE: 15 Yrs. 4 Mos. 26 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Sheepherder

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: James Read

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Miss Sorenson

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) James Read

(Address) Oakley Idaho

15. Filed June 1st 1922

W. T. Wheelan
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 19 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....

that I last saw h..... alive on ..... 19.....

and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Dr Doctor

Shot himself

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Ben Kendall M. D.

19..... (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Oakley Idaho

DATE OF BURIAL: Sept 21 19 22

20. UNDERTAKER: Bp. Rumney

ADDRESS: Oakley Id

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED MAY 22 1922 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 19

County of Minidoka Registration District No. 2015

City of Minidoka St.)

File No. 3860

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Reader

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Fem	White	Widowed

6. DATE OF BIRTH: Jan (Month) 8 (Day) 1837 (Year)

7. AGE: 84 Yrs. 11 Mos. 14 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: House Wife

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Vermont

10. NAME OF FATHER: John McDonnald

11. BIRTHPLACE OF FATHER (State or Country): Vermont

12. MAIDEN NAME OF MOTHER: Martha McDonnald

13. BIRTHPLACE OF MOTHER (State or Country): Vermont

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Fannie Bolton

(Address) Minidoka Idaho

15. Filed 4-10 1922 E H Elmore Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 22 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 18 1922 to Dec. 21 1922 that I last saw her alive on Dec. 21 1922 and that death occurred on the date stated above, at 9 A. M.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart disease

(Duration) 5 Yrs. mos. ds.

Contributory (Secondary) Chronic Interstitial Nephritis

(Duration) yrs. mos. ds.

(Signed) E H Elmore M. D.

19..... (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rupert Cemetery — DATE OF BURIAL: Dec 19 24

20. UNDERTAKER: W. G. Goodman — ADDRESS: Rupert

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51068

Form 38161 L

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
MAY 25 1922
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 19
Primary Registration District No. 2015

File No. 38161
Registered No.

1. PLACE OF DEATH

County of Minidoka
City of Rupert (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Maney Viola Mix

If death occurred in a hospital, institution or camp, give its NAME instead of street and number. 10

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Fem	White	Married

6. DATE OF BIRTH: Jan (Month) 26 (Day) 1873 (Year)

7. AGE: 48 Yrs. 11 Mos. 3 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House Wife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) M. E. Mix
(Address) Rupert Idaho

15. Filed Apr. 16 1922 Ed. H. Elmore Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 29 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 20 1921 to Dec 29 1921 that I last saw h-- alive on Dec 29 1921 and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Influenza - Pneumonia

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) C. H. Gooch M. D.

4/19 1922 (Address) Rupert

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rupert Cemetery — DATE OF BURIAL: Jan 2 1922

20. UNDERTAKER: W. A. Goodman — ADDRESS: Rupert

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19 Copy Original Sent to U. S. Rackay

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 121

Primary Registration District No. 2194

File No. 38387

County of B

City of Bonanza (No. ..... St.)

Registered No. 90

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James V. Little

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

RECEIVED JUL 1 1932 BUREAU OF VITAL STATISTICS

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): S

6. DATE OF BIRTH: March 31 (Month) (Day) 1887 (Year)

7. AGE: 14 Yrs. 7 Mos. 3 ds.

IF LESS than 1 day how ~~many~~ ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Geo M. Little

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Lucia Leigh

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Lidia Little
(Address): Bonanza

15. Filed June 20 1932 Mr. Walter E. Peters Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov 2 (Month) (Day) 1932 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11-2 1932 to 11-2 1932
that I last saw h~~e~~ alive on 11-2 1932
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows: Lupus Peritonitis

(Duration) ..... Yrs. ..... mos. 2 ds.
Contributory (Secondary): Appendicitis
(Duration) ..... yrs. ..... mos. 6 ds.

(Signed) Edwin Cutler M. D.
6/20 1932 (Address) Shelley Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. 3 days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? Utah Bonanza Idaho
Former or usual residence Bonanza

19. PLACE OF BURIAL OR REMOVAL: Woodruff Cem | DATE OF BURIAL: Nov 4 1932

20. UNDERTAKER: None employed | ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 2170
File No. 38413
Registered No. 62

1. PLACE OF DEATH
County of Bonneville
City of Iona (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Vera C Crofts

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Child

6. DATE OF BIRTH: Dec (Month) 21 (Day) 1917 (Year)

7. AGE: 4 Yrs. 11 Mos. 6 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Iona Ida

10. NAME OF FATHER: W. D Crofts

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Margaret E. Crofts

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. D Crofts
(Address) Iona, Ida

15. Filed 6/14 1922 Edgar Truman Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 27 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....
and that death occurred on the date stated above, at 6:30 A.M.
The CAUSE OF DEATH* was as follows:
Pneumonia

..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) —
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Wm J Truman M. D.
6/14 1922 (Address) Iona Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Iona, Idaho — DATE OF BURIAL: 11/28 1921

20. UNDERTAKER: C E Dunwoody — ADDRESS: Ion Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Dan Mellor
Dan Mellor Teacher

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 13
Primary Registration District No. 2170
File No. 3844
Registered No. 63

1. PLACE OF DEATH,
County of Bonneville
City of Idaho Falls
(No. 1/2 mile S. Idaho Falls St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Michael Lloyd.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widower

6. DATE OF BIRTH: Feb. (Month) 9 (Day) 1848 (Year)

7. AGE: 88 Yrs. ... Mos. ... ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ireland.

10. NAME OF FATHER: Jno Lloyd

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Dont Know.

13. BIRTHPLACE OF MOTHER (State or Country): Ireland.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. P. Lloyd
(Address) Idaho Falls

15. Filed 6/14 1922 C. E. Tussing M. D. Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. (Month) 11 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ... 19..., to ... 19...
that I last saw h... alive on ... 19...,
and that death occurred on the date stated above, at ... M.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
...(Duration) ... Yrs. ... mos. ... ds.
Contributory (Secondary)
...(Duration) ... yrs. ... mos. ... ds.
(Signed) C. E. Tussing M. D.
6/14 1922 (Address) Idaho Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rose Hill Cemetery — DATE OF BURIAL: Sept 14 1921

20. UNDERTAKER: Jeff Hayes — ADDRESS: Idaho Falls

W. Wilson

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

38473

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. X V 141
Registered No. 1

1. PLACE OF DEATH

Registration District No. 122
Primary Registration District No. 247

County of Cassia
City of Oakley (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Clarissa Layton

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): single

6. DATE OF BIRTH: Nov (Month) 9 (Day) 1912 (Year)

7. AGE: 9 Yrs. 0 Mos. 16 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Girl at home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Chauncey N. Layton

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Josephine Raddon

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chauncey N. Layton
(Address) Oakley Ida.

15. Filed May 29 1922 — Local Registrar

MEDICAL CERTIFICATE OF DEATH

120

16. DATE OF DEATH: Dec. (Month) 31 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 28 1921, to Dec 31 1921
that I last saw her alive on Dec 31 1921
and that death occurred on the date stated above, at 9 P.M.
The CAUSE OF DEATH* was as follows:

Nephritis

(Duration) 9 Yrs. 0 mos. 16 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

5/29 1922 (Signed) N. A. Nielson M. D. (Address) Oakley Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Oakley Cemetery — DATE OF BURIAL: 6-2-1923

20. UNDERTAKER: By Thos. Clark — ADDRESS: Oakley Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED JUN 27 1922 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 76

County of Custer Primary Registration District No. 2153 File No. 38485

City of Darlington (No. ..... St.) Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Amanda Missouri Brown

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. June (Month) 18 (Day) 1854 (Year)

7. AGE: 67 Yrs. 6 Mos. 2 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: Louis Mourning

11. BIRTHPLACE OF FATHER (State or Country): Kentucky

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) [signature]
(Address) [illegible] Idaho

15. Filed 6/26 1922 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH 79

16. DATE OF DEATH
12 (Month) 20 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12/20 1921, to 12/20/21 191, that I last saw her alive on 12/20/21 191, and that death occured on the date stated above, at 7 P M.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(Duration) 3 Yrs. mos. ds.

Contributory (Secondary) Chronic Nephritis

(Duration 3 yrs. mos. ds.

(Signed) F. P. Richards M. D.

12/28 1921 (Address) Marsing Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL 191

20. UNDERTAKER | ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYMS - YORK CO., PTRS. & BDRS. 24658

V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 38601

Registered No.

1. PLACE OF DEATH

Registration District No. 128

Primary Registration District No.

County of Nez Perce

City of Near Culdesac Ida (No. Culdesac & Vicinity St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William (Pike) Gilfray

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Red

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1873 (Year)

7. AGE: 48 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: William Gilfray

11. BIRTHPLACE OF FATHER (State or Country): Not Known

12. MAIDEN NAME OF MOTHER: Sum-Mikei

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Edward Bronchean

(Address) Culdesac Idaho

15. Filed Dec. 1922 George Gaignard Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. (Month) 5 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased ~~from~~ Dec 4 1921, to Dec 4 1922 that I last saw him alive on Dec 4 1921, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

..... (Duration) ..... Yrs. ..... mos. 21 ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) George Gaignard M. D.

June 1921 (Address) Culdesac Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) *Means of Injury*; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Near Culdesac Ida. DATE OF BURIAL: Dec 7 1921

20. UNDERTAKER ..... ADDRESS .....

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Killen

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 38763

Registered No. 35

1. PLACE OF DEATH. Registration District No. 19

County of Minidoka Primary Registration District No. 2015

City of ..... No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

BUREAU OF VITAL STATISTICS

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Pearl Kelley

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: Colored

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE: 39 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Texas

10. NAME OF FATHER: Not Known

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) .....

15. Filed 8-2 1922 E. H. Elmore / Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 7 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. A. Goodman M. D.

19... (Address) Coroner

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL ..... 191...

20. UNDERTAKER | ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24653

FORM V. S. No. 5-25 M. 1-19.

38765

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED JUN 20 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH — Registration District No. 624

County of Cassia — Primary Registration District No. 249

City of Oakley — (or Village or Township) — St.)

File No. XVIII

Registered No. 79

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Emma Hunt-Lewis

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): married

6. DATE OF BIRTH: June (Month) 3 (Day) 88 (Year)

7. AGE: 39 Yrs. 9 Mos. 20 ds. — IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: John Dehnke

11. BIRTHPLACE OF FATHER (State or Country): don't know

12. MAIDEN NAME OF MOTHER: Elizabeth Bennett

13. BIRTHPLACE OF MOTHER (State or Country): don't know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Rene Adams
(Address): Oakley Ida

15. Filed June 15 19 22 — A. O. Nielson, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 28 (Day) 19 21 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 28 19 21, to April 4 19 ..., that I last saw h... alive on ... 19 ..., and that death occurred on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:
Carcinoma of Breast
no Doctor in attendance
(Duration) ... Yrs. ... mos. ... ds.
Contributory (Secondary) For last 3 weeks
(Duration) ... yrs. ... mos. ... ds.

(Signed) A. O. Nielson M.D.
June 15 19 22 (Address) Oakley Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Oakley Ida — DATE OF BURIAL: June 19 21

20. UNDERTAKER: Rene Adams — ADDRESS: Oakley Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED
JUN 20 1922
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH 38766

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 30

County of Cassia

Primary Registration District No. 217

City of Oakley (If outside limits, give township) St.)

File No. X 6111

Registered No. 18

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John A. Lee

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): married

6. DATE OF BIRTH: February (Month) 15 (Day) 1865 (Year)

7. AGE: 57 Yrs. 2 Mos. 22 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: John D. Lee

11. BIRTHPLACE OF FATHER (State or Country): Don't Know

12. MAIDEN NAME OF MOTHER: Ann George

13. BIRTHPLACE OF MOTHER (State or Country): Don't Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Rose Adams
(Address): Oakley Idaho

15. Filed June 15 1922 — J. O. Nelson, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 7 (Day) 1922 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 1, 1922, to May 7, 1922, that I last saw h— alive on May 7, 1922, and that death occurred on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:

Pernicious Anemia

(Duration) 2 Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. O. Nelson M. D.

June 15 1922 (Address) Oakley Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Oakley — DATE OF BURIAL: May 9 1922

20. UNDERTAKER: Geo. Adams — ADDRESS: Oakley Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

38810

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

1. PLACE OF DEATH
County Nez Perce Reservation State Idaho Registered No. 2
Township Lapwai, Idaho. or Village or
City No. St., Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Myra Lawyer,

(a) Residence. No. Lapwai, Idaho. St., Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

8—209 d
V. S. No. 98

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Female	Indian	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ------

6 DATE OF BIRTH (month, day, and year) 12-7-1919

7 AGE	Years	Months	Days	If LESS than 1 day, ---- hrs. or ---- min.
	2			

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work ------
(b) General nature of industry, business, or establishment in which employed (or employer) ------
(c) Name of employer

9 BIRTHPLACE (city or town) Nez Perce Res.
(State or country) Idaho

PARENTS
10 NAME OF FATHER Joseph Lawyer,
11 BIRTHPLACE OF FATHER (city or town) Nez Perce Res
(State or country) Idaho
12 MAIDEN NAME OF MOTHER Amanda Jones
13 BIRTHPLACE OF MOTHER (city or town) Umatilla Res.
(State or country) Oregon

14 Informant Minnie Newton, Aunt,
(Address) R.F.D.Pendleton, Oregon.

15 Filed 1/30, 1922 Mary M. Headley
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 19, 1921.

17 I HEREBY CERTIFY, That I attended deceased from June 7—, 1921, to June 15—, 1921, that I last saw h-- alive on June 15, 1921, and that death occurred, on the date stated above, at ----m.

The CAUSE OF DEATH* was as follows:
✓ pneumonia Pneumonia

(duration) yrs. mos. 15 ds.

CONTRIBUTORY (SECONDARY)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? George Gainard

(Signed) George Gainard, M. D.
, 19 (Address) Culdesac, Idaho.

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Sweewater Ind. Cemetary	6-20-21 19
20 UNDERTAKER	ADDRESS
J.N.W ann	Lapwai, Idaho

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 38838

Registered No.

1. PLACE OF DEATH

Registration District No. 39

County of Twin Falls

Primary Registration District No. 2087

City of Burley (If outside limits, give township) No. (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Verna Van Patten

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Aug. (Month) 8 (Day) 1898 (Year)

7. AGE: 23 Yrs. 3 Mos. 1 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business or establishment in which employed (or employer) Housewife

9. BIRTHPLACE (State or Country) Iowa

10. NAME OF FATHER R. D. Lee

11. BIRTHPLACE OF FATHER (State or Country) Iowa

12. MAIDEN NAME OF MOTHER Dent Knaus

13. BIRTHPLACE OF MOTHER (State or Country) ✓ ✓

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. F. Van Patten

(Address) Burley Ida

15. Filed 6-12 1922 J. F. Murphy Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

82

16. DATE OF DEATH Nov. (Month) 9 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11-6-1921, to 11-9-1921, that I last saw h.er alive on 11-9-1921, and that death occurred on the date stated above, at 3a M.

The CAUSE OF DEATH* was as follows:

Embolismus following labor.

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo. Jennings M. D.

11-9 1921 (Address) Burley, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Burley Ida — DATE OF BURIAL: 11-11-1921

20. UNDERTAKER: Homer B. Evans — ADDRESS: Burley Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED OCT 2 19[illegible] BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 8

County of Ada

Primary Registration District No. 2008

City of Boise

(No. Near Lake School St.)

File No. 39168

Registered No. 80

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lois Maud Ragsdale

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Oct 21 – 1913
(Month) (Day) (Year)

7. AGE: 8 Yrs. 10 Mos. 17 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Canyon Co., Idaho.

10. NAME OF FATHER: G. H. Ragsdale

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Anna Armstrong

13. BIRTHPLACE OF MOTHER (State or Country): Iowa.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. McBratney
(Address) Boise Idaho

15.
Filed 9-6 1922 R. H. Pratt
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. 8 – 1921
(Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 4 1922 to Sept 8 1922 that I last saw her alive on Sept 7 1922 and that death occurred on the date stated above, at 11a. M.

The CAUSE OF DEATH* was as follows:

Diphtheria

(Duration) Yrs. mos. 6 ds.

Contributory (Secondary) Post diphtheritic heart failure

(Duration) yrs. mos. 1 ds.

(Signed) M. B. Tallman M. D.

9/8 1922 (Address) Boise, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery | DATE OF BURIAL: 9/9 1922

20. UNDERTAKER: W. McBratney | ADDRESS: Boise Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 2194
File No. 39235
Registered No. 129

1. PLACE OF DEATH

County of Bingham
City of Woodville (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Thora Tuyson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White.	Married.

6. DATE OF BIRTH: June (Month) - 6 (Day) - 1877 (Year)

7. AGE: 43 Yrs. 2 Mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Home Keeper
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Denmark.

10. NAME OF FATHER: Niels Peter Jorgenson

11. BIRTHPLACE OF FATHER (State or Country): Denmark.

12. MAIDEN NAME OF MOTHER: Maria Jacobsen

13. BIRTHPLACE OF MOTHER (State or Country): Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) .....
(Address) R 4 Idaho Falls

15. Filed Aug - 13 1922 Mrs Nate E. Paterson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) - 10 (Day) - 1921 (Year)

17. I HEREBY CERTIFY, That I ~~attended~~ deceased ~~from~~ called to and ~~saw~~ her about 20 minutes after ~~her~~ ~~10~~ ~~death~~ ~~10~~
~~that I last saw h alive on 19~~
and that death occurred on the date stated above, at 6 45 P.M.

The CAUSE OF DEATH* was as follows:

Not determined
Very sudden
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Bright's disease complicated by Pregnancy
(Duration) ..... yrs. 8½ mos. ..... ds.

(Signed) Edwin Anthe M. D.
8/12 1922 (Address) Shelley Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Woodville Cemetery	8/13 1922
20. UNDERTAKER	ADDRESS
C. E. Dunwoody	Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO. PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 61
Primary Registration District No. 1011
File No. 39396
Registered No. 23

1. PLACE OF DEATH
County of Latah
City of Moscow (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ephrum F Baughman
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Married

6. DATE OF BIRTH: May 2 1835 (Month) (Day) (Year)

7. AGE: 86 Yrs. 6 Mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Steamboat Captain
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ill.

10. NAME OF FATHER: Do not know.

11. BIRTHPLACE OF FATHER (State or Country): "

12. MAIDEN NAME OF MOTHER: "

13. BIRTHPLACE OF MOTHER (State or Country): "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H. C. Thatcher
(Address) Moscow Idaho

15. Filed 12/5/21 W. H. Carruthers Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. 5 1921 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 15 1919, to Dec 5 1921, that I last saw h[im] alive on Nov 30 1921, and that death occurred on the date stated above, at 11 P. M.
The CAUSE OF DEATH* was as follows:
Pyelonephritis
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Due to prostatitis ~~and~~ Infection of the bladder
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Chas. L. Entman M. D.
12/6 1921 (Address) Moscow, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Lewiston Ida. DATE OF BURIAL: Dec 7 1921

20. UNDERTAKER: Glen Grice ADDRESS: Moscow Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 61
Primary Registration District No. 2141
File No. 39397
Registered No. 55

1. PLACE OF DEATH
County of Latah
City of Moscow
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Baby Graves.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F.	W.	Single

6. DATE OF BIRTH Nov. (Month) 29 (Day) 1921 (Year)

7. AGE ..... Yrs. ..... Mos. 12 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Latah Co.

10. NAME OF FATHER Ira Graves.

11. BIRTHPLACE OF FATHER (State or Country) Kansas

12. MAIDEN NAME OF MOTHER Anna McNett.

13. BIRTHPLACE OF MOTHER (State or Country) Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ira Graves
(Address) Moscow Idaho

15. Filed Dec 29 1921 W. S. Carothers Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. (Month) 10 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Toxemia resulting from nursing mother who was infected with Puerperal poisoning.
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Glen Grice, Coroner, M. D.
12/11 1921 (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Moscow	Dec 12 1921
20. UNDERTAKER Glen Grice	ADDRESS Moscow Ida.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 61
Primary Registration District No. 2141
(No. ..... St.)

File No. 39398
Registered No. 24

1. PLACE OF DEATH
County of Latah
City of .....
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Anna Margaret Graves

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
F.	W.	Married

6. DATE OF BIRTH: April 15 (Month) (Day) 1 (Year)

7. AGE: 34 Yrs. 8 Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Kansas

10. NAME OF FATHER: J. McNett.

11. BIRTHPLACE OF FATHER (State or Country): Virginia

12. MAIDEN NAME OF MOTHER: Clara Louder

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ira Graves
(Address) Moscow, Idaho.

15. Filed 12/6 1921 M Hawthorn
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. (Month) 8 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12 a.m. 12/8 1921 to 2:30 P.M. 12/8 1921 that I last saw her alive on Dec 8 1921 and that death occurred on the date stated above, at 2:30 P.M.

The CAUSE OF DEATH* was as follows:
Puerperal infection.

(Duration) Yrs. ..... mos. 6 ds.
Contributory (Secondary) Child birth
(Duration) ..... yrs. ..... mos. 9 ds.

(Signed) J. Harry Erickson M. D.
12/8 1921 (Address) Moscow, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Moscow Idaho	Dec. 10 1921

20. UNDERTAKER	ADDRESS
Glen Grisa	Moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 40000

Registered No.

1. PLACE OF DEATH

County of Ida

City of White Bird

Registration District No.

Primary Registration District No.

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Martha June Jillson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Married

6. DATE OF BIRTH

Feb (Month) 23 (Day) 1866 (Year)

7. AGE

54 Yrs. 4 Mos. 22 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Missouri

10. NAME OF FATHER Eliga Vaden

11. BIRTHPLACE OF FATHER (State or Country) Don't know

12. MAIDEN NAME OF MOTHER Jane Glenn

13. BIRTHPLACE OF MOTHER (State or Country) Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. A. G. Davis

(Address) White Bird

15.

Filed ..... 19 .....

W. A. Foskett
Local Registrar

MEDICAL CERTIFICATE OF DEATH 28

16. DATE OF DEATH

July (Month) 18 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 1920 to July 17 1921 that I last saw her alive on " " 1921, and that death occurred on the date stated above, at — M.

The CAUSE OF DEATH* was as follows:

Tuberculosis

(Duration) 2 Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

19 ..... (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
White Bird	July 19 1921
20. UNDERTAKER	**ADDRESS**
E. S. Hancock	Grangeville

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

8—209 d
V. S. No. 98

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

40132

1 PLACE OF DEATH
County Owyhee State Idaho Registered No.
Township or Village Three Forks or
City No. St., Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Humpy Lamar

(a) Residence. No. St., Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: Indian
5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1902

7 AGE 20 Years | Months | Days | If LESS than 1 day, ---- hrs. or ---- min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Vaquero
(b) General nature of Industry, business, or establishment in which employed (or employer): Running Horses and Cattle
(c) Name of employer Unknown

9 BIRTHPLACE (city or town)
(State or country) Idaho.

PARENTS
10 NAME OF FATHER Humpy John
11 BIRTHPLACE OF FATHER (city or town) Idaho.
(State or country)
12 MAIDEN NAME OF MOTHER Tom Ida.
13 BIRTHPLACE OF MOTHER (city or town) Fort Hall
(State or country) Idaho.

14 Informant
(Address)

15 Filed ----------, 19 ----------
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 12 1921

17 I HEREBY CERTIFY, That I ~~attended~~ did not attend deceased from
----------, 19----, to ----------, 19----,
that I ~~last saw~~ did not see him alive on ----------, 19----,
and that death occurred, on the date stated above, at ----------m.

The CAUSE OF DEATH* was as follows:
Tuberculosis

---------- (duration) ---- yrs. ---- mos. ---- ds.

CONTRIBUTORY (SECONDARY) N

---------- (duration) ---- yrs. ---- mos. ---- ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John I. Rees, M. D.
, 19 (Address) Owyhee Nev.

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Owyhee Nev.	19
20 UNDERTAKER	ADDRESS

FORM V. S. No. 5-12 M. 6-15-17.

RECEIVED
DEC 10 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH 30138

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3
Registered No. 136

1. PLACE OF DEATH
County of Power
City of American Falls,
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 25
Primary Registration District No. 2072
(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Sara McGlothlin

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. April (Month) 7 (Day) 1879 (Year)

7. AGE: 42 Yrs. 10 Mos. 15 ds.
IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ken

10. NAME OF FATHER: Marion Brown

11. BIRTHPLACE OF FATHER (State or Country): Ken

12. MAIDEN NAME OF MOTHER: Permedia Hall

13. BIRTHPLACE OF MOTHER (State or Country): Ken

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. Emc Glothlin
(Address)

15. Filed 12-2 1921 R. T. Voth
Local Registrar.

MEDICAL CERTIFICATE OF DEATH 40

16. DATE OF DEATH Oct. (Month) 22 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 3 1921 to Oct 22 1921 that I last saw her alive on Oct 22 1921 and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:
gastric Carcinoma
(Duration) Yrs. mos. ds.
Contributory (Secondary)
(Duration) Yrs. mos. ds.
(Signed) V. G. Logan M. D.
19.... (Address) American Falls,

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days, In the State....yrs....mos....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Am Falls Ida — DATE OF BURIAL: Oct. 24 1921

20. UNDERTAKER: A W Davis — ADDRESS: Am Falls Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-12 M. 6-15-17.

RECEIVED DEC 10 1921

CERTIFICATE OF DEATH

40139 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3
Registered No. 137
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Power
City of Amerivan Falls, Idaho
(No. ....., ... St.)
Registration District No. 25
Primary Registration District No. 2072
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Gottlieb S. Mayer

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Feb (Month) 12 (Day) 1885 (Year)

7. AGE: 36 Yrs. 8 Mos. 24 ds.
IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Russia

10. NAME OF FATHER: Fred Mayer

11. BIRTHPLACE OF FATHER (State or Country): Russia

12. MAIDEN NAME OF MOTHER: Dora Walter

13. BIRTHPLACE OF MOTHER (State or Country): Russia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Lena L. Mayer
(Address) American Falls, Idaho

15. Filed ..... 191....
R. F. Roth
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

40

16. DATE OF DEATH: Nov. (Month) 6 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 25th 1921 to Nov. 6th 1921
that I last saw h[illegible] alive on Nov. 6th 1921
and that death occurred on the date stated above, at 11 a M.

The CAUSE OF DEATH* was as follows:
Hepatic Cancer
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... Yrs. ..... mos. ..... ds.
(Signed) V. G. Logan M. D.
19.... (Address) American Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: American Falls, Ida
DATE OF BURIAL: Nov. 8. 1921

20. UNDERTAKER: American Falls
ADDRESS: Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 25
Primary Registration District No. 2072
File No. 40140
Registered No.

1. PLACE OF DEATH.
County of Power
City of American Falls (No. Idaho St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Chas Newton Joiner

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Not known

6. DATE OF BIRTH
Not known (Month) (Day) (Year)

7. AGE
About 61 yrs. mos. ds.
IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Not known
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Not known

10. NAME OF FATHER: Not known

11. BIRTHPLACE OF FATHER (State or Country): Not known

12. MAIDEN NAME OF MOTHER: Not known

13. BIRTHPLACE OF MOTHER (State or Country): Not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A. W. Davis Coroner
(Address) American Falls, Idaho

15.
Filed 191
R. F. Nott
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Nov 28th 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 27th 9:30 PM 1921, to 191, that I last saw h alive on Nov. 27th 9:30 PM 191, and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows: Uraemia Dr Logan
Gave him a hypodermic
Heart medicine at 9:30 PM Nov 27th
(Duration) yrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) W. F. Logan M. D.
19 (Address) American Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
American Falls, Ida	Dec 2 1921

20. UNDERTAKER	ADDRESS
A. W. Davis	Am Falls, Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED
DEC 10 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH.

40141

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 21-

Primary Registration District No. 2072

File No. 3

Registered No. 138

County of Power

City of American Falls, Idaho (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lydia H. Bliss

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH. Feb (Month) 22 (Day) 1840 (Year)

7. AGE: 81 Yrs. 9 Mos. 6 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): ILLs

10. NAME OF FATHER: J.P.Miner

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Bennett

13. BIRTHPLACE OF MOTHER (State or Country): New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elmer L Decker

(Address) American Falls, Idaho

15. Filed 12-2 1921

A F Mott
Local Registrar

MEDICAL CERTIFICATE OF DEATH 64

16. DATE OF DEATH: Nov (Month) 28 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 27 1921, to Nov 28 1921, that I last saw h alive on Nov 28 1921, and that death occured on the date stated above, at 9 a. M.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary) Carbuncle

(Duration ..... yrs. 6 mos. — ds.

(Signed) C. F. Schlick M. D.

11/29 1921 (Address) Amer Falls, Ida

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Bliss Idaho — DATE OF BURIAL: Dec 2 1921

20. UNDERTAKER: A W Davis — ADDRESS: Am Falls Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24658

RECEIVED
MAR 23 1923
BUREAU OF VITAL STATISTICS

FORM V. S. No. 5-25 M. 1-16

CERTIFICATE OF DEATH.

41146

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 41146

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Owyhee

City of Bruneau

Registration District No. 44

Primary Registration District No. .....

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Milton E Reynolds

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. January 20 (Month) (Day) 1874 (Year)

7. AGE: 47 Yrs. ..... Mos. 3 ds. 14

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Bank Cashier

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: James A Reynolds

11. BIRTHPLACE OF FATHER (State or Country): Virginia

12. MAIDEN NAME OF MOTHER: Laura Moore

13. BIRTHPLACE OF MOTHER (State or Country): Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Minnie B Reynolds

(Address) Bruneau, Idaho

15.

Filed May 4 1921 H. H. Becker, Local Registrar

SYMS - YORK CO., PTRS. & STRS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 4 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 19 1921, to May 4 1921, that I last saw him alive on May 4 1921, and that death occured on the date stated above, at 11 P. M.

The CAUSE OF DEATH* was as follows: Acute Nephritis

(Duration) ..... Yrs. ..... mos. 2 1 ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) H. H. Becker M. D.

19..... (Address) Bruneau Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mountain Home Ida

DATE OF BURIAL: May 5 1921

20. UNDERTAKER: A. W. Conover

ADDRESS: Mountain Home Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM U.S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 43220
Registered No. 18

1. PLACE OF DEATH
County of Elmore
City of Mtn Home (St.)
Registration District No. 34
Primary Registration District No. 2020
If death occurs away from usual residence, give facts called for under special information.

RECEIVED DEC 8 1921 BUREAU OF VITAL STATISTICS

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Joseph P. Boyle

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	white	Widower

6. DATE OF BIRTH
unknown (Month) (Day) 1 (Year)

7. AGE
about 70 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Merchant + P. M.
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Ohio Indiana

10. NAME OF FATHER unknown

11. BIRTHPLACE OF FATHER (State or Country) " "

12. MAIDEN NAME OF MOTHER " "

13. BIRTHPLACE OF MOTHER (State or Country) " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) S. W. H. Easton, Coroner
(Address) Mtn Home Ida

15.
Filed 10-22- 1921
J. E. Evans
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH 182

16. DATE OF DEATH
Oct 16 1921
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....,
that I last saw h..... alive on ....., 19.....,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Gun shot wound in back of head, from the hand of unknown assassin
motive robery (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) S. W. H. Easton, Coroner M. D.
10/18 1921 (Address) Mtn Home Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL C. M. Conover Undertaker Mtn Home Ida — DATE OF BURIAL ..... 19.....

20. UNDERTAKER C. M. Conover — ADDRESS Mtn Home Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

46236

1 PLACE OF DEATH
County Nez Perce State Idaho Registered No. 1
Township Indian reservation or Village or
City No. St., Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME William Alfrey

(a) Residence. No. St., Ward.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word)
Male	Indian 1/2	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Ellen Broncheche

6 DATE OF BIRTH (month, day, and year) 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ---- hrs. or ---- min.
	43			

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Indian Res
(State or country) Idaho

PARENTS

10 NAME OF FATHER Bill Alfredy(White)
11 BIRTHPLACE OF FATHER (city or town) unknown
(State or country)
12 MAIDEN NAME OF MOTHER Isaac, Mary
13 BIRTHPLACE OF MOTHER (city or town) Indian res
(State or country) Idaho

14 Informant Frank Broncheche
(Address) Culdesac, Id ho

15 Filed 12-7-21, 19 Corbett Sawyer
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-7-21 19

17 I HEREBY CERTIFY, That I attended deceased from
, 19, to , 19,
that I last saw h alive on , 19,
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY
(SECONDARY)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Corbett Sawyer Lease clk M. D.
, 19 (Address) Lapwai, Idaho

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Indian cemetary	12-8-21, 19
20 UNDERTAKER Lapwai,	ADDRESS

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

8—209 d
V. S. No. 98

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

46212 2

1 PLACE OF DEATH
County Nez Perce State Idaho Registered No.
Township Indian Reservztion or Village or
City No. St., Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Pelalekartsat

(a) Residence. No. St., Ward.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Female	Indian 4/4	SINGLE

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66			

8 OCCUPATION OF DECEASED.
(a) Trade, profession, or particular kind of work Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Indian res
(State or country) Idaho

PARENTS

10 NAME OF FATHER unknown
11 BIRTHPLACE OF FATHER (city or town) unknown
(State or country) Idaho
12 MAIDEN NAME OF MOTHER unknown
13 BIRTHPLACE OF MOTHER (city or town) unknown
(State or country)

14 Informant Corbett Lawyer
(Address) Lapwai, Idaho.

15 Filed 2-26-22, 19 Corbett Sawyer
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-26-21 19

17 I HEREBY CERTIFY, That I attended deceased from
, 19, to , 19,
that I last saw h alive on , 19,
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:

Old age

(duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed Corbett Sawyer Lease Clerk, M. D.
, 19 (Address) Lapwai, Idaho.

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Indian cemetary 2-26-21	19
20 UNDERTAKER Wm, Lapwai, Idaho	ADDRESS

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

8—209 d
V. S. No. 98

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

1 PLACE OF DEATH
County Nez Perce State Idaho Registered No. 4
Township Indian Reservation or Village or
City No. St., Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Daniels (Unnamed baby)

(a) Residence. No. St., Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word)
Male	Indian	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 7-27-21

7 AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
			1	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Indian reservation
(State or country) Idaho

PARENTS

10 NAME OF FATHER William Daniels

11 BIRTHPLACE OF FATHER (city or town) IndRes
(State or country) Idaho

12 MAIDEN NAME OF MOTHER Molly Seven

13 BIRTHPLACE OF MOTHER (city or town) Ind Res
(State or country) Idaho

14 Informant John Seven
(Address) Juliaetta Idaho

15 Filed 7/27/22 19 Coarbett Lawyer
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-28-21 19

17 I HEREBY CERTIFY, That I attended deceased from
, 19, to , 19,
that I last saw h alive on , 19,
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:

Unknown- No attending physician

(duration) yrs. mos. ds.

CONTRIBUTORY
(SECONDARY)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Coarbett Lawyer Lease Clk M. D.
, 19 (Address) Lapwai, Idaho

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Indian cemetary	7-28-21 19
20 UNDERTAKER J.N.Wann L ADDRESS Lapwai, Idaho	

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

8—209 d
V. S. No. 98

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

40215
Registered No.

1 PLACE OF DEATH
County Idaho County State Idaho
Township Ind reservation or Village or
City No. St., Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Dickson, Willis

(a) Residence. No. St., Ward.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word)
Male	Indian	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of
---

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ---- hrs. or ---- min.
		3		

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Ind reservation
(State or country)

PARENTS

10 NAME OF FATHER James G. Dickson

11 BIRTHPLACE OF FATHER (city or town) Ind res
(State or country) Idaho

12 MAIDEN NAME OF MOTHER Edith Corbett

13 BIRTHPLACE OF MOTHER (city or town) Ind res
(State or country) Idaho

14 Informant J. J. Guyer
(Address) Kamiah, Idaho

15 Filed 9-27-21 19 Corbett Lease Cl
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-27-21 19

17 I HEREBY CERTIFY, That I attended deceased from
---, 19---, to ---, 19---,
that I last saw h--- alive on ---, 19---,
and that death occurred, on the date stated above, at ---m.
The CAUSE OF DEATH* was as follows:

Pneumonia

--- (duration) --- yrs. --- mos. --- ds.

CONTRIBUTORY (SECONDARY) ---
--- (duration) --- yrs. --- mos. --- ds.

18 Where was disease contracted if not at place of death? ---
Did an operation precede death? --- Date of ---
Was there an autopsy? ---
What test confirmed diagnosis? ---

(Signed) Corbett Lease Clerk, M. D.
, 19 (Address) Lapwai, Idaho

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Indian cemterary	9-28-21 19
20 UNDERTAKER	ADDRESS
Trennary	Kooskia, Idaho

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

8—209 d
V. S. No. 98

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

1 PLACE OF DEATH
County Nez Perce State Idaho 10651 Registered No. 1
Township Indian Reservation or Village or
City No. St., Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Grant, Jennie

(a) Residence. No. St., Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word)
FEMALE	Indian 4/4	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Bej. Thomspon

6 DATE OF BIRTH (month, day, and year) 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55			

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Indian reservation
(State or country) Idaho

PARENTS
10 NAME OF FATHER Jesse James
11 BIRTHPLACE OF FATHER (city or town) Ind Res
(State or country) Idaho
12 MAIDEN NAME OF MOTHER unknown
13 BIRTHPLACE OF MOTHER (city or town) Ind Res
(State or country) Idaho

14 Informant Benj Five Crows
(Address) Myrtle Idaho

15 Filed 8-4-21, 19 Corbett Lawyer
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-4-1921 19

17 I HEREBY CERTIFY, That I attended deceased from
, 19, to , 19,
that I last saw h alive on , 19,
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:

Heart failure

(duration) yrs. mos. ds.
CONTRIBUTORY
(SECONDARY)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Corbett Lawyer Lease Clk, M. D.
, 19 (Address) Lapwai, Idaho

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Indian cemetary	8-5-21 19
20 UNDERTAKER Mann, Lapwai, Idaho	ADDRESS

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

8—209 d
V. S. No. 98

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

1 PLACE OF DEATH
County Nez Perce State Idaho Registered No. 2
Township Indian reservation or Village or
City No. St., Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Bronche, Jr., Joseph

(a) Residence. No. St., Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Male	Indian 3/4	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ---------

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ---- hrs. or ---- min.
	1			

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work -none-
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Spalding,
(State or country) Idaho

PARENTS
10 NAME OF FATHER Joseph Bronche
11 BIRTHPLACE OF FATHER (city or town) Ind Res
(State or country) Idaho
12 MAIDEN NAME OF MOTHER SOPHIA DAVIS
13 BIRTHPLACE OF MOTHER (city or town) Indi Res
(State or country) Idaho

14 Informant Carlett Sawyer
(Address) Lapwai, Idaho.

15 Filed 8-24-21 Carlett Sawyer
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-24-21 19

17 I HEREBY CERTIFY, That I attended deceased from
----------, 19----, to ----------, 19----,
that I last saw h---- alive on ----------, 19----,
and that death occurred, on the date stated above, at ----------m.
The CAUSE OF DEATH* was as follows:
pneumonia

---------- (duration) ---- yrs. ---- mos. ---- ds.
CONTRIBUTORY
(SECONDARY)
---------- (duration) ---- yrs. ---- mos. ---- ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? ---------- Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) Carlett Sawyer Clerk, M. D.
, 19 (Address) Lapwai, Idaho

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Indian cemetary	8-25-21 19
20 UNDERTAKER Wann, Lapwai, Idaho.	ADDRESS

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

8—209 d
V. S. No. 98

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
40252 2

1 PLACE OF DEATH
County Nez Perce State ____ Registered No. ____
Township Indian reservation or Village ____ or
City ____ No. ____, ____ St., ____ Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Mary Carter

(a) Residence. No. ____ St., ____ Ward. ____
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word)
Female	Indian 4/4	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of widowed

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	82			

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) ____
(c) Name of employer

9 BIRTHPLACE (city or town) Indian Res.
(State or country) Idaho

PARENTS
10 NAME OF FATHER unknown
11 BIRTHPLACE OF FATHER (city or town) unknown
(State or country)
12 MAIDEN NAME OF MOTHER unknown
13 BIRTHPLACE OF MOTHER (city or town) Indian Res
(State or country) Idaho

14 J.J. Guyer
Informant
(Address) Kamiah, Idaho.

15 Filed 10-10-21, 19 Leahutt Lawyer
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-9-21, 19

17 I HEREBY CERTIFY, That I attended deceased from ____, 19____, to ____, 19____,
that I last saw h____ alive on ____, 19____,
and that death occurred, on the date stated above, at ____m.
The CAUSE OF DEATH* was as follows:

T.B.

____ (duration) ____ yrs. ____ mos. ____ ds.
CONTRIBUTORY (SECONDARY) ____
____ (duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death? ____
Did an operation precede death? ____ Date of ____
Was there an autopsy? ____
What test confirmed diagnosis? ____

(Signed) Lease Clk, M. D.
, 19 (Address) Lapwai, Idaho.

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Indian cemetary	10-10-21
20 UNDERTAKER Johnson, Kamiah, Idaho.	ADDRESS

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

8—209 d
V. S. No. 98

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

8—209 d
V. S. No. 98

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

1615

1 PLACE OF DEATH
County Nez Perce State Idaho Registered No. 1
Township Indian reservation or Village or
City No. St., Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Philip McFarland

(a) Residence. No. St., Ward.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word)
Male	Indian	Single

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of widowed

6 DATE OF BIRTH (month, day, and year) 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ---- hrs. or ---- min.
	66			

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Indian Res
(State or country) Idaho

PARENTS

10 NAME OF FATHER Enoch McFarland

11 BIRTHPLACE OF FATHER (city or town) Indian Res
(State or country) Idaho

12 MAIDEN NAME OF MOTHER Mary McFarland

13 BIRTHPLACE OF MOTHER (city or town) Indian Res
(State or country) Idaho

14 Informant Mary Ellenwood
(Address) Lapwai, Idaho.

15 Filed 10-5-21, 19 Cashett Lawyer
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct5 1921 19

17 I HEREBY CERTIFY, That I attended deceased from
, 19, to , 19,
that I last saw h alive on , 19,
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY
(SECONDARY)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) Cashett Lawyer Lease clk M. D.
, 19 (Address) Lapwai, Idaho.

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Indian cemetary	10-6-21 19

20 UNDERTAKER Ente prise Under. Enterprise Ore
ADDRESS

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

46254
Registered No. 1

1 PLACE OF DEATH
County Indian Res State Idaho
Township ____ or Village ____ or
City ____ No. ____ St., ____ Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Charles Bartlett

(a) Residence. No. Lapwai, Idaho St., ____ Ward. Lapwai, Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Male	Indian ½	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1891

7 AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	32			

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Invalid
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Ind Res.
(State or country) Idaho

PARENTS
10 NAME OF FATHER Ned Bartlett
11 BIRTHPLACE OF FATHER (city or town) Whiteman
(State or country) (Unknown)
12 MAIDEN NAME OF MOTHER Louisa Bartlett
13 BIRTHPLACE OF MOTHER (city or town) Ind Res
(State or country) Idaho

14 Informant Corbett Lawyer
(Address) Lapwai, Idaho.

15 Filed 7/7/21 19 Corbett Lawyer
REGISTRAR

11—3184

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-7-21 19

17 I HEREBY CERTIFY, That I attended deceased from
____, 19____, to ____, 19____,
that I last saw h____ alive on ____, 19____,
and that death occurred, on the date stated above, at ____m.
The CAUSE OF DEATH* was as follows:

Killed in auto accident

____ (duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (SECONDARY) ____
____ (duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death? ____
Did an operation precede death? ____ Date of ____
Was there an autopsy? ____
What test confirmed diagnosis? Corbett Lawyer

(Signed) Lease Clk, M. D.
, 19 (Address) Lapwai, Idaho

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Indian cemetary	7/8/21 19
20 UNDERTAKER Wann Bros. Lapwai, Idaho	ADDRESS

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

8—20M d
V. S. No. 96

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

40255

1 PLACE OF DEATH
County Indian Res State Idaho Registered No. 2
Township ____ or Village ____ or
City ____ No. ____, St., ____ Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Martha Cornelius
(a) Residence. No. Ahsahka Idaho St., ____ Ward. ____
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

8—200 d
V. S. No. 98

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Female	Indian ½	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Widow

6 DATE OF BIRTH (month, day, and year) 18 54

7 AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	67			

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Ind Res. Idaho
(State or country)

PARENTS

10 NAME OF FATHER unknown
11 BIRTHPLACE OF FATHER (city or town) Idaho
(State or country)
12 MAIDEN NAME OF MOTHER Hotyayah ~~unknown~~
13 BIRTHPLACE OF MOTHER (city or town) Idaho
(State or country)

14 Informant ____
(Address) Lapwai, Idaho.

15 Filed 7-17-21 Corbett Sawyer
REGISTRAR

11—3184

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-17-21 19

17 I HEREBY CERTIFY, That I attended deceased from
____, 19____, to ____, 19____,
that I last saw h____ alive on ____, 19____,
and that death occurred, on the date stated above, at ____m.
The CAUSE OF DEATH* was as follows:

T B

(no physician)

____ (duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (SECONDARY) ____
____ (duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? ____ Date of ____
Was there an autopsy?
What test confirmed diagnosis?

(Signed) Corbett Sawyer Lease Clk, M. D.
, 19 (Address) Lapwai, Idaho

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Indian cemetary	7-18-23 19
20 UNDERTAKER	ADDRESS
Orofino Undertaking Co.	Orofino, Idaho

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

46256
Registered No. 23

1 PLACE OF DEATH
County Indian Reservation State Idaho
Township ____ or Village ____ or
City ____ No. ____, St., ____ Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Wapsheli, Bertha

(a) Residence. No. ____ St., ____ Ward. ____
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

8—209 d
V. S. No. 96

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: Indian
5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE — Years: 3 | Months: | Days: | If LESS than 1 day, ____ hrs. or ____ min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town): Bundy, Idaho
(State or country)

PARENTS

10 NAME OF FATHER: Willie Wapsheli
11 BIRTHPLACE OF FATHER (city or town): Ind Res
(State or country): Idaho
12 MAIDEN NAME OF MOTHER: Nancy Hoyt
13 BIRTHPLACE OF MOTHER (city or town): Ind Res
(State or country): Idaho

14 Informant: J. J. Guyer
(Address): Kamiah Idaho

15 Filed 7-18-21 Corbett Lawyer
REGISTRAR

11—3184

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-18-21 19

17 I HEREBY CERTIFY, That I attended deceased from
____, 19____, to ____, 19____,
that I last saw h____ alive on ____, 19____,
and that death occurred, on the date stated above, at ____ m.
The CAUSE OF DEATH* was as follows:

T.B.

(No physician)

____ (duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (SECONDARY) ____
____ (duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death? ____
Did an operation precede death? ____ Date of ____
Was there an autopsy? ____
What test confirmed diagnosis? ____

(Signed) Corbett Lawyer Lease Clk, M. D.
, 19 (Address) Lapwai, Idaho

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Indian cemetary	7-18-21 19
20 UNDERTAKER: W.A.Shaw,O	ADDRESS
rofin	

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

1 PLACE OF DEATH
County Nez Perce State Idaho Registered No. 40251 2
Township Indian Reservation or Village ____ or
City ____ No. ____, ____ St., ____ Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Caleb McAtty

(a) Residence. No. ____ St., ____ Ward. ____
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word)
Male	Indian	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Ellen McAtty

6 DATE OF BIRTH (month, day, and year) 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	65			

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Indian Res.
(State or country) Idaho

PARENTS

10 NAME OF FATHER unknown
11 BIRTHPLACE OF FATHER (city or town) Indian Res
(State or country) Idaho
12 MAIDEN NAME OF MOTHER unknown
13 BIRTHPLACE OF MOTHER (city or town) Indian Res
(State or country) Idaho

14 Informant J.J. Guyer
(Address) Kamiah, Idaho.

15 Filed 11-29-21, 19 Carlell Langer
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-29-21 19

17 I HEREBY CERTIFY, That I attended deceased from ____, 19____, to ____, 19____,
that I last saw h____ alive on ____, 19____,
and that death occurred, on the date stated above, at ____m.
The CAUSE OF DEATH* was as follows:

T.B.

____ (duration) ____ yrs. ____ mos. ____ ds.
CONTRIBUTORY (SECONDARY) ____
____ (duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death? ____
Did an operation precede death? ____ Date of ____
Was there an autopsy? ____
What test confirmed diagnosis? ____

(Signed) Smith Lawyer Le se Clerk, M. D.
, 19 (Address) Lapwai, Idaho

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Indian cemetary	11-30-21 19
20 UNDERTAKER Johnson, Kamiah, Idaho.	ADDRESS

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

8—209 d
V. S. No. 98

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

10258 1

1 PLACE OF DEATH
County Nez Perce State Idaho Registered No.
Township Indian reservation or Village or
City No. St., Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Arthur Allen

(a) Residence. No. St., Ward.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word)
Male	Indian	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ---- hrs. or ---- min.
	15			

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Indian Res.
(State or country) Idaho

PARENTS

10 NAME OF FATHER Calvin Allen

11 BIRTHPLACE OF FATHER (city or town) Ind Res
(State or country) Idaho

12 MAIDEN NAME OF MOTHER Annie Allen

13 BIRTHPLACE OF MOTHER (city or town) Indian Res
(State or country) Idaho

14 Informant Corbett Lawyer
(Address) Lapwai, Idaho

15 Filed 11-10-21, 19 Corbett Lawyer
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-9-21 19

17 I HEREBY CERTIFY, That I attended deceased from
----------, 19---, to ----------, 19---,
that I last saw h--- alive on ----------, 19---,
and that death occurred, on the date stated above, at ----m.
The CAUSE OF DEATH* was as follows:

T.B.

---------- (duration) --- yrs. --- mos. --- ds.

CONTRIBUTORY (SECONDARY) ----------
---------- (duration) --- yrs. --- mos. --- ds.

18 Where was disease contracted if not at place of death? ----------

Did an operation precede death? ---------- Date of ----------

Was there an autopsy? ----------

What test confirmed diagnosis? ----------

(Signed) [illegible] Lease Clerk, M. D.
, 19 (Address) Lapwai, Idaho.

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Indian cemetary	11-10-21 19
20 UNDERTAKER Wann, Lapwai, Idaho.	ADDRESS

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

8—209 d
V. S. No. 98

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH 46366

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 46366

Local Registrar's No.

Registration District No. 79

Primary Registration District No. 2156

1. PLACE OF DEATH

County of Boundary

City of Bonners Ferry

(No. County Jail St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Frank Rizzo

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

6. DATE OF BIRTH: Unknown (Month) 1 (Day) (Year)

7. AGE: 41 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Common laborer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ciminna, Italy

10. NAME OF Father: Unknown

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER: Maria Orlando

13. BIRTHPLACE OF MOTHER (State or Country): Italy

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) F. Celio

(Address) 223 Wash. St. Spokane, Wash.

15. Filed July 22 1921

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 20th (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..., to ..... 19...,

that I last saw h... alive on ..... 19...,

and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Suicide

Hanging

(Duration) ... yrs. ... mos. ... ds.

Contributory (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) E. E. Simmons Coroner M. D.

July 21 1921 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... ds.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL ... 19...

20. UNDERTAKER | ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Please return to [illegible] Idaho

STATE OF IDAHO)
) ss.
County of Boundary)

E. E. Saunders, being first duly sworn on oath, deposes and says that he was from the second Monday in January, 1921 to the second Monday in January, 1923, the duly elected, qualified and acting coroner of the County of Boundary, State of Idaho; that on or about the 20th day of July, 1921 he was called to the county jail of Boundary County and upon going there found a man, giving the name of Frank Rizzo, hanging by the neck from the iron grating on the rear end of the cells in the jail of Boundary County, Idaho; that Frank Rizzo was dead when he arrived and had been dead, from the examination made at that time, approximately an hour and a half or two hours, and that he had evidently committed suicide.

Further affiant sayeth not.

E. E. Saunders

Subscribed and sworn to before me this 21st day of July, 1924.

O. C. Wilson

Notary Public for State of Idaho
Residing in Bonners Ferry.

Delayed Complete June 1921

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

50965

RECEIVED
OCT 23 1922
U.S. VITAL STATISTICS

PLACE OF DEATH
County ____ Ft Hall Reservation State Idaho Registered No. 6
Township ____ or Village ____ or
City ____ No. ____, ____ St., ____ Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Raphael Bat

(a) Residence. No. ____ St., ____ Ward. ____
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred ___ yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Male	Ind 4/4	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ____

6 DATE OF BIRTH (month, day, and year) 1916

7 AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	5	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work at home
(b) General nature of industry, business, or establishment in which employed (or employer) ____
(c) Name of employer ____

9 BIRTHPLACE (city or town) ____
(State or country) Ft. Hall Reservation

PARENTS
10 NAME OF FATHER Johnnie Bat
11 BIRTHPLACE OF FATHER (city or town) ____
(State or country) Idaho
12 MAIDEN NAME OF MOTHER Maggie Bobb
13 BIRTHPLACE OF MOTHER (city or town) ____
(State or country) Nevada

14 Informant Johnnie Bat
(Address) Ft. Hall, Idaho

15 Filed ____, 19 ____ REGISTRAR

11—3184

MEDICAL CERTIFICATE OF DEATH

10

16 DATE OF DEATH (month, day, and year) June 30 1921

17 No doctor attending

I HEREBY CERTIFY, That I attended deceased from ____, 19____, to ____, 19____,
that I last saw h____ alive on ____, 19____,
and that death occurred, on the date stated above, at 5 a m.

The CAUSE OF DEATH* was as follows:

Ilio

(duration) ___ yrs. ___ mos. 5 ds.

CONTRIBUTORY (SECONDARY) Pneumonia Bronchial

(duration) ___ yrs. ___ mos. 5 ds.

18 Where was disease contracted if not at place of death? ____

Did an operation precede death? No. Date of ____

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Henry R. Wheeler, M. D.
,19 (Address) Ft. Hall, Idaho

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Ft. Hall Reservation	July 1. 1921
20 UNDERTAKER Brown & Eldredge	ADDRESS Blackfoot Idaho

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

5—209 d
V. S. No. 98

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-23 M. D. 19 RECEIVED NOV 13 19

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 55208

Local Registrar's No. 46

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Custer

City of Clayton

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 108

Primary Registration District No. 2186

(No. ..... St.)

2. FULL NAME Tony Yacomella

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	White	

6. DATE OF BIRTH: Jan. (Month) 10 (Day) 1921 (Year)

7. AGE: ..... Yrs. ..... Mos. 12 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF Father Antone Yacomella

11. BIRTHPLACE OF FATHER (State or Country) Italy.

12. MAIDEN NAME OF MOTHER Domenica Del Re

13. BIRTHPLACE OF MOTHER (State or Country) Italy.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) .....
(Address) .....

15. Filed Oct. 23 1926 Edna McKenny Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 22 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 16 1926. to Jan 16 1926., that I last saw him alive on Jan 16 1926, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Pneumonia

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. L. Kirtley M. D.

19 ..... (Address) Clayton Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Clayton — DATE OF BURIAL: Jan 23 1926

20. UNDERTAKER: Friends — ADDRESS: Clayton

RECEIVED AUG 11 1931

Shaw Stone 26 54

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 28

Primary Registration District No. 2161

File No. 4 J 75788

Registered No. 3653

1. PLACE OF DEATH.

County of Bannock

City of Pocatello (No. St Anthonys Hosp St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Sarah Gertrude (Shaw) Stone

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
F	W	Married

6. DATE OF BIRTH: Mar 4 1867 (Month) (Day) (Year)

7. AGE: 54 yrs. 8 mos. 2 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ut.

10. NAME OF FATHER: John Nelson

11. BIRTHPLACE OF FATHER (State or Country): Ut.

12. MAIDEN NAME OF MOTHER: Sarah Addaide Wheeler

13. BIRTHPLACE OF MOTHER (State or Country): Ogden Ut.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Nelson
(Address) Pocatello

15. Filed 11/9 1931 H E Lemmon Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Nov (Month) 8 (Day) 1931 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 5 1931, to Nov 8 1931 that I last saw her alive on Nov 8 1931 and that death occurred on the date stated above, at 20 P.M.

The CAUSE OF DEATH* was as follows:

Peritonitis

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) Ruptured Gall Ectopic Pregnancy

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H E Lemmon M. D.

11/8 1931 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Blackfoot	11/10 1931

20. UNDERTAKER	ADDRESS
W T Walden	Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

RECEIVED MAR 7 1932

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 78120

PLACE OF DEATH
County of Shoshone
City of Kellogg

Registration District No. 123
Primary Registration District No. 1201

78120
Local Registrar's No. 16

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

101 9

2. FULL NAME John Biotti

(a) Residence. No. 139 W St. Mission
(Usual place of abode) (If nonresident give city or town and state)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Rachela Biotti

6. DATE OF BIRTH (month, day, and year) August 9, 1851

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
70 years	1	1	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookeeper, etc. Businessman

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Saloon-keeper

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation 35 yrs

12. BIRTHPLACE (city or town) Besano
(State or country) Lombardia, Italy

FATHER

13. NAME Barnard Biotti

14. BIRTHPLACE (city or town) Besano
(State or country) Lombardia, Italy

MOTHER

15. MAIDEN NAME Margerita Vergobbi

16. BIRTHPLACE (city or town) Besano
(State or country) Lombardia, Italy

17. INFORMENT E.P.Biotti
(Address) 199 W Mission, Kellogg, Ida

18. BURIAL, CREMATION, OR REMOVAL
Place Kellogg, Ida. Date Sept 12 21

19. UNDERTAKER M.E. Thornhill
(Address) Kellogg, Idaho

20. FILED Mar. 4, 1932 Mrs. Helen McBride
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, and year) Sept 10 1921

22. I HEREBY CERTIFY, That I attended deceased from ....., 193..., to ....., 193...
I last saw h alive on Sept 10, 1931: death is said to have occurred on the date stated above, at ..... m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Lobar pneumonia	
Other contributory causes of importance:	
Sclerosis	

Name of operation None Date of .....
What test confirmed diagnosis? Clinical Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide? ..... Date of injury ....., 193..
Where did injury occur? .....
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place. .....
Manner of injury .....
Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased?
..... If so, specify .....
(Signed) Oscar Kennett, M. D.
(Address) Kellogg, Idaho

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

RECEIVED JAN 5 1933

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 81766

PLACE OF DEATH
County of Gooding
City of Hagerman
Registration District No.
Primary Registration District No. Local Registrar's No.
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Emma Sophrona Jolley

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and state)
Length of residence in city or town where death occurred. 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Milton M. Jolley

6. DATE OF BIRTH (month, day, and year) Feb 17 1873

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
59	8	1	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookeeper, etc. Housewife

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Shunesburg Utah

FATHER

13. NAME James Saxton

14. BIRTHPLACE (city or town) (State or country) Dent Knox

MOTHER

15. MAIDEN NAME Mrs Helen Grimes

16. BIRTHPLACE (city or town) (State or country) Dent Knox

17. INFORMENT (Address) Milton M. Jolley Hagerman

18. ~~BURIAL, CREMATION,~~ OR REMOVAL Place Jolley Date Oct 20 193?

19. UNDERTAKER (Address) Evans & Sons Buhl

20. FILED Oct 20, 1932 R. H. Evans Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, and year) Oct. 18 1932

22. I HEREBY CERTIFY, That I attended deceased from May 27-1931, 193?, to Oct 18th, 1932

I last saw her alive on Feby 20th, 1932: death is said to have occurred on the date stated above, at m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Thyroid Adenoma Toxic	Nov 1930

Other contributory causes of importance

Myocarditis Toxic Secondary to dilation Acute Heart.	Dec 1930

Name of operation None Date of

What test confirmed diagnosis? BMR Was there an autopsy No

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? No Date of injury , 193

Where did injury occur? None (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place. No

Manner of injury No

Nature of injury No

24. Was disease or injury in any way related to occupation of deceased? No If so, specify

(Signed) Duncan L. Alexander, M. D.

(Address) Twin Falls Ida

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

Form V. S. No. 12

CAUSE OF DEATH

STATE OF WYOMING
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

County of _____ RECEIVED AUG 10 1921 BUREAU OF VITAL STATISTICS

File No. 87638

Town of _____ Registration District No. _____ Registered No. _____

or

City of _____ No. _____ St.

[If death occurred in a Hospital or Institution give its NAME instead of street and number.]

[If death occurs away from USUAL RESIDENCE give facts called for under "Special Information"]

FULL NAME Earl Marks

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

M. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, that it may be properly classified. The "Special Information" for persons dying away from home should be given in every instance

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

COLOR: White

DATE OF BIRTH: Sept (Month) 29 (Day) 1901 (Year)

AGE: 19 years, 8 months, 21 days.

SINGLE, MARRIED WIDOWED OR DIVORCED: Single

BIRTHPLACE (State or Country): Butte, Mont.

OCCUPATION: Laborer

NAME OF FATHER: David Marks

BIRTHPLACE OF FATHER (State or Country): Austria

MAIDEN NAME OF MOTHER: Smith

BIRTHPLACE OF MOTHER (State or Country): Germany

THE ABOVE STATED PERSONAL PARTICULARS ARE TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF

(Informant) Father

(Address) Blackfoot Ida

Filed _____ 19____ Mrs Chas Delo... Reg...

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: June (Month) 19 (Day) 1921 (Year)

I HEREBY CERTIFY that I attended deceased from May 20 1921 to June 19 1921 that I last saw him alive on June 19 1921 and that death occurred, on the date above stated, at 6.45 P.M.

The CAUSE OF DEATH was as follows:

Pneumonia (Lobar)

Where contracted? Nisqa Construction Camp (Duration) 4 wks.

Contributory delayed resolution

Where contracted? _____ (Duration) _____

(Signed) Chas W Hunt M. D.

June 19 1921 (Address) Jackson Wyo

SPECIAL INFORMATION only for Hospitals, Institutions, Transients or Recent Residents.

Former or Usual Residence

How long at Place of Death? _____ Days

PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL _____ 19____

UNDERTAKER

ADDRESS

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No.....

County of.....

Primary Registration District No.....

File No.....

City of.....

(No....., ...St.)

Registered No.....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Earl Marks

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Sept. (Month) 29 (Day) 901 (Year)

7. AGE: 19 Yrs. 8 Mos. 21 ds.

IF LESS than 1 day how many..... hrs. or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: laborer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Butte, Mont.

10. NAME OF FATHER: David Marks

11. BIRTHPLACE OF FATHER (State or Country): Austria

12. MAIDEN NAME OF MOTHER: Smith

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant): Father

(Address): Blackfoot, Ida.

15. Filed.....19..... Mrs. Chas. Delor ---?

Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 19 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 20 1921 to June 19 1921 that I last saw him alive on June 19 1921 and that death occurred on the date stated above, at 6:45 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia (lobar)

contracted in construction camp.

.....(Duration) .....Yrs.....mos.....ds.

Contributory (Secondary) delayed resolution

.....(Duration) .....yrs.....mos.....ds.

(Signed) Chas. W. Huff M. D.

June 10 1921 (Address) Jackson, Wyo.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL .....19.....

20. UNDERTAKER | ADDRESS

91530

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
91530
State File No.

PLACE OF DEATH

County of Cassia
City of Burley

Registration District No. 117
Primary Registration District No. 2196 Local Registrar's No. 542
(No. 427 D. Paul Idaho)
(If death occurred in a hospital or institution, give its name instead of street and number)

106

2. FULL NAME Henry Fenstermaker

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and state)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. Color or Race: White
5. Single, Married, Widowed or Divorced (write the word): Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day, and year): Jan 24 1898
7. AGE — Years: 23 — Months: 7 — Days: 17 — If LESS than 1 day,... hrs. or ..... min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as **spinner, sawyer, bookkeeper, etc.**: Farming
9. Industry or business in which work was done, as **silk mill, saw mill, bank, etc.**:
10. Date deceased last worked at this occupation (mo. and yr.):
11. Total time (years) spent in this occupation:

12. BIRTHPLACE (city or town) (State or country): Grantsville Utah

FATHER
13. NAME: David A. Fenstermaker
14. BIRTHPLACE (city or town) (State or country): Grantsville Utah

MOTHER
15. MAIDEN NAME: Alice A. Lucas
16. BIRTHPLACE (city or town) (State or country): Salt Lake City Utah

17. INFORMANT (Address): Alice Fenstermaker Paul Idaho
18. BURIAL, CREMATION OR REMOVAL
Place. Burley Ida. Date Sept 12 1921
19. UNDERTAKER (Address): L. B. Gallogly
20. FILED Oct 15 1921 Dr. J. C. Patterson Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day and year): Sept 10 1921

22. I HEREBY CERTIFY, That I attended deceased from Sept. 8, 1921, to Sept. 10, 1921
I last saw him alive on Sept. 10 1921; death is said to have occurred on the date stated above, at 8 a. m.
The **principal cause of death** and related causes of importance were as follows:

	Date of onset
Pulmonary Embolism	
Other **contributory causes** of importance:	
Cancer	

Name of operation..... Date of.....
What test confirmed diagnosis?.... Was there an autopsy?..

23. If death was due to exter'l causes **(violence)** fill in also the following:
Accident, suicide, or homicide?..... Date of injury.., 193.
Where did injury occur?.....
(Specify city or town, county, and state)
Specify whether injury occurred in **industry**, in **home**, or in **public place**.....
Manner of injury.....
Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?.... If so, specify.....
(Signed) H. H. Cooper, M. D.
(Address) Burley Idaho

N. B.---WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING